MEDICALIZATION OF ACADEMIC TROUBLES: THE CASE OF PSYCHOSTIMULANT MEDICATION USE AMONG UNIVERSITY STUDENTS

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ABSTRACT

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Psychostimulant medications which are normally used in the treatment of Attention Deficit Hyperactivity Disorder have been receiving increased academic attention. The existing literature has been focused on explaining the growing psychostimulant use as a function of increasing ADHD diagnoses from the lens of medicalization; as well as exploring the illicit usage of these medications for purposes of performance enhancement, from a health and ethics perspective. Both these approaches fail to represent the complex relationships individuals build with their academic troubles, ADHD diagnoses, and psychostimulant medication use. By shifting the focus to the lived experiences of individuals, this study aims to contextualize performance as it relates to the recognition of academic troubles. The main research question is "How do university students from two high ranking universities in Turkey experience the use of psychostimulant medications as a response to the everyday and academic troubles they encounter?". Through data that was collected from 15 in-depth interviews with students from Middle East Technical University and Boğaziçi University, qualitative analysis was realized around Emerson's (1977) conceptualization of "trouble". The analysis is organized around two themes: i) *Initiation to ADHD and Psychostimulant*

Use, which explores the ways in which students become introduced to the category of ADHD and psychostimulant medications after attempting to formulate intrinsic/informal responses to the troubles they are experiencing, and ii) *Strategies for Ensuring Continual Use*, which focuses on the processes that unfold after extrinsic/official responses have been applied to the trouble that is experienced.

Keywords: medicalization, psychostimulant medications, ADHD, higher education

ÖZ

AKADEMİK SORUNLARIN TIBBİLEŞMESİ: ÜNİVERSİTE ÖĞRENCİLERİ ARASINDA PSİKOSTİMÜLAN İLAÇ KULLANIMI ÖRNEĞİ

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Dikkat Eksikliği ve Hiperaktivite Bozukluğu (DEHB) tedavisi için kullanılan psikostimülan ilaçların öğrenciler tarafından kullanımı son yıllarda sosyal bilimler literatürünün dikkat çektiği bir konu olmuştur. Literatürde iki temel yaklaşım mevcuttur. Tıbbileştirme literatürü bu ilaçların kullanımını DEHB tanısının yaygınlaşması üzerinden açıklamaktadır. Diğer yaklaşım ise bu ilaçların birer performans arttırıcı olarak DEHB tanısı olmaksızın kullanımını ele alır ve bunun sağlık ve ahlaki boyutlarına dikkat çeker. Bu çalışma, bu iki yaklaşıma ek olarak, bireylerin yaşanmış deneyimine odaklanır ve performans kavramını akademik sorunların tanınıp fark edilmesi süreci içinde yeniden bağlama oturtmayı amaçlar. Araştırmanın temel sorusu "Psikostimülan ilaçlar akademik ve günlük zorluklara bir yanıt olarak Türkiye'de yüksek sıralamalı iki üniversiteye kayıtlı öğrenciler tarafından nasıl deneyimlenmektedir?" olarak formüle edilmiştir. Bu çalışma için 15 Orta Doğu Teknik Üniversitesi ve Boğaziçi Üniversitesi öğrencisi ile yarı-yapılandırılmış derinlemesine mülakatlar yapılmıştır ve elde edilen nitel veri, Emerson'un (1977) "sorun" kavramı üzerinden analiz edilmiştir. Analiz iki tema etrafında yapılmıştır. Birinci tema öğrencilerin karşılaştıkları akademik zorluklara geliştirdikleri içsel

yanıtların başarısız olması sonucunda DEHB tanısı ve psikostimülan ilaçlar üzerinden nasıl dışsal/resmi yanıtlar oluşturduklarına odaklanırken, ikinci tema bu sorunlara dışsal/resmi yanıtlar verildikten sonra gerçekleşen süreçleri ele alır.

Anahtar Kelimeler: tıbbileşme, psikostimülan ilaçlar, DEHB, yüksek öğretim

To Nisan!

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CHAPTER 1

INTRODUCTION

1.1. Contextual Introduction

In the recent decades, we have witnessed a growing use of psychostimulant medications among university students, both by those who are diagnosed with ADHD and by those who are engaging in medication use for so-called non-medical purposes especially in the North-American context. Methylphenidate-based substances or "psychostimulant medications" as they will be referred in this thesis, are used in the treatment of Attention Deficit and Hyperactivity Disorder (ADHD). ADHD is "characterized by a persistent pattern of inattention and/or hyperactivity/impulsivity that interferes with functioning or development" (American Psychiatric Association, 2013). Pharmacological therapy is considered first line of treatment for ADHD (Durand-Rivera et al., 2015). Only methylphenidate-based stimulants are available in Turkey and they are sold under the brand names of Ritalin, Concerta and Medikinet. They belong to "the group of medications called central nervous system (CNS) stimulants" (Mayo Clinic, 2022). They increase "the levels of dopamine and norepinephrine in the brain with the potential of augmenting cognitive functioning" (Colzato & Arntz, 2017). Ritalin comes only in the form of immediate release (IR) meaning that active ingredient of the medication is released quickly and its effects last up to 6 hours (Morton & Stockton, 2000), while extended released medications (ER) such as Concerta are released gradually with the effects lasting up to 12 hours.

There have been limited studies done to explore the scope of psychostimulant medication use in Turkey. For instance, there is no available data on the prevalence of non-medical use of psychostimulant medications in Turkey, or on the prevalence rates

of psychostimulant medication use in a sample of university students. The limited number of studies that have been published show an increase in psychostimulant medication use: In their time series study, Oner et al. (2017) stated that between the years of 2009-2013, the annual use of psychostimulant medications increased 2.18 times. Their research utilized IMS Health database, that is, only medically prescribed use cases were identified and taken into calculations. The data is not segregated by age groups or educational level. Another study on the use of controlled prescription medications in Istanbul documented that methylphenidate-based medications are one of the most used controlled prescription medications (Demircan et al., 2013). The study indicated that psychoanaleptics, the category of medications to which methylphenidate belongs, was the fourth most prescribed group of medications among the total of 502,874 reported controlled prescription medications. In other words, despite the limited research and data on the topic, it is safe to say that psychostimulant medications are used nation-wide, and the number of users has been growing steadily in the past decades.

The sociological literature seeking to explain psychostimulant medication use has been biased towards representing the non-medical use cases, and the large-scale quantitative studies have outnumbered the smaller scale, qualitative studies. Large scale studies are focused on measuring prevalence rates, and are mainly interested in who uses psychostimulant medications, for what purposes they are used, and the ethical concerns that arise out of the popularization of medication use, as well as health concerns. In these studies, "performance" is taken as a motivating factor that pushes the students into psychostimulant medication use. However, viewing performance as merely a source of motivation results in a very restricted perspective. Medication use cannot be explained solely by an individual's competitive urges or their desires to enhance their performance.

Medicalization is the second main approach that we see in the literature, which I will expand on in my literature review. Medicalization literature is focused on the discussion of how everyday experiences and problems gain medical meanings and medical significances, becoming treatable disorders in the process. As I will go into detail in the coming sections, medicalization studies frame this discussion in terms of

the spread of medical authority and the colonization of everyday life by medical knowledge. By itself, it cannot answer the question of why medicalization happens in a more concentrated manner when performance concerns become visible and become recognized as troubles. What is required to answer this question is contextualizing performance and collecting individual experiences by keeping contextual and structural factors in mind. Therefore, although this study contributes to medicalization studies, it also seeks to provide some additional context.

In my analysis, I will approach performance as a mechanism that pushes the individual into questioning their own academic trajectory, or self-questioning and evaluating one's own experiences from a medical lens. Therefore, psychostimulant medication use is not viewed as being about individual ambitions of performance enhancement, but rather problematizing of one's own conduct through self-questioning, how academic troubles are reframed as medical categories like ADHD, and the role of performance in the formation of academic troubles like these.

This mechanism is located in a specific socio-historical context. The principal processes that characterize this socio-historical context are higher education failing to keep its old promises in terms of employment guarantees, the transformation of the meanings given to higher education by individuals, the growing number of degrees that do not directly translate into employment opportunities, and the increase in the number of graduates and therefore in competitiveness post-graduation. All of these processes render higher education as a competitive environment in which individuals are expected to distinguish themselves from their peers by means of their personal performance.

Here, performance appears as a concern that comes out of the responsibilization of individuals through shouldering risks that arise out of structural imbalances. In this context, the individual holds their performance as equal to their self-value, because the only thing that can promise them future employability and financial security is their ability to distinguish themselves in an environment of competition. Another factor that causes this dynamic is the perception of entrance to higher education and to the job market through a binary narrative of success or failure: If the person exerts enough

self control, ambition and effort, then they are expected to succeed. If they do not "try hard enough", then they will likely fail. In short, the matter of performance is understood from a highly individualized, personal perspective that puts the burden of structural forces onto the shoulders of individuals.

The main objective of this thesis is to understand how certain moments or perceptions of failure in academic settings become troubles, and how these troubles are reframed as the symptoms of a disorder. This issue is intrinsically related to the socio-historical context that is mentioned above, because the rendering of academic difficulties as personal troubles and their description in terms of medical categories is in fact an example of these broad structural facts becoming individualized in people's experiences.

Therefore, the problematization of this study depends on the social context I mentioned above. I selected my sample from two of the highest ranking universities in Turkey (Middle East Technical University and Boğaziçi University) where these dynamics are most prevalent and visible. Although this context surrounds the entire educational system, we cannot claim that all universities are affected in the same way. Even high-ranking universities can no guarantee a predictable, linear life course to their students and graduates, and it is in this specific context that performance is rendered a matter of trouble.

In this thesis, I focused on the individuals' experiences rather than the construction of performance in a socio-historical context. My main research question is thus "How do students from two high-ranking universities in Turkey experience the use of psychostimulant medications as a response to the everyday and academic troubles they encounter?".

1.2. Literature Review

The literature on the use of psychostimulant medications draws largely on the sample of university students and their patterns of psychostimulant use. Studies that are positioned along the lines of the medicalization thesis suggest that the prevalent use of

psychostimulant medications results from rising rates of Attention Deficit Hyperactivity Disorder (ADHD) diagnosis among university students. The literature of medicalization primarily focuses on the questions of how did ADHD emerge as a legitimate category of disorder, and how does pharmacological treatment get so prevalent. Expansion of ADHD as a medical entity in a way to cover ever-new difficulties within its definition and refocusing on "inattention" as the primary diagnostic criteria change the perception of ADHD as it being an exclusively childhood disorder. These changes took place in the 1994 version of the Diagnostic Statistical Manual for Mental Health Disorders (DSM-IV), stating that adults showing symptoms of ADHD in their childhood are qualified for an ADHD diagnosis (American Psychiatric Association, 1994; Conrad & Potter, 2000). Together with the increasing number of studies suggesting that symptoms of ADHD in childhood can persist into adulthood (Barkley, 2014), and adding work environment and recreational settings as spaces where ADHD-related dysfunction could be observed in adults as the symptoms interfering with "developmentally appropriate social, academic, or occupational functioning" (American Psychiatric Association, 1994), the category of ADHD expanded towards new spaces and populations. Conrad and Potter argue that shifting the definition of ADHD in DSM-IV in the way of accommodating "more variations of symptomatic behavior across and within settings" (Conrad & Potter, 2000, p.569) expanded the boundaries of ADHD diagnosis. The reframing of ADHD in such a way that the new definition allows adults to be diagnosed with the disorder resulted in increasing self-diagnosis (ibid.). As more adults come across the description of ADHD as a disorder, adults seek a doctor's opinion only to get a confirmation of their suspicions (ibid.). Conrad and Potter (2000) conclude that medicalization of everyday difficulties for adults happens to have resulted from adults' information sharing on ADHD, self-labeling themselves, and seeking a diagnosis.

According to the medicalization thesis, this might explain the recent surge in numbers of ADHD diagnoses among adults in the age group of 18 to 24 (Montejano et al., 2011). Increases in the diagnosis of ADHD bring about the broader use of psychostimulant medications as treatment options. The growth does not only occur in using psychostimulant medications with a prescription by the patients. The increasing availability of psychostimulant medications among students results in an exchange

between students and gives way to a relatively new phenomenon of non-medical use of prescription stimulants.

While medical use has been extensively studied from the perspective of the medicalization thesis, non-medical use has been studied beyond the limited terrain of medicalization studies. A sizeable amount of these studies adopts a public health perspective highlighting the health risks associated with psychostimulant medication use. Other studies illuminate ethical and social considerations that the broader use of non-medical prescription stimulants brings about. These studies rely on large-scale research projects employing questionnaires structured around students' patterns of non-medical psychostimulant use and its consequences. One of the major motives for these studies is estimating the prevalence of psychostimulant use within university campuses and taking proper measures to get a hold of the increasing rates of use. Such studies document that drug misuse is most prevalent among university students compared to their non-university peers. (Bennett & Holloway, 2017) Some draw attention to the methodological bias in the overrepresentation of the student population due to the fact that they are the most accessible group to run a study on (Hupli, n.d.; Lopes et al., 2015). Still, it is reported almost unequivocally that prevalence estimates of once-in-a-lifetime use are significantly high for university students, especially in the context of the United States (DeSantis et al., 2008a; Desantis & Curtis Hane, 2010; Petersen et al., 2015a; Robitaille, 2018). Tully et al. (2019) report that lifetime non-medical use of prescription stimulants among students is being estimated within the range of 5-55% for the United States (McCabe et al., 2014), and in parallel with that, the rates of 5-46% are being estimated for the European context. Although the reliability of these results is questionable due to the problems with the standardization of questionnaires and the lack of studies with a representative sample (Tully et al., 2019), it is safe to assume that psychostimulant medication use is more prevalent than ever. The higher estimates of prevalence rates these studies present fuel concerns over health risks (Morton & Stockton, 2000) and raise ethical questions. This, in turn, drives more studies to be done monitoring the students' practices of using psychostimulant medications, their ways of getting access to these medications, and questioning the motivations behind using these medications.

The medicalization thesis has served as a critique of medical knowledge as it showcases how medical professionals maintain social control over those who diverge from prevailing norms of society (Furedi, 2006). This approach proved to be fruitful in showing that a diverse group of medical categories is imbued with the purposes of social control. Obesity, addiction, alcoholism, anxiety, and hyperactivity are just some of the cases where medical knowledge is mapped onto normative judgments and thus results in social control being exerted. The weakness of the medicalization thesis is that they have overestimated the medical profession's power as being the driving force behind medicalization. This critique has been restricted to the study of the "expansion of medical authority into the everyday life" (Dixon et al., 2013). I believe that the medicalization thesis, in its fixation on the expanding jurisdiction of medicine, overlooks the way medical knowledge is constituted by the experiences of individuals during their encounters with the difficulties of daily life. Presenting the accounts of people who are diagnosed with ADHD challenges the view of medicalized individuals as a "docile lay populace in thrall to expansionist medicine" (Ballard & Elston, 2005). I will show that medicalization falls short of taking into account the lay individual's role in constructing medical categories within their everyday experiences.

1.2.1. The Prominence of the Medical Profession in Medicalization Studies

The tendency to assign a prominent role to the medical profession is evident as early as Freidson's (1970) description of doctors as professionals who are "active in seeking out illness" and ambitious to discover new illnesses. Conrad gave a similar account of medical professionals, describing them as medical crusaders echoing Becker's (1963) famous metaphor of "moral crusaders." Moral crusading basically means highlighting of particular behaviors as problematic and setting new normative standards of behavior against problematic behavior through imposing rules of conduct. Such rules are usually suggested by the organization of people from a higher status group with a morally righteous purpose of rehabilitating or eliminating undesirable behavior. In parallel with the original use of the term, Conrad describes medical crusading as a process where particular conditions are highlighted by medical professionals as medical problems with the purpose of changing the public's attitude toward that condition, that is, forcing the public to embrace that condition as a medical problem

(Conrad, 1992). According to this approach, the origin of medicalization is traced back to the intentional effort of professional interest groups. The process of medicalization is framed as if it is a product of the intentional effort of a particular professional group.

This is more evident in a group of medicalization studies that draw on the theme of professionalization. It is another central theme that tries to explain the construction of new medical categories. Reinterpreting everyday problems as medical conditions "mandates and licenses medical profession to provide some type of treatment for it" (Conrad, 1975). Such an approach views medicalization exclusively from the perspective of the medical professions' conscious pursuit of their interest (Furedi, 2006). In other words, the causes of medicalization are sought in the medical organizations that act as political interest groups and try to capitalize on the social problems (Conrad & Schneider, 1992). In their analysis of the medical profession in the US, Conrad and Schneider argue that the source of the status of the medical profession lies primarily in its ability to act as an organized political group through lobbying activities and securing the support of the political and economic elite and that contributes further to their monopolistic status in respect to other professional groups. The significance of establishing their professional dominance is holding the power to develop their medical definitions of deviance over certain conditions that previously had no medical connotations. As Conrad and Schneider (1992) state, "medical work can lead to the creation of new medical norms, whose violation is deviance, or, in the cases we present, new categories of illness." Medicine as an institution simply replaced the institutions of law and religion in their task of imposing social regulation (Freidson, 1970). Professionalization of medicine, its competition with other interest groups, and interprofessional contests are the leading dynamics that contribute to medicalization. That is, medicalization is considered the byproduct of the doctors' attempt to promote their interest by expanding the area over which they claim authority. "Expert control" and "medical social control" have traditionally been two critical themes of medicalization studies (Hafferty, 2006).

1.2.2. Revisions on the Prominence of the Medical Profession

After medicalization studies came under criticism for their overemphasis on the role of medical professionals in the rise of medicalization, the proponents revised their positions. Conrad insisted that medical professionals did not occupy such a critical role in his account of medicalization as he shifted his core concern from the expansion of medical jurisdiction to "how behaviors [are] defined in medical terms" (Busfield, 2017, p.761). Medicalization is now portrayed as a multifaceted, social-cultural process that does not necessarily require the participation of medical professionals, although it might result in the expansion of their authority (Hafferty, 2006). He conceded that professional dominance was a major theme in explaining the process of medicalization but that the role of the medical professionals was essentially accompanied by many other actors, which made it hard to say that medical professionals are at the center of the process (Ballard & Elston, 2005). Conrad's (1975) early study on hyperkinesis presents evidence for his position regarding the centrality of the medical profession within his work. The study shows that hyperkinesis is formed as a medical entity as a result of an interplay between three agents: the first of them is the "pharmaceutical revolution," which pointed out the significance of the production and marketing of stimulants for childhood problems in the construction of "hyperkinesis" as a medical category (Conrad, 1975). The second one is about "trends in the medical profession," which basically refer to a growing psychiatric approach at the time that tends to explain "behavioral problems as biochemical and organic in origin" (Rafolovich, 2004, p.3). Lastly, he cited governments' reports showing their involvement in allowing the use of psychostimulant medications for the treatment of hyperkinesis and also their role in "unifying the symptoms of hyperkinesis into the clinical entity of 'minimal brain dysfunction" (Rafolovich, 2004, p.4). His exposition of the problem can be taken as proof that medical professionals or medicine as an institution alone was not the primary driver of the process of medicalization. He expanded on this line of thought in his later writings, adding that there are other significant actors that are prominent in this process.

The problem is that his study did not deal with the question of how individuals, parents, and the broader public deal with the label of ADHD. The assumption was that it was

all three agents that took part in the creation of a medical entity who came up with a definition without acknowledging how it was received by the public.

1.2.3. Later Studies of Medicalization and Commercialization of Healthcare

Later studies of medicalization propose that it does not take place exclusively on the grounds of the activities of pharmaceutical companies, medical organizations, or governmental action. A whole new array of actors finds their place in Conrad's account. He described these new actors as shifting engines of medicalization whereby consumers, managed care, and biotechnology replaces the privileged position assigned to medical professionals in the medicalization studies (Conrad, 2005). While the early works identify professionalization as the main dynamic of medicalization, later works concentrate on other agents than the process of de-professionalization as the new dynamic of medicalization. The shift in his focus to the changes in the organization of healthcare from the 1980s onward erodes the role of medical authority (Conrad, 2005). While the new model of healthcare is increasingly organized around financial concerns, other players have become increasingly involved in the decision-making process (Conrad & Leiter Valeri, 2004). With the advance of managed care, medical institutions have become commercialized, and healthcare payers have been suggested as the new stakeholders with whom medical professionals have to negotiate their power (Conrad, 2007).

To show that medicalization is not entirely about "medical imperialism," that is, it is not a process that has the end goal of expanding the jurisdiction of medical professionals and sustaining social control (Conrad, 2013), Conrad directs our attention to the changing organization of healthcare, which facilitates the active involvement of consumers in healthcare. As I have stated earlier, this shift in focus was another attempt to give a more comprehensive picture of medicalization that is sensitive to the way the public participates in the process. The discourse of financialization enabled Conrad, and other studies on medicalization, to introduce the consumers as effective agents in the process. According to them, the logic of financialization made the healthcare services a commodity in the marketplace where

users of health services become consumers who are purchasing healthcare and health insurance (Conrad, 2005).

With an adequate amount of knowledge, consumers can hold accountable those with whom they have transaction on the matters of whether they are satisfied with the services provided or whether the services address their needs. So, modeling healthcare service on the transaction between the consumer and the service provider changes the power dynamic and reserves a powerful position for consumers. The demand of consumers can also shape the sort and quality of services offered; that is, demand can push service providers to offer more desirable sorts of services. This is one way that consumerism contributes to medicalization. Consumers, on the basis of the available knowledge, can demand either treatment for a condition that they might be suspicious about experiencing or can demand recognition from doctors about their particular problems as illnesses. Some of the disability rights movements or movements seeking the recognition of certain conditions as mental health disorders are examples of consumerist trends because they exemplify that it is not the medical profession per se that decides the legitimacy of symptoms that patients experience as illness.

These discussions surrounding consumerism mark the closest point Conrad gets to assigning a position to individuals or the lay public in his descriptions of medicalization. It is portrayed as if the power of medical professionals came to be shared with the other actors as a result of structural transformation in the health landscape. A growing number of new terminologies such as “expert patients” are being invented to describe consumerist tendencies and their role in medicalization. I believe this is an unsuccessful attempt to capture both the experiences of those who are medicalized and their role in the process of medicalization. The revision of the approach with the introduction of new groups of actors such as consumers does not change the basic framework, even though it seems to make a change on a rhetorical level. The fact that referring to individuals who are medicalized as active consumers in control of their medical knowledge and their illness trajectories still operates within a framework where medical knowledge is assigned a privileged role. The only difference is the idea that the medical professional can no longer gatekeep that

knowledge, as the individuals are assigned some agency by way of their active status through their consumer positions.

1.2.4. A Critique of the Medicalization Thesis

My main contention with the current medicalization framework is that it's being fixated on the medical profession and the institutions as the primary movers of the process of medicalization. As I have described previously, the "discovery of ADHD" primarily attended to the developments within the medical framework – psychiatric thought and medical professionals' diagnostic behavior, in addition to pharmaceutical companies and government intervention. The problem is that the central role assigned to medical professionals and medical thought constructs a framework according to which medical knowledge is being constituted within an expert domain and later on being disseminated through the public domain (Rafalovich, 2004). The public is taken to be passive and has an accepting attitude toward embracing disease categories. Rafalovich describes the relationship imagined between the medical profession and the wider public within the medicalization framework as a "dependency in which the public continually seeks medical professionals for the definition of problems outside of the lay purview" (Rafalovich, 2004). The emphasis on medical professionals and framing of the public as a passive entity ready to be controlled by "disease mongering" makes ADHD seem like a made-up category as if it is significant only to the extent that it enables medical institutions and professionals' social control over the public. The asymmetrical relationship is overemphasized to the point that the patient is portrayed "not a lay client, but the victim of the consultation" (Atkinson, 1995, p.33) ADHD being an invention or a "discovered" category as being devised for the purpose of contributing to the interest of a particular social group minimizes the value of ADHD as a category "in which individuals' hopes, anxieties, and discontents become expressed in medical and psychiatric terms" (Dixon et al., 2013; Rose, 2007). Conrad's original intent was to show how ADHD as a medical entity was constructed within a social context, but the single emphasis that was put on how it is constructed in a medical domain made a simplified account of ADHD as if it is an ideological project, a fabricated entity loaded with oppressive powers toward those who is eligible for the

diagnosis. Its reality as it is being experienced by those who are diagnosed with it is not accounted for.

1.2.5. Rational Drug Use Paradigm

It is very common to think that prescribed medications are acquired through "prescription by well-informed professionals of well-studied drugs to well-informed patients for well-defined conditions" (Cohen et al., 2001, p.444). This model is described as "rational drug use paradigm" which gives priority to the acquisition of medications through the medical professionals' diagnosis and to users following the suggested regimen that specifies the appropriate use of medications. This model views medications as official tools that have been developed to manage and recuperate disorders. Having intrinsic chemical structures, medications are material objects that are administered to the body of the patient to produce a desirable medical outcome. Medical and pharmacological research provides the scientific background for medications' potential risks and efficacy. Health policy based on calculating "cost-benefit, necessity and efficiency criteria", defines the conditions under which these medications can be prescribed. Moreover, it is assumed that the doctors can easily identify the complaints as a distinctive set of symptoms and put these symptoms under a specific category of disorder. Against the apparent discrepancy in the level of knowledge and authority between the doctor and the patient, individuals are left with the only option of following the drug regimen that the doctor suggested.

"Rational drug use paradigm" portrays medication use as resulting from an exchange between the medical professional and the patient. The paradigm also relies on an essentialist notion of medications. Medications are viewed strictly from the lenses of biomedical knowledge, having a group of effect released into the body on the condition that they are being consumed within a medically sanctioned way. That is, the effect of pharmaceuticals is thought to be intrinsic to their chemical compositions (Bundy & Quintero, 2017). As Van Der Geest and Whyte (1989) describes, "the meaning of each pharmaceutical has to do with its biochemical properties, and fits into a complex system of knowledge about disease and the biopsychological functioning of human beings" (van der Geest et al., 1989, p.351). According to this model, deviating from

the medically sanctioned way of administering medications is regarded as misuse or abuse.

These views – starting to use medications through diagnosis and the efficacy of medications having to do strictly with its chemical basis – are very limited in their power in explaining medication use. First of all, they assume that individuals are well-informed about their health, and capable of distinguishing ordinary problems from medical ones, and asking for doctor's opinions for those problems that they identified as medically significant. It starts off with the assumption that the individual, knowing that his or her complaint represents a disorder, seeks out medical advice from someone who is capable of dealing with the problem (Freidson, 1970). For the context of the thesis, ADHD, rather than being a self-evident reality expressed itself with a set of symptoms, and experienced as it *is*, it is experienced within a social context where individuals face difficulties in relation to "turning points" in their life course such as critical moments. A group of behavioral traits associated with 'inattention' does not necessitate individuals exhibiting a help-seeking behavior, neither indicate problem of a medically significant nature, until individual connects the experience of inattention with the risk of failure in significant moments. Even in this stage, trouble remains vague. These vague troubles become concrete after individuals start looking for ways of managing these difficulties. "Symptoms" are not physical attributes experienced as a material reality, they have rather constructed as symptoms only when individuals go through a long process of interaction with his or her immediate social circle and seek ways of managing the difficulties. In other words, the prescription psychostimulant medication use does not always follow a linear trajectory as the rational drug use paradigm predicts.

1.2.6. An Overview of Prevalent Qualitative Studies

Loe and Cuttino (2008) explore how psychostimulant medication use shapes students' construction of their selfhood. They found that an ADHD diagnosis makes them feel that they are not capable of seizing control of their bodies naturally. So, psychostimulant use first appears as a tool for correcting the deficiencies of the body and optimizing it in a way to achieve academic success. However, psychostimulant

use poses questions for the construction of a coherent story of self, as the students feel that their authentic identity got disturbed by these medications. Their sense of self is being divided into two conflicting versions: the authentic self and the medicated self. Using medications implies leaving the authentic version of self, as a result, some of them consider finding other ways of managing their ADHD instead of using psychostimulants. For the others though, dropping psychostimulants is not an option as it would mean not being able to manage their academic performance. To navigate through this ambivalence and to establish continuity between these forms of selves, they engage strategic pharmaceutical use. Choosing their time of use strategically and self-dosing enable them to preserve a sense of agency while not letting the academic ideals fail.

Petersen, Nørgaard and Traulsen's (Petersen et al., 2015a) study is based on qualitative research on the experiences of students who are using psychostimulant medication. The study contributes to the treatment-enhancement debate as it showcases different ways that students legitimize and justify their practices of using psychostimulant medications for enhancement purposes. Using psychostimulants for enhancement purposes results in questioning whether the use of prescription stimulants is morally acceptable, or not. The participants navigate through the moral questioning in different ways. One way is using doctors and getting prescriptions for these medications instead of acquiring it by other means. The fact that doctors prescribe the medications legitimizes the use and makes it less of a problem. Secondly, by providing a "good cause" for using prescription stimulants, they come to terms with their medication use.

Petersen, Nørgaard and Traulsen's (Petersen et al., 2015b) study, which is based on students' experiences of psychostimulant use, suggests that individuals view these medications as means for seeking pleasure in their studies, and avoiding procrastination that is resulted by feelings of insecurity or being disinterested. That is, psychostimulant use elevates individuals' mood and results in feelings of excitement. While most of the previous studies look into enhancement as getting better results in quantitative terms, this study investigates the emotional dimension of enhancement. Experience of having pleasure and excitement in working hard is an important part of enhancing study experience.

Steward and Pickersgill (2019) conducted research on students' patterns of psychostimulant medication use and their perception of risks and benefits associated with the medications. The study also draws a parallel between the demanding educational context and students' feeling of necessity to modify the parts of lives to meet educational demands and secure future achievements. The medications serve as tools managing the stress related educational tasks such as exams and work-related goals. The risks associated with the use of "study drugs" are significantly minimized as the users develop competencies and compare the risks of using it with the other problems like heightened stress they may have suffered in the cases of not using them. Students' perspective of risks and benefits of the medications depends on the contexts of use, being in the demanding context and suffering from anxiety related to academic stress minimizes the risk perception of the medication.

Vargo and Petroczi (2016) suggested that the stimulant medications – they draw on the example of modafinil – is preferred by students as a result of growing popularity of these online and in media. Because these are medications that can only be obtained through pharmacies, they were considered as safe substances. Moreover, the fact that individuals are able to observe the use of these medications in the peer-network and the positive experiences of users in their peer-network, they considered trying these medications out without having a specific purpose of enhancing their cognition. In line with the previous qualitative studies, individuals' account on the efficacy of these medications show that these medications primarily used to get a motivational kick, and sense of productivity one would feel while on medication. So, the real efficacy – that could be described in medical terms, and the students' perception of the efficacy as feeling enjoyment and confidence in studying blend together and couldn't be separated easily. Another important finding is that the users of the stimulant medications are engaging in practices to regulate and control their use. These practices involve adjusting dosage and choosing the time of use to avoid sleep-deprivation.

1.3. Theoretical Framework

The main conceptual framework of this thesis relies on Emerson's conception of "trouble". In their 1977 article titled "The Micro-Politics of Trouble", Emerson and

Messinger state that any social setting is bound to cause the emergence of difficulties that may be identified as being deviant from the norm. They propose that by employing a natural history framework, we can uncover the "processes of informal reaction [to troubles] and (...) their relation to the reactions of official agencies of social control" (p.121). As Katz (2015) puts it, Emerson's work on troubles is "part of the critique of the prevailing positivistic approach to explaining crime and deviance" (p.xiv). Thus, in order to better explain Emerson's point of view and contribution, I will first take a short detour and discuss how crime and deviance studies ground his work on troubles.

One of the main points of discussion in the sociology of crime and deviance has been the question of nature vs. nurture, or, whether it was the criminals' genetic make-up or their social environment that led them to exhibit criminal behavior. Favoring the latter explanation, the mainstream sociological approach focused on identifying the motivations behind individuals' criminal behaviors. The starting point for the mainstream approach was identifying "some stable, objective quality of deviant behavior" (Freidson, 1970, p.213) which would enable them to build theories about the social causes of criminal behaviors. That meant that the label of "deviance" was not separated from the behavior to which the label is attributed. In other words, the quality of deviance was derived from the behavior itself, and that some behaviors were inherently deviant. Interactionists were at odds with the idea that certain behaviors contained the quality of being deviant. They rejected the approach that treats categories of deviance in absolute terms as if they represent a moral discourse which is invariable to time and space. According to them, "deviance" is not a particular quality of an action; it is rather a label that is attached to certain actions. Thus, it is not a meaningful question to ask if a particular behavior is "really" deviant, because it is not the "objective" properties of a behavior that qualifies the behavior as deviant. It is rather the societal response to different sorts of behaviors that attributes them the status of being deviant. As Conrad puts it, "it is not acts, but the definition that makes something deviant" (Conrad & Schneider, 1992, p.6). Thus, although it sounds counterintuitive, separating the label from the act enables us to view how deviance categories were developed in the first place (Freidson, 1970).

Deviance-designations are not made superficially. They are rooted in rules and norms of a given social context. So, deviance designations have no separate reality other than the social norms and the societal response that these norms incite. In other words, deviance-designations are means of social control that are applied to "minimize, eliminate and normalize the deviant behavior" (Conrad & Schneider, 1992, p.7). When a particular behavior is labeled as being deviant, it is moved from the status of being a mere difference to a social role. That is, that individual's life - what to expect from them, how to manage them, how to approach them - is organized around their status of being a deviant as a result of labeling their particular behavior. Interactionists, then, focus on "the declaration that behavior is deviant and on the way the status of being deviant is organized by the pressures of the immediate social life in which the individual finds himself" (Freidson, 1970, p. 216) . This is a good example for labeling theory's basic premise that labeling creates deviance. Societal response in the form of labeling shapes the individual's own ideas about what sort of a person they are. Social sanctions do not simply function by eradicating deviant behavior through punishment, they also produce it by categorizing the said behaviors into stable roles (Conrad & Schneider, 1992).

In short, turning our attention to how the behavior is reacted by society - on individual, interpersonal and official levels - yields significant insight. Unless any given social group designates a particular behavior as deviant, and unless they react to the person who commits that behavior with regard to the status of being a deviant, the action cannot be considered as deviant. In other words, deviance is an inherently social category.

The dynamic between the mainstream sociological approach and the interactionist approach to deviance is paralleled in the dynamic between the medical model and the constructionist approach to illness. The medical model starts from the assumption that diseases are universal entities that exist independently of our thoughts and evaluations. Although constructionism concedes that illness as a medical term enables us to describe the qualities of diseases, their etiology and possible remedies, it argues that the medical model took the labeling of symptoms as illnesses for granted. In his major work "Profession of Medicine", Freidson argues that "illness as such may be a

biological disease, but the idea of illness is not, neither is the way human beings respond to it" (1970, p.210). Here, Freidson marks constructionism off from the medical model. He implies that the central question is not whether or not illness is based on a valid biological condition. The "idea of illness" is first and foremost an outcome of designating certain attributes, entities, behaviors as undesirable. Labeling particular symptoms as illness by means of a diagnosis is a social act comprising an evaluation of a given condition as undesirable. Much like deviance, illness is reinterpreted as a social category that depends on societal interpretations of what is good, bad, healthy, unhealthy, fit, or unfit.

It is usually assumed that the trouble comes to be defined in particular ways, and only afterwards the response to the trouble is prepared on the basis of the definition. For instance, the official / judicial category of deviance makes it necessary to apply a particular reaction to a person who commits the deviant behavior. That is, the response to a certain behavior is determined on the basis of the definition given to that behavior. The medical case that corresponds to this example would be specifying a set of behaviors as symptoms of a particular condition and then applying a treatment protocol on the basis of the definitions. Interpreting experiences of difficulty as a medical condition, identifying oneself with the medical category and applying a treatment are forms of responses that one could give to the trouble they are experiencing. The problem is that the responses do not always stem from a specific definition. It is equally possible that the available responses can shape how the trouble gets defined. That is, rather than following a sequence of define-first and respond-second; the group of available responses can shape how the problem is going to be interpreted in the first place.

In "The Micro-Politics of Trouble" Emerson and Messinger (1977) describe the processes by which troubles become "identified, defined, responded to, and sometimes transformed into a recognized form of deviance" (p.121). They hold that troubles are identified in relation to the responses/remedies that are available at the time. As their work offers a more generalized perspective, I will also utilize the medicalization thesis to bring the focus back into how students' personal troubles become interpreted as ADHD symptoms and responded to by psychostimulant medication use. As discussed

in the previous section, the medicalization thesis dictates that behaviors, conditions and situations that were not previously deemed as medical facts increasingly start being interpreted from a medical lens. However useful, the medicalization thesis overemphasizes the official systems, responses and domain, hence why I rely on Emerson's framework which highlights the informal processes that take place prior to and following the interpretation of troubles as recognized forms of deviance.

Emerson and Messinger (1977) argue that "the transformation of a trouble into a designated form of deviance can be seen through the trouble's discussion in "informal" and then "official" realms" (Katz, 2015). Emerson shifted the focus from official categories of deviance to informal ones and showed how the informal troubles get recognized and assume concrete forms as a result of processes of interpretation and getting reaction. The individual will initially attempt to address their troubles through informal, intrinsic means. However, as these informal methods become exhausted and fail to correct the troubles, they will turn to official, extrinsic responses. It must be noted that intrinsic responses do not cease to be relevant with the shift to official responses. On the contrary, these informal responses remain important even when there is an official category in place, as the interpretation of troubles does not stop there.

1.4. Methods and Research Process

1.4.1. The Advantages of Employing Qualitative Research Methods in Psychostimulant Medication Research

The majority of the bioethics, public health and prevalence studies start with distinguishing medical from non-medical use, and treat the latter as an illicit practice. These studies report individuals' motivations such as enhancing cognition or gaining a competitive edge over others as reasons for why individuals engage in the use of psychostimulant medications. These studies approach enhancement and recreational use as two broad categories that cover different groups' practices of psychostimulant medication use. By conducting a qualitative study, I distanced myself from ready-

made categorical distinctions, and I was able to observe how everyday practices of use could not be cleanly put into distinct categories.

In large scale quantitative studies, participants are usually presented with a predefined list from which they pick an option that best resembles their motivation for use (Coveney & Bjønness, 2019). While it is certainly important to uncover the motivations individuals have for psychostimulant usage, finding out the reasons for one's use are far from being enough to shed light on the multiplicity of ways individuals engage in psychostimulant medication use.

On the contrary, qualitative studies provide contextual information on various topics which remain hidden in large scale quantitative studies. This includes individuals' conceptions regarding psychostimulant medications, and how this conception changes and evolves throughout the different stages of medication usage. Individuals' ideas about these medications are shaped through their interactions with their immediate social circles including their friends and family members, as well as online spaces like forums. However, with regular use of psychostimulant medications, their conceptions blend with their own experiences and it brings about revised conceptions of these medications. Qualitative studies provide information about these processes and their role in helping individuals locate these medications within their everyday life. Learning what motivates individuals to use them and coming up with a clear argument do not explain how the medication use causes disturbances like moral dilemmas and how individuals manage or fail to deal with these moral dilemmas. In other words, the use of psychostimulant medications is contingent upon many other factors that remain hidden in large scale quantitative studies.

Qualitative studies on the other hand view such distinctions as a moral stance part of a policy framework that inhibits our understanding of how psychostimulants as socio-cultural objects that are grounded in the everyday life of individuals and represented in ways that are beyond their medical meanings and significance. Qualitative studies help us answer an immense number of questions that, I believe, are skipped over by large scale quantitative studies. Some of the questions that qualitative studies help us answer are how individuals encounter the psychostimulant medications as objects that

do not necessarily have medical connotations, how the meaning of these objects changes across different contexts, how individuals exchange their understanding and information about these objects with each other through varying mediums online, or their peer-networks, and how a non-user or a new user negotiates the meaning of these objects - that is, how their everyday life is shaped with the use of these medications, how in some instances fail to justify the use and reject further use of medications.

1.4.2. Research Process and Sample Characteristics

I have initially started my research with the aim of exploring psychostimulant medication use among university students as study aids, or as a strategy to overcome academic difficulties through enhancing their cognitive capacities. However, after conducting the first two interviews it became clear to me that a significant part of the experience of using psychostimulants is shaped by the individual's ADHD diagnosis. This prompted me to approach the rest of the interviews with an expanded and improved focus, one which included seeing ADHD as a crucial contributing factor in the narratives of psychostimulant medication usage. ADHD experiences were closely related with performing well on significant academic turning points of individuals, and seeing that dimension helped me locate ADHD within individuals' life context. Furthermore, the ADHD experience which included being diagnosed and using psychostimulant medications under the supervision of a medical professional had implications for students' regular use of psychostimulants. Seeing the category of ADHD as inseparable from "non-medical" use of psychostimulants rendered the distinction between medical vs. non-medical use trivial and superficial. Thus, I attempted to approach my interviews and my data without any strong preconceptions separating medical from non-medical use. My main objective during the interviews was to understand the students' experiences with psychostimulant medication use and the medical category of ADHD. I have employed a constructionist approach towards the reality and the category of ADHD.

I have conducted 15 semi-structured interviews with university students who had experience with using methylphenidate, which is sold under the brand names of Ritalin, Concerta and Medikinet in Turkey and used for the treatment of ADHD.

All of the respondents were students in higher education at the time of the interviews. The sample was composed of 7 PhD students, 5 Master's students, and 3 undergraduate students. 14 out of the 15 students were diagnosed with ADHD at one point, and they were prescribed with psychostimulant medications by their psychiatrists. Their ages ranged from 22 to 40, and there were 8 women and 7 men in the sample of students. The participants were selected from two of the highest-ranking universities in Turkey. Both Middle East Technical University (METU) and Boğaziçi University are public universities that are located in large metropolitan areas. These universities have the highest entrance criteria among Turkish public universities, only the candidates who get the highest points in their respective areas become eligible to study in these universities. This means that my sample was composed of students who have gotten competitive scores in the university entrance exams. In terms of employment status, 4 of these students were working as research assistants, while 5 of them either had scholarships or earned their living from working in research projects. 2 others were working at full-time jobs at the time the interviews were held.

The interviews were conducted in 2021, and they lasted about 90 minutes on average. A small number of the interviews were done face to face, and the rest were realized via Zoom. The audio recordings were transcribed verbatim, and later coded on MAXQDA. In order to maintain the anonymity of the respondents, they were given pseudonyms as Students A through O and some of the identifying details were altered or omitted from the quotations featured in the analysis chapters. As the interviews were held in Turkish, the featured quotations are translated versions of the originals.

The interviews were guided by four sets of predetermined questions: The respondents were asked questions about i) their initiation to psychostimulant medications, ii) their use experience and changes in their everyday lives after starting regular use of psychostimulant medications, iii) their peer network's involvement in their psychostimulant use, and iv) their experiences in clinical sessions with medical professionals.

In order to reach my respondents, I started by reaching out to a small number of students, and asked them to reach out to their friends and acquaintances who had also

used / were also using psychostimulant medications. Doing so allowed me to see how information about psychostimulant medication use and acquiring a supply of psychostimulants is exchanged among peer-networks. Interviewing friends who have witnessed others' practices of use helped me understand how information and the meaning of psychostimulants are circulated within peer-networks. 10 of the 15 respondents were found through snowball sampling, while the remaining 5 were recruited through a call I posted on Facebook groups that are popular among university students.

My initial recruitment criteria included a minimum of 3 months of psychostimulant medication (Ritalin, Concerta, or Medikinet) use. However, upon realizing that it would be useful to collect the experiences of those who discontinued use after using the medications a couple of times, I decided to include two participants who fit this description.

1.4.3. The Contextual Background of the Field

Over the last decade, the number of university graduates in Turkey has multiplied. In 2008, university graduates constituted 5% of the population over the age of 6, while in 2019 this rate has risen up to 13,9% (TÜİK, 2019). In parallel, the rate of individuals who obtained post-graduate degrees has risen from 0,5% to 1,8% (TÜİK, 2019). Moreover, the density of university graduates is higher in the major cities. This increase in the number of university students is a result of the large number of private and public universities being founded over the past decade. Today, there are 129 public and 75 private universities in Turkey, and there is at least one university in each of the 81 cities (*Yükseköğretim Bilgi Yönetim Sistemi*, n.d.). Furthermore, the requirement of obtaining a predetermined minimum score to be able to enroll in an undergraduate program has recently been eliminated as, making it easier than ever for young people to attend university. As a result of these changes, the current number of university graduates exceeds 10 million. The problem is that the increase in the number of graduates is twice as fast than the number of university graduates in employment. In other words, the increase in the number of university students does not translate into an increase in youth employment.

Although the discrepancy between the skilled workforce and the economy's needs indicates deeper problems, the current crisis the Turkish economy is going through makes the situation worse for the youth. The youth are one of the groups that are affected the most by the economic crisis, as many of them have no prior experience entering the workforce (Hansen, 1987), and the less experienced, young employees are often the first to be let go in moments of economic crises (Rittersberger-Tılıç & Çelik, 2016).

The above data hints to us what sort of employment opportunities recent graduates and university students are going to have when they enter into the workforce. Difficulties regarding performance that are formed within this environment and context are inherently different from those formed in the North-American or European contexts. Keeping these structural issues in mind; the increasing number of university students and graduates, the imbalance between the numbers of new graduates and employment opportunities, the demands of the market, make it so that a university education can no longer guarantee a secure employment and future for a young person. Thus, ideological approaches that view unemployment as being caused by the individuals' personal shortcomings in networking and social skill-building completely disregard the structural aspects that underlie the problem. These structural issues push the individuals into distinguishing themselves from their peers by maximizing their performance in order to overcome the challenges that await them in the employment market post-graduation. Performance anxiety, in this context, arises as a result of the individual taking on the responsibility of these structural challenges. Unemployment is recontextualized as an individual problem requiring an individual response, and if these personal measures are not taken, the resulting unemployment or job insecurity are understood as natural, expected consequences.

In this context, psychostimulant medication use is expressed as individuals trying to fulfill performance norms on a surface level, but in fact it acts as a productivity agent that plays an active role in the individualization of social risk, and the individuals' constant attempts towards bettering themselves in as little time as possible as visibly as they can.

1.5. Limitations of the Thesis

As it is the case with most qualitative studies, the findings of the study cannot be generalized into a broader context. As the sample of university students is mainly composed of students from two high ranking universities, the students who are involved in the research represent a specific demographic that is not representative of all university students in Turkey. It should be noted that the students from these universities have been part of a culture of competition from the early moments of their educational trajectories. This culture could not be generalized as taken-for-granted quality of every university in Turkey.

Secondly, the main sampling technique that was employed in the research was snowball sampling. Although it provided unique advantages (which will be outline in the section regarding methods and research process) it also came with certain disadvantages. By using snowball sampling, I reached friends and members of the same peer-network who have depended on each other for knowledge about psychostimulant medications. Their beliefs, values and practices toward psychostimulant medication use and the category of ADHD showed similarity to certain degree.

Third, due to the scope and limited resources I had for this project, I was able to interview 15 students regarding their psychostimulant medication use. I believe it would be useful to include more students who engaged in psychostimulant medication use without a prescription, as well as more students who discontinued use after a limited number of uses to be able to provide a more well-rounded comparative analysis.

1.6. Outline of the Chapters

The first chapter of this thesis presented a contextual introduction, a literature review, a theoretical framework and an outline of the methods that were employed during the research process.

In the second chapter, titled “Initiation to ADHD and Psychostimulant Use”, I will focus on how students make sense of the troubles they are experiencing in their daily and academic lives. I will first discuss the ways in which they delay the recognition of their troubles as they attempt to generate intrinsic responses to them, such as normalization, externalization, and trivialization of the problems they are experiencing, which contribute to the students living around their troubles. Second, I will explore how significant turning points function as catalysts that push students towards extrinsic, official responses such as ADHD diagnoses and psychostimulant medication prescriptions. I will argue that failing at significant moments like graduation years or important exams risk the linearity of the student’s life course, and thus appear as turning points that may force the student into reinterpreting their troubles as serious ones that cannot be handled by intrinsic responses alone. Finally, I will discuss the role that the immediate social circle and the peer-network of the student plays in their initiation to the category of ADHD and to psychostimulant medication use.

In the third chapter, titled “Strategies for Ensuring Continual Use”, I will focus on the processes that unfold after an extrinsic / official response has been applied to the trouble that is experienced by the student. I will argue that the act of getting diagnosed with ADHD and starting psychostimulant medication treatment is not the end of the student’s troubles – rather, the introduction of an official medical category and a treatment plan in the form of psychostimulant medication use often brings about new sets of issues that need to be resolved. I will show that students once again turn to intrinsic, informal responses in order to deal with the issues that are brought about by the application of extrinsic, official responses. To do so, I will first discuss they ways in which an ADHD identity contributes to the student’s continual use of psychostimulant medications. I will show that a working ADHD identity plays a crucial role in one’s justification and rationalization of medication / drug use. Second, I will explore the techniques and practices students engage in in order to accommodate psychostimulant medication usage in their everyday lives. This section will provide examples of the ways in which students customize their psychostimulant use and dealing with the undesirable effects that are caused by the medications. Finally, I will discuss the processes by which students manage their medication supplies, with a focus

on the students who follow a medical path to do so – which has been neglected in the existing literature on psychostimulant medication use among university students.

In the fourth and final chapter, I will offer a brief conclusion as well as discuss directions for future studies in this topic.

CHAPTER 2

INITIATION TO ADHD AND PSYCHOSTIMULANT USE

2.1. Chapter Introduction

This chapter will explore how a diverse group of problems is understood and perceived as signs of ADHD by students in university settings, and how students come to use prescription psychostimulants as a response to the problems they experience. I will refer to this diverse set of problems as "troubles", which can be conceptualized as difficulties that individuals experience in different fields of their lives. Emerson and Messinger (1977) argue that personal troubles, which find vague explanations in individuals' claims that something simply is not right, are transformed into a "recognized form of deviance". In this case, these deviances from the norm are all explained by the medical category of Attention Deficit Hyperactivity Disorder (ADHD).

The concept of trouble is intimately tied to the idea of "normalcy". Normalcy refers to a particular "social and normative order" in relation to which ordinary troubles arise when the individual departs from the norms (Emerson, 2009). Academic settings are important fields where students come face to face with strict norms of success and failure, and thus they also constitute breeding grounds for troubles to emerge. The students internalize ideal studying habits (which are seen as necessary for conforming to the norms of success) such as being able to continuously study for long hours, studying every single day, being focused on the work in hand, meticulously following deadlines, and so on. These practices are crucial in the formation of normalcy in an academic setting.

One's commitment to the norms of success might explain how the experience of perceived failure is disrupting to the flow of everyday life, as well as one's general life course. Important turning points such as significant exams, graduations, applications appear as instances where the student can recognize the nature of the trouble they are experiencing, and attempt to fix it. It is in moments like these that we see the students turning to the medical category of ADHD for an explanation of the trouble they are having, and to prescription stimulants for a solution for dealing with it.

The student's path to recognizing the trouble they are experiencing and seeking a solution for it is not always straightforward. The manifestations of the trouble are often contextualized and properly understood upon comparing one's experience with a friend. The student may not recognize that they are having a substantial difficulty until they come across a friend who is using prescription stimulants and trying them out themselves. This initial meeting with a psychostimulant often appears as a key player in the student's narrative of success, failure, trouble and remedy. The social circle of the student plays a crucial role in the student's initiation to ADHD as medical category and to the use of psychostimulant drugs.

In this chapter, I will first discuss how students delay their recognition of the troubles they are experiencing through processes of externalization, normalization and trivialization of their issues. I will show how these processes contribute to the students' living around of their troubles. Second, I will discuss how significant moments in the students' lives act as catalysts for initiating psychostimulant use. To do so, I will first look into how threats of failure push students into recognizing their troubles and seeking remedies for them, and second, I will look into how graduations and exams appear as significant moments that hold the power of disrupting one's life course. Third, I will show the important role the social circle of the student plays in the student's initiation to psychostimulant use.

2.2. Delaying the Recognition of the Trouble

Before students get their hands on psychostimulant medications, they must first recognize that something is wrong with their studies or other aspects of their lives.

"The perception of 'something wrong' is often vague at the onset" (Emerson & Messinger, 1977, p.121) and problems are recognized in different ways. We can talk about three processes which hinder the recognition of the trouble in students' lives, their coming to terms with the category of ADHD, and their usage of psychostimulant medications: Externalization refers to processes by which the individual assigns blame and responsibility to persons and situations outside of themselves. Normalization refers to processes by which the individual accepts the problematic situation as normal, universal experiences. Trivialization refers to the individual making light of the issues they are experiencing in their academic and daily lives, and not seeing them as significant problems. Through these three processes, the students figure out ways of living around the troubles they are experiencing rather than directly addressing them.

2.2.1. Externalization

The process of externalization was apparent in a number of my interviews with students who later started using psychostimulant medications. An interesting example of this process came from Respondent A, who is a graduate student in her late 20s. Her introduction to psychostimulant medications was through a friend who recognized signs of ADHD in her behavior and referred her to a psychiatrist. When asked how she first started using psychostimulant medications, she started talking about her retrospective thoughts on her experiences in educational settings:

> Yeah, so when I was in high school, listening to my teachers in class, I really didn't understand anything they were talking about. I couldn't fully give myself to the class, and I explained it away saying "Oh the teacher isn't doing a good job at lecturing, there isn't anything wrong with me." Then I started my undergraduate studies and the same thing kept happening, and I still though the professors were just bad at teaching. (Respondent A, a 28-year-old Master's student)

Looking back at her high school and undergraduate years, she reminisces on how she always thought her issues with following the lectures were caused by inadequate teachers and lecturers. She holds the other actors responsible for the emergence of the problem she is experiencing, and by locating the origin of the problem outside of herself, the problem is rendered as unchangeable and unfixable. As Emerson and

Messinger put it, “there is indeed something wrong; there is nothing that can be done or that the attempt to do something would be doomed from the start” (1977, p.122)

Here it is apparent that externalization acts as a strategy for “living with or around a disturbance” (Emerson, 2009, p.537), and it therefore delays or prevents the individual from seeking out remedies that would help with the troubles they are experiencing. It is precisely because of this dynamic that Respondent A never tried to deal with her academic problems until a friend of hers suggested that the problem may not be with the external figures in her life, but rather caused by an attention disorder. In other words, the externalized trouble has no choice but to be a vague set of problems. It is only after the externalization is dealt with that the trouble can assume a more concrete form, and thus appear as something that can be bettered. Trying to find out the proper response and seeking out a remedy is the starting point for the difficulty to be moved to a more definite category – which, in our case, in the medical category of ADHD.

2.2.2. Normalization

The process of normalization of troubles often assumes the form of the individual believing the problems they are experiencing are universally experienced by their peers. Through this belief, they think that there is nothing to be done because their issues are just parts of the universal human experience. This was demonstrated by a few respondents talking about their past experiences with school. Student B, who is a graduate student in her late 20s serves as a solid example of this process. She came to recognize her personal issues with inattention in her undergraduate education, when a friend of hers pointed out how distracted and inattentive she was while they were studying together. When he asked her if she was aware of this, she reported being completely taken aback and surprised. Her following retelling of her experiences from primary, middle and high school show us why she was so surprised by his remarks:

> I was a good student in primary school and in middle school, like I don’t remember having issues with not being able to listen to class or with socializing. (…) But then in high school, which is the earliest time I can see myself having issues looking back, I wasn’t able to listen in class, but I thought it was a universal experience. I thought no one was able to concentrate in class,

> or that everyone had to read the same passage six times when reading a book, because that way my experience with reading. (Student B, 28-year-old Master's student)

As the above quote shows, Student B's first experiences of difficulty in class were accompanied by the impression that everyone else was having an equally difficult time concentrating in class or reading. Through this sense that this is actually a universal experience, she normalizes the situation she finds herself in. Similar to the process of externalization, we see that the origin of the difficulty is located elsewhere. Except in this case, rather than holding others responsible, we see the individual globalize their problems by arguing that they are no different than others. Although the thought process is different, the result is the same: Because the individual does not acknowledge the existence of a problem that is personal to them, they also don't end up seeking a remedy for it, delaying their introduction to psychostimulants.

2.2.3. Trivialization

The third and final process that delays one's initiation to the category of ADHD and psychostimulant medication use is that of trivialization. Here we see individuals run into certain problems in their academic and daily lives, but they do not hold others accountable for them or think that these are common experiences. Rather, they acknowledge the existence of the problem, but do not give it much weight or importance. Even significant issues that cause disruptions to the students' lives are explained away as minor inconveniences.

A particularly interesting example of this dynamic came from Student C, who is a PhD candidate in his early 30s. In my interview with him, one of the first things he said in introducing himself was that he had changed his field of study from one branch of biology to another one. He recounted how he initially started working in a wet lab[1] with one of his professors during his Master's degree, but after a year switched to

[1] A "wet lab" is the name given to laboratory environments where different chemicals and "wet" hazardous substances are handled. This requires the space to be carefully designed and supervised for potential incidents of spillage and contamination.

computational biology with another one of his professors. When questioned about the reasoning for this switch, he described his experiences in the wet lab:

> I think I'm a generally distracted person. I would always forget something when I was doing experiments in the lab. For example, in an experiment you're supposed to have a negative control and a positive control, and I would forget to add these things when I was doing an experiment, and then the whole thing would go to waste. I was having issues like that, and although they aren't massive issues, these experiments would take a very long time like three or four months, and not being able to get the results I was expecting to get from them because of these errors has really demotivated me. I was already interested in bio-informatics, so when I talked with my professor about it, he was very understanding about it. He told me that I didn't have to stick to a single area of research, and he really helped me in that time. (Student C, a 31-year-old PhD student)

Student C mentions making frequent errors during his time in the wet lab, but immediately brushes them away as not being too big of a problem. However, looking at the nature of the errors he was making, we can see that they were causing significant, three- or four-month delays in his laboratory work, resulting in large amounts of wasted time and effort. Despite the relative severity of these errors, he doesn't recount them as being "massive issues". What is rather unique and interesting in his case is the fact that his self-proclaimed distracted nature and the multiplicity of the "small" errors he was making pushed him into a rather dramatic change in field of study. He removed himself from the environment where he was experiencing problems that he deemed were trivial, and started working in a completely different environment. Although he was trivializing the issues he was experiencing during our interview, he also inadvertently showed us that they were not so trivial in nature. It is after he started working on writing an article, feeling the need to work for long, continuous hours and trying a prescription psychostimulant from his friends that he decided his problems could indeed be solved by psychostimulant use.

2.2.4. Living Around Troubles

One thing that these three processes of externalization, normalization and trivialization have in common is that they all lead to the individual living with or around the troubles they are having. Rather than recognizing and addressing the troubles as they are, they

figure out ways of compensating, or they find alternative ways of living that do not involve naming and framing their troubles. This process was especially apparent in the example of Student C, who had changed his field of study following issues he experienced with his laboratory work.

This general tendency of figuring out a way of living around troubles was apparent in most of my interviews. Student D, who is a graduate student in his mid-20s, provided multiple examples of this sort of behavior during my interview with him:

> Generally speaking, I see now that I always tried to do everything through shortcuts, especially in terms of physical activity. For example, I would be late to school so I would just take a cab. Now I can just wake up early and walk. (…) This summer I experienced a long drive for the first time, it was like a 10-hour trip. I kept thinking how I would never take this trip if I wasn't on Concerta. I don't know if it's a good thing or a bad one, but I would have just found another way. I would have still gone to the destination but it would be through different means. Driving for 10 hours can be a completely normal, mundane activity for someone else, but I would have never been able to stand that long of a drive. (Student D, a 25-year-old Master's student)

By mentioning that he solved his issues with being late to class by taking taxi rides or his fixation on the idea that he would have definitely found another way of travelling to his destination if he wasn't on psychostimulant medications, he draws our attention to the fact that he can get around the disparate group of problems he identified early on. Since he was able to find ways around dealing with the problems themselves, the troubles he was experiencing did not materialize and confront him, resulting in remedy-seeking behavior.

These accounts show us that in the initial stages of experiencing these difficulties, the difficulties are not necessarily perceived as signs of a complete and distinctive sort of problem or norm-violating practices. Rather than being the symptoms of a specific disorder, they have been indicated as unpleasant or worrisome, and the individuals "may attribute many everyday irritations and upsets […] to human and social forces beyond our individual control" (Emerson, 2015, p.31). Mundane disturbances of everyday life usually do not push individuals to take specific measures to handle the problem. Individuals think "nothing serious is happening" (ibid., p.32) or that the

disturbances can be viewed as “unimportant incidents produced by the overloads of everyday life” (ibid., p.33). We have seen in the accounts of the respondents that such difficulties can get resolved, despite not completely, rather than turning into serious difficulties. Locating the origin of the difficulties outside of the self, normalizing the difficulty by saying that everybody has similar experiences, and finding other ways, trivializing the problems they are experiencing, and living around the difficulties the face prevents individuals from seeking active intervention or remedy for the problem.

2.3. Disruption of the Life Course

A common experience that was shared by multiple respondents was recognizing the trouble they were having in significant moments that had the potential of disrupting the course of the students’ lives. As explained in the previous section, students often do not recognize and identify their troubles until they face some external force that pushes them into doing so. In this section and the next, I will discuss how two such forces function. This section will focus on the role of significant turning points and life events in one’s recognition of troubles and seeking remedy, and the next section will explore the role of one’s social circle in becoming acquainted with ADHD and psychostimulant medications.

Throughout my interviews, it became apparent that students do not get to identify their problems as indicative of a serious issue until they have built up concerns about keeping up with the norms of success that are prevalent within an educational context. These concerns are built around moments that mark the transition into a new phase of life and that are thus found significant by the respondents. As Gaylene Becker (1997) puts it, the dominant belief that life is structured in a linear fashion presenting continuity and constant development as individuals go through different stages of their life, reserves a significant place for the transitionary moments in the eyes of respondents. What I call norms of success are not composed of abstract ideals but rather concrete expectations of the students that materialize in significant turning points. Examples include graduating from university, completing one’s thesis, performing well in important exams like university entrance exams or foreign language exams and so on. The students I interviewed all shared a linear, progressive

course of life that involved performing well in different academic settings, and the significant points they emphasized acted as turning points that either ensured or hindered the passage to the next life stage. Many of them pointed out that a "meaningful life" was possible by them completing their degrees, earning scholarships, studying abroad, or working at a fulfilling job. Due to their significance in the students' lives, they often act as catalysts for pushing the students into recognizing their past and current experiences around failure and low performance as concrete troubles that may point to them having ADHD and / or needing the support of psychostimulant medications.

Experiences of failure that are perceived as disruptions or risks of disruption from the ordinary courses of their lives indicate a trouble that is harder to get around compared to the difficulties that were described in the previous section. While externalized, normalized or trivialized difficulties could be and were somehow managed by the students, troubles of this kind cannot easily be swept away. While the student can blame their teacher for the classes they could not follow or think that reading the same passage multiple times over is a normal, common experience, when they fail at an important exam and face the repercussions that come with this failure, they recognize that something more serious may be wrong with them and that some sort of an intervention may be needed.

2.3.1. Threats of Failure

Although an actual instance of failure is effective in pushing individuals toward a turning point and revising their interpretative schemes on what is going on, the actual experience of failure is not required for the individual to feel that they need to take measures for a problem. Threats of failure put pressure on individuals and heighten their anxieties over those significant moments. For instance, when asked how she started using psychostimulants, Student E who is a PhD student in her late 20s explained that her grade point average started falling in her second year of undergraduate studies due to her having a more active social life. As her grades fell, her father felt the need to intervene and warn her that if she wanted to pursue a career in academia as she initially planned, a GPA of 2.10 simply was not good enough. This

apparent threat to her planned life course in the shape of a low GPA put a significant amount of pressure on her, causing her daily distress and it ultimately pushed her into discussing this issue with her psychiatrist who diagnosed her with ADHD and prescribed her with psychostimulant medications. In summary, she did not have to experience a finite failure in pursuing an academic career to consider getting help to a problem that presented itself as serious, the sheer threat of a disruption was enough.

A similar response to a threat of failure was given by Student F, who is a graduate student in her mid-20s. When asked how she first started using psychostimulant medications, she identified her senior year of high school as a turning point. She explained that she had never been particularly good at mathematics, and her inability to do math became a significant problem for her during the year she was preparing to take the university entrance exams. She realized that the only way she could get a decent score was through avoiding the math-based questions and exams, but that was not an option for the sorts of departments she was interested in:

> When I was in my senior year of high school, my situation with math kept worsening. I'm just completely unable to do math. My little brother was already diagnosed with ADHD and was prescribed psychostimulant medications. My university exam prep was going so poorly, and I thought the only way I would get a decent result was through my TS (Turkish – Social Sciences) score. But the program I wanted to study didn't accept a TS score, and I just couldn't concentrate when it came to do math. That's when my mother suggested that I take half a pill from my brother's stash to see if it would help out. (Student F, a 26-year-old Master's student)

In the case of Student F, we see that she is no longer able to live around her troubles because the stakes are too high. If she does not find a way of dealing with her problems with math, she risks studying in a field she is not interested in, and potentially jeopardizing her entire life course. Thus, her troubles appear in front of her as solid, material beings that must be dealt with rather than avoided. The threat of failure and the risk of studying in an undergraduate program she has no interest in acts as a guiding force in her initiation to psychostimulant medications.

2.3.2. Graduations and Exams

For many of the students I interviewed, graduations and exams act as significant turning points in their lives. The linear trajectory of their life course is divided by these significant points, and failing to perform well on any given point causes a major disruption to their course of life. As I discussed in the previous section, the sheer threat of disruption is often enough to make the student take their troubles more seriously and resort to psychostimulant medication use. In this section, I will go over examples of students who started using psychostimulant medications in order to get over some exams they had in their futures, or to be able to graduate from the programs they were enrolled in. Through these examples, I am aiming to show how the increased pressure that the students face pushes them towards considering external agents of help – such as psychostimulant medications.

Graduations (from both undergraduate and graduate programs) show up as significant turning points in the lives of the students because they mark the time where the students transition towards a context where they position themselves within a new web of relationships. They are commonly moments where the student is forced to seriously think about what is next for them, and future prospects suddenly become more visible and present in their lives. Extending their studies for another year (or two), or graduating with a low GPA appear as serious problems that can affect the rest of their lives. When talking about her final year of undergraduate studies, Student A mentioned how central the idea of graduation became in her life:

> I mean, you get into such a mindset in the third and fourth year of university that all you care about ends up being finishing school, you completely stop caring about your health. My health didn't matter much to me, what mattered was that I was using these drugs to study so I could finish school. (Respondent A, a 28-year-old Master's student)

Although Student A sees prescription psychostimulants as detrimental to her general health, that concern takes a backseat in relation to the concerns about graduating. Due to some other mental health issues that she was experiencing, her psychiatrist was reluctant in prescribing her with psychostimulant medications, but she took it upon

herself to convince her psychiatrist that these drugs were the only way she was going to be able to finish school and that she needed them at all costs.

A similar scenario unfolds around important exams in the students' lives. As Gaylene Becker (1997) argues, the linearity of the life course serves as a normative value for the individual. The life stages are understood as hierarchical, and it is believed that individuals develop going through these stages. The university entrance exams mark one's passage from high school to university, exams like ALES and YDS mark one's passage from undergraduate studies to graduate programs, foreign language exams and GRE can indicate a passage to studying abroad, and so on.

Student G, who is a graduate student in his late 20s, was diagnosed with ADHD when he was 9 years old, and was prescribed with Ritalin. Although he used it on and off for a few months following his diagnosis, he ended up not using it for many years. However, the university entrance exam marked a significant turning point for him, and he decided to take a pill right before the exam. This practice of using psychostimulants to get himself through important exams became somewhat of a habit, and he repeated the same practice when he took the ALES, TOEFL, and the research assistantship exam:

> Because I'm an idiot, I took a whole pill when I was taking the university entrance exam and it was a complete shitshow, so I decided not to take any in the next exam. (…) Half a pill is enough for me, and if I take a full pill, it has the reverse effect of distracting me, I feel more attentive when I take half a pill. (…) The previous summer I took some for taking the ALES, and it was really useful in that situation because you absolutely need to be focused in that exam. I also took one for the research assistantship exam here, I also probably took one in that other assistantship exam for another university… No no wait, I only took one for this position because it was way more important for me. (…) The most benefit I saw from Ritalin was when I took it to take the TOEFL exam. (Student G, a 27-year-old Master's student)

The relationship between the student perceiving these exams as significant turning points and feeling the need to resort to psychostimulant medication use is apparent in his retelling of the two times that he entered exams for research assistant positions in different universities. As can be seen in the quote above, he forms a direct link between the perceived importance of an exam and his psychostimulant usage. He had first

entered an exam for a research assistantship at University A, but decided to try his luck again when University B announced the opening of the same position. Since he saw the position in University B as much more important and desirable, he decided to use psychostimulant medications in that exam but not the other one.

Student G uses psychostimulant medications exclusively during significant exams in his life. In the public health and ethics literatures, such sorts of uses of prescription stimulants are described as using for "performance enhancement" (DeSantis et al., 2010; Desantis & Curtis Hane, 2010; Lucke et al., 2018; Racine & Forlini, 2010), and they are primarily focusing on the enhancement of cognition. These studies present that students mostly use them to be able to increase their concentration for a longer period of time and stay awake to study and improve other cognitive capabilities like memory. (DeSantis et al., 2008b) Although it is true that individuals do take prescription stimulants with such motives, what these studies overlook is the context within which certain troubles are constructed as problems that require a specific treatment, which otherwise result in a disruption of the ordinary course of life. It is not just a general improvement in performance that the individuals are hoping to get with the use of prescription stimulants - it is rather dealing with troubles including a diverse group of concerns like the risk of failure, unpredictability, losing financial security, et cetera.

A similar narrative was present in the case of Student H, who is a graduate student in her late 20s. She had used Concerta and Ritalin on and off for many years, but stopped using them at one point because she was mostly done with her important coursework and exams. However, when she decided to take GRE, TOEFL and IELTS she quickly went back to using psychostimulants:

> I needed to take a few exams during this process, such as the GRE, TOEFL, and IELTS, but because I was done with most of my exams, I had already stopped taking meds. I didn't know what it meant to be concentrated, what it meant to be able to pay attention. I was able to make do without taking my meds in daily study sessions and other daily activities, but I felt that I needed the support of these meds because I had really important exams ahead of me, like the GRE. (Respondent H, 28-year-old woman, Master's student)

As the outcomes of these exams act as the deciding factors for her admission to a graduate program abroad, they are assigned with significant meaning for the course of her life. The importance of these exams pushed her into resuming use of psychostimulants both in the period leading up to the exams, and during the exams.

Student I, who is a PhD student in his early 40s, experienced multiple instances of academic difficulty in his life. He left the first undergraduate program he was enrolled in after 4 years of perceived failure, and started a new program. He then enrolled in a Master's program in the same field, and completed his coursework. It was in the final stretch of writing his Master's thesis that he first felt the need to use psychostimulant medications. Following this initial use, he stopped using them until years later, when time came for him to take his doctoral qualifying exam:

> I popped a pill before taking the doctoral qualifying exam, thinking what could be the worst thing that could happen. I was already in a very bad headspace before taking the exam, so I took it when I was completely demoralized and I'm not gonna lie, it worked. I went into this tunnel vision, and when I lifted my head back up it was already 1.30 pm and I didn't have much left to write. So, I started taking smoking breaks and stuff, but that was the last time I used it. (Respondent I, 40-year-old man, PhD student)

Both of these instances (finishing the writing of a Master's thesis and successfully passing the doctoral qualifying exam) mark crucial points in his life, and potential threats to his livelihood. As he was working as a research assistant, his livelihood depended on him being able to complete his thesis and then to pass his doctoral qualifying exam. This increased pressure guided him towards using psychostimulant medications, as his troubles appeared as less vague and more concrete owing to their connections to the student's life course.

These three examples reaffirm the points I made in the previous sections: Low levels of concentration, problems with inattention, and many other so-called problems that are considered as symptoms of ADHD do not automatically appear as troubles in the experiences of individuals, unless they pose a threat of disruption in the ordinary course of daily life. The fact that the individual clearly states that she is not a person who is able to concentrate, but she is not using stimulants either when there is no

approaching date of such significant exams proves that the trouble is not self-evident in the cognitive function; they have rather experienced by the individuals in significant moments when there is risk of failure and further risk of disrupting ordinary course of life.

In other words; individuals may articulate discontents about their work ethics, they might not be satisfied the amount of work they have done to prepare for exam, or these can be associated with inattention and lack of concentration in the language of ADHD. However, such discontents do not always provoke a response from individuals or push them to consider use prescription stimulants or view themselves as persons with ADHD. Such judgements are formed in relation to the significant turning points that shape the life course of individuals.

These difficulties are not readily organized into a single concept. In my case, ADHD is the concept that explains most of the difficulties that arise in relation to the troubles of performance. For the individual to apply the label of ADHD to their experiences in order to make sense of them requires more than just the experience of difficulty. That is, individuals do not seek medical labels after every difficulty that face, nor do they seek to intervene to their bodies with the medications to get over difficulties. To get to that stage and to be diagnosed as a person with ADHD or just to use these pharmaceuticals without having much concern, they need to consider these difficulties as serious problems that are more severe than other everyday difficulties. Regarding them as serious difficulties does not mean that individuals readily refer to the medical categories, because ADHD as a medical discourse and as a treatment repertoire is not readily available to the person to whom the difficulties stand as rather vaguely.

After individuals establish a link between their everyday difficulties of performance with their future projection, the trouble that it led to, difficulties become more concrete. Having recognized the problem as a serious one requires establishing a link between the field of underperformance and other fields of life and future. At this stage, the individual's feeling of fear in their future projections might push them to seek the ways of getting over the trouble. However, that does not have to be the individual that actively evaluate the trouble and seek the ways of overcoming that. It is through the

involvement of the others and applying particular solutions for the difficulties individuals' life and future prospects that the trouble is identified.

2.4. The Role of the Social Circle in Initiation

In the previous two sections, I have discussed how certain problems and difficulties that are experienced by the students may be interpreted as vague issues that do not result in remedy seeking behavior; and how the threat of disruption to one's course of life often acts as a catalyst in the students' recognition of troubles as serious matters that require intervention in the form of psychostimulant medications. The social circles of the students often fulfill a similar role in their initiation to ADHD and psychostimulant medications in that in many instances, the friends and family members of the students play an active role in their conceptualization of daily difficulties as serious troubles. In this section, I will elaborate on the ways in which the social circle of the students contributes to the recognition of troubles and the initiation to psychostimulant medication use.

Within my sample of 15, 7 students were introduced to psychostimulant medications by one of their friends or a member of their peer-networks, and 2 by their family members. I also had the opportunity of interviewing friends that belong to the same peer-network, which gave me the chance of tracking the complete story of how some of them started using psychostimulant medications.

Peer-networks provide a comprehensive body of knowledge for a non-user about prescription medications (Quintero et al., 2006). They function as sources of information as a non-user sets up a foundation for the medication-use "through chain of research, reasoning and assessment" (Quintero & Bundy, 2011, p.8). The initial use within the peer-networks informs the subsequent use of prescription stimulants and decision-making processes about whether or not the user will continue to use prescription medications later on. What makes peer-networks different from other sources of information is that they not only provide information, but they also lay down the ground for individuals to experiment with the medications, and to see if it works out for their using purposes and compare their experiences with that of their friends.

2.4.1. Clearing Doubt

One of the primary roles that the social circle of the student plays is the clearing of doubt about the potential side effects of psychostimulant medications and reassuring the student that these medications are safe to use. As psychostimulant medications are only given with a strict and restrictive prescription, many students are wary of using them before being prescribed by a medical professional. In the cases where the friends and family members recommend the use of psychostimulant medications to the student, they also act as a source of safety and security, helping to clear any doubts the student may have about using these drugs.

This dynamic was apparent in the relationship between Student M and one of his friends. Student M who is a graduate student in his late 20s, recommended his friend to use psychostimulant medications to get through an important exam so that he could graduate in time:

> In the following morning he had to take this exam, and he was completely wasted, totally drunk that night. He wasn't able to study at all, and he kept insisting that he was going to go to bed and sleep. And I kept telling him that he was going to graduate in the morning, that he had to sit down and study, and that he should just go ahead and take it [the psychostimulant medication]. He insisted that he didn't want to take this foreign, synthetic substance, which was ridiculous because he was fine with doing MD/MA. (Student M, a 28-year-old Master's student)

Student M added that he kept insisting that his friend take the medication, trying to reassure him that was far safer than any other drug he was using. Here we can focus on two interesting, simultaneous processes: First, Student M sees his friend's exam and subsequent graduation as highly important, and thus his inability to study as a significant trouble for him, which results in his suggestion that the friend should take a Ritalin so that he can graduate. This serves as yet another example of disruptions to life courses acting as catalysts for the initiation of psychostimulant medication use. Second, we can see that Student M tries to fulfill the important role of reassuring the friend of the drug's safety. Despite the friend's objection to taking this "foreign, synthetic substance" into his body, Student M insists that it is not dangerous. He is incapable of understanding his friend's rejection of taking the medication, as he had

witnessed him use a variety of illicit drugs. To him, the psychostimulant medication's status of being a medication makes it safer than illicit drugs, even when the person is using them without a prescription. The fact that potential risks that are associated with use and the side effects are clearly stated in prospectus make these medications predictable in the minds of both non-users or users who is approached by a friend demanding a prescription psychostimulant. In contrast to illicit drugs whose quality, "purity and intensity of the drug is an unknown" (Quintero & Nichter, 2022), gives the users a sense of safety toward both using and keeping these medications.

Another interesting example came from my interview Student F, who is a graduate student in her mid 20s. As I mentioned in the previous section, she first started using psychostimulant medications when her preparations for the university entrance exam were going badly, through her mother's recommendation:

> My little brother was always a problem child in terms of his education, which is how he first got prescribed with Ritalin. (…) My university exam prep was going so poorly, and I thought the only way I would get a decent result was through my TS (Turkish – Social Sciences) score. But the program I wanted to study didn't accept a TS score, and I just couldn't concentrate when it came to do math. That's when my mother suggested that I take half a pill from my brother's stash to see if it would help out. That half a pill was so helpful that my mom contacted a psychiatrist friend of hers, who wrote me a prescription for Ritalin. I had no time for regular seances with this psychiatrist, so I just started using it. (Student F, a 26-year-old Master's student)

Here, we can see the mother step in to help her daughter cope with the significant trouble she is experiencing in her preparation for the university entrance exam. Two points are of interest here: First, the mother assumes the role and the responsibility of a medical professional by stepping in to make her daughter try the medication and by getting her a prescription from a friend. While functions like clearing doubt and reassuring the user of the drug's safety would regularly be fulfilled by the medical professional who is prescribing the psychostimulant, in this case they are transferred to the mother. Prescription medications are usually considered more acceptable than other drugs, it is because they are believed to developed for the treatment of specific ailments, manufactured within a professional environment and they have been through extensive laboratory testing (Quintero et al., 2006). The quality of being a medical

product which is prescribed by a doctor and acquired from pharmacy gives the immediate circle of the individual a sense of safety in terms of sharing the medication. Second, we see that the mother suggests that her daughter take half a pill to start. Examples of dosage control such as this are common among introductory experiences of those who have tried it without prescription. The introducing party assumes the role of establishing the safety of non-user, and gives suggestions about the proper dosage, proper type of use, what not to mix it with, et cetera.

2.4.2. Peer-Networks

As I had the opportunity of interviewing four students who belong to the same peer-network, I was able to obtain a fuller picture of how peer-networks and friends' function in the initiation of non-users to psychostimulant usage.

Student B, who is a graduate student in her late 20s, came to recognize her troubles with inattention during her undergraduate education when one of her friends drew her attention to her inability to focus while they were studying together. Upon seeing a psychiatrist, getting diagnosed with ADHD and being prescribed psychostimulant medications, she started recommending the psychostimulant medications to some of her friends who were struggling in their academic pursuits. She recalled one such time in the following way:

> Yeah, I told her [Student A] that in the time we set aside for studying, she didn't appear to be working all that much and that she seemed distracted. I asked her if she had something else on her mind, if there was something going on with her life. She told me that she wasn't able to concentrate, that other things kept intruding on her thoughts when she tried to focus on studying. That's when I told her that I was on psychostimulant medications, and asked her if she would like to try one. She said yes, so I gave her a pill. (Student B, a 28-year-old Master's student)

We can see that Student B plays a crucial role in her friend's introduction and initiation to psychostimulants. First, she frames her observations regarding her friend's studying habits in terms of inattention, inability to focus, and distraction. She opens up space for her friend to talk about her lack of concentration. Next, she introduces the idea of

using psychostimulant medications to overcome such difficulties, and renders them a safe and viable option in her friend's eyes by establishing that she herself is using them.

Switching to her friend's perspective, this is how Student A recalls the same time in her life:

> I didn't know that I had ADHD back then, or that there were medications like this. Then one day, my friend [Student B] saw some signs of ADHD in my behavior. She asked me if it was possible for me to have ADHD, and I said I didn't know. Then I went to my psychiatrist and got a prescription. (…) The first time I used Concerta was when [Student B] gave me one when we were at the library together. I couldn't believe how well I was able to understand what I was reading, how much I could concentrate. That's why I immediately went to my psychiatrist. (Student A, a 28-year-old Master's student)

That day at the library marks a significant turning point for Student A, as it is through the medication that her friend introduced to her that she begins to feel "normal" for the first time in her life. She described her experience with the medication as "the medication bringing her perception to normal, regular levels".

Student B also introduced Student M, a graduate student in his late 20s to psychostimulants:

> We were studying at the library, and I was working on a lab project on one side and on my classes on the other. It was the evening, and I was really tired. [Student B] had some [psychostimulants] on her, and I knew that those were used to study. I knew that even if you didn't have a prescription or a diagnosed disorder, they worked in making you study harder. So, when [Student B] offered me some, I took it. (Student M, a 28-year-old Master's student)

When asked how he knew about the effects of psychostimulant medications before starting to use them, Student M pointed to his peer-network and friends for supplying that information. Here, the peer-network of the student is responsible for rendering the psychostimulant medications as helpful agents in the student's mind, as well as clearing any potential doubt about using these medications off-prescription. The peer-network is also responsible for the actual supplying of the medication for the initiating moment of use. It is also worth noting that Student M was familiar with

psychostimulants in the context of partying, and he had previously taken them as party drugs. However, through the intervention of his friend, we see a recontextualization of the psychostimulants take place for Student M. He gets re-introduced to psychostimulant medications as substances to be used in a library rather than a party setting, and the place and purpose of use, as well as method of intake (snorting vs. taking the pill orally) completely changes through the friend's involvement.

The third and final example of initiation through this specific peer-network comes from Student L, who is an undergraduate student in his late 20s. He was introduced to psychostimulants by Student B and Student M, and he described his initiation story in the following way:

> [Student B] talked about them [psychostimulants], because she had gone to her doctor and did research about them, talked to others about them. So, she told me all about them. When I asked them "[Student M], [Student B], do you think it would work for me? I just need to decrease my caffeine intake and for it to carry me through the night, would it do that for me?" they immediately said "Are you kidding me, of course it would work. You're thinking too small, it will do far more for you than helping you stay awake at night, it'll help you focus, just relax and take it." That how I went "Ok, I should try this." I knew that I didn't want to use it regularly, that idea didn't appeal to me. At first the psychostimulants didn't have a very clear representation in my head, I was confused about them. But then when I saw such close friends of mine use it in such a professional way – like they would take a pill and then immediately finish writing the essay they were working on – that helped me too. They are all successful, bright kids, they are not like me, they work hard, they know how to approach these things. And I feel like they get that energy from the pills. (Student L, a 27-year-old undergraduate student)

Student L's retelling of his introduction to and perception of psychostimulant medications very clearly demonstrates how his friends who were already using psychostimulants informed him, relaxed him, and persuaded him to start using these medications. His rather limited expectations from psychostimulants were met with enthusiastic, convincing arguments about the powers of psychostimulants. He wanted to decrease his caffeine intake while still finding a way to stay up for longer so he could study, but these medications were promoted to him as being so much more than that. We can also see that Student L associates his friends' success and ability to work hard with their psychostimulant usage, and that this more "professional" and

successful way of using these medications helped him change his mind about not using psychostimulants on a regular basis. In other words, we can say that Student L received a complete re-education about psychostimulants from his friends. They informed him of the psychostimulants' capabilities, they addressed his concerns about regular usage, they soothed his worries and initiated his usage.

Through these interconnected examples and narratives, we can see how a non-user witnessing a friend who is using prescription stimulants might either directly ask what the medication is about, or indirectly observe a friend using the medication and become convinced that these medications could also work for them. Seeing these medications being tried and tested by a friend helps the non-user develop a rough conception of psychostimulants medications as effective agents. This "rough conception of the psychostimulant" is required to be able to make an interpretation about the medication. Being able to develop a preliminary idea of what the prescription psychostimulant is about is required for the non-user to at least try the medication out, and this is especially the case when there is no authoritative medical judgement relieving the person's doubt about the medication, or reassuring them that it is completely safe. It is the non-user's friend or family member that foregrounds the idea that the medication is safe and usable. Even if it does not take place like a friend actively convincing the non-user about how desirable using the drug is, non-user observing a trusted friend using it for some time for instances of academic difficulty, make sure that it is okay and preferable to use it.

2.5. Chapter Conclusion

Emerson describes "response" as an action that is "initiated in reaction to an irritating event or worrying state of affairs" (Emerson, 2015, p.11). Reactions may involve a clear response to a trouble – like identifying the experience of academic difficulty as having ADHD and applying a treatment protocol to it– or response may show up in more covert forms, like managing the difficulty without putting it into a definitive category. In this chapter, I described three main strategies by means of which individuals delay the recognition of their troubles as ADHD: By externalizing their problems they assign responsibility to agents and systems outside of themselves, by

normalizing their issues they distribute the problem to a wider population of people and treat it as a universal experience, and by trivializing the difficulties they face, they undermine the severity of the troubles they are experiencing. Through these strategies, students attempt to integrate the experience of trouble into their daily lives, without recognizing it in concrete, medical terms such as ADHD symptoms.

Whether the trouble will move to the level of receiving an extrinsic response (concrete form involving official judgements and friends or families in terms of providing medication, information, and helping) depends upon the success or failure of previous intrinsic responses. In other words, if the individuals could not deal with it by their own means, or normalizing the problem does not give solace or help the individual, the trouble could be interpreted and reframed as a significant one, requiring external response and the individuals to go beyond their own resources. Trouble is defined as "the recognition of something wrong and must be remedied" by Emerson and Messinger (Emerson & Messinger, 1977, p.121). If the intrinsic resources could not provide a solution for it, the remedy takes the form of an extrinsic response which requires the involvement of other agents and means. This is what we encountered in the following sections of this chapter, *Disruption of the Life Course* and *The Role of the Social Circle in Initiation*.

As the students' own strategies and techniques of coping with their problems fail them (or simply threaten to fail them), the students are pushed towards recognizing the nature of the issues they are experiencing in more concrete terms. Significant life events and turning points appear as testing grounds for these intrinsic responses that are developed by the individuals. As the threat of disruption to one's life course grows, the problems become recontextualized and reframed as significant troubles that require some sort of extrinsic intervention.

The social circles of the students appear as a second catalyst in this process of redefining and renaming the troubles. As I demonstrated, the immediate social circle of the student often plays a crucial role in informing them about the existence and potential benefits of psychostimulant medication treatment, and in clearing the students' doubts about psychostimulant medication use. The bringing forth of a

remedy to the experienced troubles helps the student come to recognize their problems in a new light: as troubles that require intervention, or as symptoms of ADHD that require treatment.

CHAPTER 3

STRATEGIES FOR ENSURING CONTINUAL USE

3.1. Chapter Introduction

In the previous chapter, I have discussed the factors that contribute to an individual's initiation to ADHD as a medical category and the use of psychostimulant medications. This chapter will focus on the strategies that are employed by the students to ensure the continuity of their psychostimulant medication use. To do so, I will first discuss how ADHD acts as important identity for the students in continuing their use of the medications. I will argue that the existence of a strong ADHD identity is one of the important contributing factors to continual use of psychostimulant medications because it provides grounds for the justification and rationalization of drug use. Second, I will explore the practices they engage in to accommodate the effects of psychostimulant medications. Here, I will first discuss the practices that are used to customize psychostimulant use and second, the ways students use for dealing with the undesirable effects that are caused by psychostimulant medications. Third, I will show the ways that students manage their psychostimulant medication supply through their interactions with the medical professionals including psychiatrists and pharmacists.

3.2. The ADHD Identity

Sociological literature on illness experience is built on illness narratives (Charmaz, 1983, 1995). As the individuals experience physical changes in their bodies and the taken-for-granted functioning of their bodies is being disrupted, they compare their past experiences of their bodies with the new ones. This results in their sense of self being redefined, as the prior unity between body and self is shaken (Charmaz, 1995).

It is the experiences of illness that force the sufferer to reconstruct their life and the relationship between self and body in light of new bodily changes and dysfunction.

The case of ADHD presents a different trajectory from the previous sociological accounts of illness experiences. ADHD is not recognized as something that happens to the individuals (Loe & Cuttino, 2008). As I discussed in the previous chapter, ADHD is recognized in the moments where it threatens to disrupt the linear life course of the individual. It needs a social context in which it can be situated as causing trouble in one's life. The difficulties that are experienced by the individual may not be recognized as being caused by ADHD unless they pose a threat to one's course of life, and thus they may not pose a sudden rupture in the experience of body and self. The vast majority of the students in my sample recognized themselves as having ADHD after starting to use prescription psychostimulants and seeing their effects on their bodies and selves.

This relationship between the disorder and its remedy is exemplified in Davis and Pastello's (2005) article on the effect of medication use on the users' perception of self. They argue that the meanings that are attributed to cures are just as important as those attributed to the illness experiences. In my case, the treatment plan for ADHD almost always involves the use of psychostimulant medications. I hold that psychostimulant medications do not simply act as a cure or a remedy, but rather, they serve as the condition for ADHD to be experienced in the first place. Although the remedy acting as the ground upon which the disorder is constructed sounds counter intuitive, this dynamic is exemplified in other studies. Most notably, as Karp (1994) mentions in his article on the experience of depression, the construction of an illness identity takes place as a result of the individuals' involvement with the medication and psychiatric experts. Medication is of particular importance for our case as significant changes take place for the students with the use of prescription stimulants. Individuals start "reconstructing and reinterpreting their past experience in terms of current experiences" (Karp, 1994, p.22) Understanding what sort of self-conception that these processes lead into is crucial, because the subsequent questioning of identity and the emergence of a new sense of self are directly relevant to the continuous use of prescription stimulants. That is, being able to construct a meaningful and justified

identity may contribute to continuous use of prescription stimulants, and the lack of such an identity may prevent the continuity of the use. This relationship goes both ways in that constructing an identity around ADHD affects the students' use of psychostimulant medications.

In this section, I will discuss how the ADHD identity contributes to the continuous use of psychostimulants. To do so, I will present examples from students who possess a strong, working ADHD identity as well as examples from students who engage in a strategic use of psychostimulants without the presence of an ADHD identity.

3.2.1. The Effect of the ADHD Identity Over Psychostimulant Medication Use

The acceptance of ADHD as a medical category that applies and sheds meaning to one's life experiences affects how individuals approaches psychostimulant medication use. This can be clearly demonstrated through a comparison between Student B and Student F's narratives of psychostimulant medication use and their differing approaches to ADHD and their understanding of their troubles and accomplishments.

Student B has a very clear understanding of herself as someone who has ADHD. She reads all her past experiences with failure and disorganization through the lens of ADHD, and points out the stark difference she has observed in her behaviors and capabilities after starting to use psychostimulant medications. Right after leaving her first appointment with the psychiatrist who diagnosed her with ADHD, she called her mother and many of her friends and expressed her joy at the fact that "the problem did not lie with her" and that everything was looking up for her, now that she knew what was wrong with her. She reported that following her initiation to psychostimulant medication use, she started taking enjoyment from her school work for the first time in her life. My conversation with her made it clear to me that she believes there is a biophysical, objective, "real" condition with her brain that limits her capabilities. As she put it,

> For someone who doesn't have an attention deficiency, someone who can study on their own, it [psychostimulant medications] boosts their capabilities from

> 80% to 120%. (…) But I'm not at the same level as everyone else, my performance is at a 20% when I'm not on medication. I'm just trying to reach 60% or 80% through medication use. (Student B, a 28-year-old Master's student.)

She sees psychostimulant medications as tools that help her study at the level of others who do not have ADHD. Medications retain their medical meanings for her, and she sees them as treatment-centered objects first. Because she approaches the category of ADHD and the psychostimulant medications in this way, she has a much smoother experience with the continual use of these medications compared to someone like Student F.

Student F has been diagnosed with ADHD in her senior year of high school, and she can be described as a textbook example of ADHD for all intents and purposes. She experiences daily problems with her focus, concentration and attention levels, as well as having a hard time sitting still. Upon her diagnosis, her personal research on ADHD only served to convince her more that she did indeed have ADHD. She went over the online lists of symptoms many times, always reaching the conclusion that they truly described her. However, after using these medications all throughout her undergraduate education, she started to experience serious doubts about the category of ADHD and the safety of psychostimulant medications:

> By that time, I started thinking that - and I still think so – what we call ADHD is just a lie. I no longer believe it is a chemical imbalance in the brain, that it's a biological fact. It's a psychological addiction. I even went as far as believing in those conspiracy theories about big pharma and how it's making us addicted to these drugs from childhood. I kept thinking that I got gamed by the pharmaco-medical complex and it made into an addict and now I can't concentrate on anything and I'm full of rage. (Student F, a 27-year-old Master's student)

Having lost her belief in ADHD as a legitimate medical category, we see that her belief in psychostimulant medications as legitimate treatment options waver as well. Psychostimulant medications no longer appear to her as benevolent, medical substances; but rather as malevolent, addictive substances that push the individual towards a state of unhealthiness. Her ideas about psychostimulant medications and ADHD only grew stronger with the reaction she received from her psychiatrist:

> I told my therapist about all this, and she told me to talk to my psychiatrist about it. So then I went to my psychiatrist and explained everything to her, told her that I kept using more and more of the medication. She brushed it off saying it's nothing to worry about, that my tolerance must have built up. She would just send me away with a higher dosage. So I lost all trust in the medical aspect of this whole thing. (Student F, a 27-year-old Master's student)

When asked about her current practice of psychostimulant medication use, Student F said that she wants to quit the medications, but she does not feel strong enough to quit them by herself. She feels that she needs the support of a therapist to be able to quit, but she cannot afford to go to therapy with her current financial situation. This puts her in a tough spot, because she needs to take psychostimulant medications to be able to do her job and earn money and to be able to afford therapy, and she needs to go to therapy to be able to quit using the psychostimulant medications.

Another serious point of contrast between the experiences of Student B and Student F comes from the way they interpret their achievements. Whereas Student B sees the achievements she obtained during her psychostimulant medication use as her overcoming a difficulty and unleashing her true potential, Student F feels like her achievements do not truly belong to her:

> I'm not gonna lie, I would often think about if my close friends were thinking that I was an imposter, that I was fake. Because they were the people with whom I would talk about Ritalin the most, and I would obsess over whether or not people who knew I was on Ritalin were judging me. I used to think like "They know I'm on Ritalin so they know I'm a fake, they know I'm not actually smart." (…) Even in my Master's, I would write really good papers and even get like an 11 out of 10 on the papers I wrote, but I would also feel like I didn't really deserve to feel proud of myself. It was the same in undergrad, I thought that I didn't actually deserve to be successful, that it was all because I was on meds, that I was just an imposter. I still think about it today. (Student F, a 27-year-old Master's student)

Unlike Student B who saw her achievements and new found capabilities with concentration as her potential being revealed by medical, treatment-centric substances, Student F saw them as fake, disingenuous results that were caused by enhancement-centric substances.

In comparing the contrasting experiences of Student B and Student F, we can see how accepting ADHD as a part of one's identity can have dramatic effects on one's psychostimulant medication use. ADHD, as a medical category, grounds these medications firmly in the sphere of medicine and treatment, and the absence of such a disorder pushes them into the world of illicit, addictive drugs. While the individual feels at ease about continual use in the former case, in the latter case they are left questioning the safety of the medications and feeling trapped by their addictive qualities.

When Student B starts feeling more competent in handling her school tasks and becomes able to meet deadlines and attend her classes, she experiences that her agency is re-sustained. Her example shows that agency is sustained through regular use of prescription stimulants as the troubled part of her life – underperformance, failure etc. – gets resolved, she feels more in control. Being able to locate the past difficulties within a medical framework and making sense of them changes her vision of herself from "a not so successful person" to a well-functioning individual. Student B's self-conception underwent a significant change as the medication effected positive changes. Although Student F picked similar stories of failure to present her problems (such as not having control over her time, stories of failure etc.), and she presented that such problematic domains of her life significantly got better as she started using prescription stimulants; she did not have a similar sense of "sustained agency". On the contrary, she had problems with claiming the achievements and positive changes that came along with the prescription psychostimulant use as her own. I suspect the reason behind this is not being able to construct an ADHD identity. Student F's problems and doubts with her psychiatrist and her "unhealthy" relationship with the prescription stimulants do not allow her to view her condition as medical. Furthermore, Student B has people who are using psychostimulant medications around her, she could communicate her problems with the medication or her condition. Her immediate social circle is composed of successful people who are using psychostimulant medications:

> I started to study more, to read more, and I started basing my friendships on these activities. What brought [Student A] and me so close together was studying together. She started using psychostimulant medications about the same time as I did, maybe a few months after me. We would take our meds

> together, sit down and study for hours, and then celebrate having studied so well by drinking a beer and smoking a few cigarettes. (Student B, a 28-year-old Master's student)

Student F does not have such a friend group. The people with whom she spent the most time and to which could compare herself were not using prescription stimulants. That made her feel like she is enjoying a level of success that she did not deserve, because people around her were successful without having to use prescription stimulants. The absence of a solid ADHD identity – because of her denial of medical explanation, her feelings of distrust toward psychiatrists, and perpetual need for increasing the dosage – does not allow her to justify her prescription psychostimulant use.

To conclude, Student B experienced a breaking point with the use of prescription stimulants and she regained her agency as she obtained control over things that require her to perform well – such as exams, deadlines, time-organization, learning new skills in extracurricular activities– she felt like she was becoming who she was meant to be, unveiling her true potential. Meanwhile, Student F failed to evaluate her troubles through a medical lens. She did not have a proper experience with medical professional – having problems with medication and medical expertise forestalled her attempt to form a working illness narrative. In the absence of an illness narrative, her use of prescription stimulants made her feel like she was damaging her "natural self", and after stopping use of psychostimulant medications she looked for other career options that could accommodate her "natural self":

> When I worked in marketing, I always worked under the effect of Medikinet, and I took a lot of Ritalin to be able to write those documents. I hated my job, and I couldn't do it well unless I took meds, so earning a livelihood became seriously linked to my addiction to these medications for me. This is why I decided to change my carreer and become a tour guide. I saw it as something that I could do without relying on medications. I don't want my livelihood to depend on my ability to concentrate. (Student F, a 27-year-old Master's student)

Respondent L talks about his "natural self" in a similar way to Student F. After experimenting with prescription stimulants a few times, and witnessing his friends' instances of psychostimulant use for a long time, he realized that prescription stimulants made certain tasks a lot easier than they "should be". This does not provide

him with a sense of agency. Unlike Student B who grew ever more confident in her life decisions, Student L did not experience such a confidence in his agency. For Student L, the fact that tasks and difficulties became so easy under medications robbed him of his power of choice, as dealing with school work became unnaturally easy for him, pushing him towards an academic future. The option of completing school and pursuing an academic track became easier with the use of psychostimulant medications, and the easier it easier, the less it is an option, but a necessity.

> Now, this state of intense focus had an interesting aspect based on my experiences. (…) Sure, the medication made me focus but the focus it gave me felt really mechanical. It was as if an external algorithm was uploaded to my brain that was designed to get the job done, to just focus and do it. It all felt really mechanical and I really didn't enjoy it. So, I started to feel like there was no sense in me pushing it, like if I couldn't do something as my own body and brain, I shouldn't take that road. I sensed that the medications could force me towards an academically successful path, and sure it's a good path, but it's not necessarily a path that [Student L] would take if left alone. Maybe my body is trying to tell me something when it's not as successful at doing something. (Student L, a 27-year-old undergraduate student)

While for some, taking psychostimulant medications feel like accessing their true potential, for Student L it felt like a foreign, external force, "an algorithm" was guiding his actions towards a predetermined future on which he had very little say. The existence of such a coercive feeling ultimately resulted in him discontinuing use of psychostimulant medications, as he could not come to terms with the effect the psychostimulant medications had on him.

3.2.2. Us vs. Them

As hinted in the previous sections, students who retain their ADHD identities often frame those who use psychostimulant medications without a diagnosis of ADHD as a separate, other group to themselves. This results in a frequent usage of an "us vs. them" language when they are talking about their psychostimulant medication use compared to the others' use. In this section, I will discuss how students who have fully formed, functional ADHD identities build a division between themselves and others. The following section will focus on the other side of the coin, where I will explore the

perspective of students who use strategically use psychostimulant medications, but who do not think they have ADHD.

During my interview with her, Student E talked at length about how others perceive psychostimulant medications and how she finds their understanding of psychostimulants naïve and misguided:

> For example, I remember coming across this sort of post very frequently in [a popular Facebook group among her university's students]: "I have two classes left that I'm taking again, and I have a month left until the exams. They told me about something called Concerta, apparently it makes studying super easy." I guess people think that this is some sort of magic pill and that when you take it, information just reveals itself to you. (…) It's serious business taking these medications. I always tell them, there is a reason this medication is under a red prescription. That means that if you are not prescribed with this medication, you don't actually need it. (…) Rather than going door to door, looking for someone who will give them a few pills they could spend their time doing something more meaningful like studying. To me, those who ask for a few pills always try to take the easy way out of studying, they are always looking for it so that they can deal with the two exams they have in front of them. I never took these medications for an exam, I used them because I had big academic ambitions but I couldn't even understand the lectures. (Student E, a 27-year-old PhD student)

Student E draws a clear distinction between her motivations and reasons for using psychostimulant medications and the motivations of those who wish to use psychostimulants without a proper ADHD diagnosis. At the root of this distinction there lies her identity as someone who qualifies with ADHD. She states that she has never approached her medication as a substance that will allow her to pass from an exam, rather she approached it as a medical intervention tool that allows her to overcome the disorder she is dealing with. When we remove the disorder from the equation, we are left with an individual who has the capacity to sit down and study but for one reason or another, refuses to do so. She characterizes this other as someone who is trying to find a shortcut out of studying, someone who doesn't actually need psychostimulant medications. It is through this perceived need - or lack thereof - that she draws a border between herself and others.

A similar sentiment was also present in Student B's remarks about some of her friends who use psychostimulant medications. In particular, when talking about Student M (who, as I mentioned in previous sections, started using psychostimulant medications after seeing their positive effects on Student B) she mentioned that she did not believe Student M had an actual problem with inattention. She did not think of Student M as someone with ADHD, and this leads to her seeing his psychostimulant medication use as a form of enhancement, a boost to his already high capacity:

> [Student M] used to use psychostimulant medications to boost his capacity from an 80% to a 120%, and I don't find this sort of use very meaningful. If he wasn't such a close friend, I wouldn't share my medication with him for this sort of use. I'm dead set on this, because I really don't think he needs, and using these medications without actually needing them isn't good for him. Besides it not being good for him, it makes me really angry, because I take these meds so that I can function at his normal level while he's taking them to go beyond that. What's next then, is everyone else in academia going to start using psychostimulant medications? (Student B, a 28-year-old Master's student)

Besides seeing their experiences as fundamentally different, she also has a strong, negative, emotional reaction to the sort of psychostimulant medication use Student M engages in. While she perceives her own use as justified on the basis that she has ADHD, Student M's use is seen as a separate, "other" experience by her. This is parallel to Student E's negative depictions of students who take the easy way out by using psychostimulant medications. Both of them rely on their disorder to separate themselves from others who engage in different use scenarios, and both of them express judgement towards those others.

This separation between herself and her friend is even more evident in how she experiences and interprets the side effects that come with psychostimulant medication use. She holds that if one's body doesn't actually need these drugs - meaning, if one doesn't truly have ADHD – the side effects are much more severe and difficult to manage for the individual. She, on the other hand, as someone who has a chemical imbalance in her brain, finds the side effects minor and manageable:

> Yeah, I honestly don't think [Student M] has attention deficiency. I think it's deeply related to that, to whether or not your body actually needs it. For example, the medications really trigger [Student M]'s anxiety, he becomes

> really tense and difficult to communicate with, he's really grumpy by the evening. There's definitely an imbalance between what it gives to him and what it takes away from him. Me, because I benefit from the medication so much, I can also deal with the side effects. (Student B, a 28-year-old Master's student)

The experiences of Student E and Student B in relation to their psychostimulant medication use versus the use of others are echoed in the interviews I held with other students who identify as "really" having ADHD. Through their act of distinguishing themselves from others - others who they see as being in the wrong about their psychostimulant medication use - they also justify their own use cases, which, in turn, helps them in enabling their continual use of psychostimulant medications.

3.2.3. Strategic Use of Psychostimulant Medications

In the previous section, we saw how students who possess the ADHD identity utilize their difference from students who use psychostimulant medications without having real problems with inattention as a way of justifying their use and ensuring in continuity. This section will focus on the accounts of students who belong to the latter camp, students who use psychostimulant medications in strategic points in their lives. As the following examples will show, without the presence of the ADHD identity to ground the medication use, the students are not likely to continue using psychostimulant medications once they surpass whatever difficulty they were trying to manage by using psychostimulants. This strengthens my finding that the ADHD identity stands in strong correlation with the continual use of psychostimulant medications. Unless the individual assumes an ADHD identity, their instances of psychostimulant use remain limited to particular, strategic times.

Student C's case provides a supporting argument for my premise. Student C is a PhD student in his early 30s, and his main motivation for going to the psychiatrist and seeking out a psychostimulant medication prescription was to be able to complete the article he was writing at the time. As I have described previously, there are two important pillars in the construction of illness identity. One is starting to view past experiences of difficulty and trouble in the light of present experiences and the second is locating the troubles onto a particular illness narrative, that is, accounting for the

gap between the past and the present with reference to an ADHD narrative. Rather than grounding his psychostimulant medication use in ADHD, he stated that his lack of organizational skills and planning abilities were the reason why he had to resort to medication use.

His conversation with his psychiatrist does not give him any sign that he might "really" have ADHD either. On the contrary, the psychiatrist explains to him that she does not believe Student C has ADHD, and that she was writing the prescription under the condition that he would stop using the medication once he was finished with the article he was writing at the time. She made it clear to him that his prescription would not be renewed once this period was over. The psychiatrist's comments and diagnosis, when combined with Student C's self-perception, show us that he has no reason to believe he has ADHD. This leads to him seeing psychostimulant medications as substances that can help him deal with the immense workload he was under. His relationship with the prescription stimulants is a strategic one.

As strategic substances, the psychostimulant medications can only find a place in Student C's life as long as they serve their purpose of helping him study for long, continuous hours and providing a smooth studying experience. This is why Student C abandoned using the psychostimulants upon experiencing side effects like lowered moods and feelings of anxiety, which disturbed his smooth study sessions.

In short, the ADHD identity requires the user to think of prescription stimulants as less problem-specific, strategic substances, and more like substances providing a thorough benefit to the individual. If the users' perception of efficacy is associated with completing tasks and meeting deadlines, then it is hard to subsume the medication into a more general narrative of healing. The problems that occur in the process of using psychostimulant medications makes the user think twice about continuing psychostimulant use, as the psychostimulants do not fit into a general and grounded healing narrative and ADHD identity.

Student J, who is a PhD student in her early 30s, had a similar experience. She started using psychostimulant medications to be able to complete her Master's thesis in time,

and abandoned them once she was finished with her thesis. She stated that she believed she could have also finished her thesis without the help of psychostimulants, and that she felt ambivalent about having used them in the writing process:

> Yeah, I mean you feel sort of odd when the thing you accomplished came with the use of meds. I thought about it a lot after the fact, changed my mind about it all. When I do something using meds, it's not really my own success. It's both the medication's and mine. That's why I don't think I would use psychostimulants if I was in the same spot now, I think I could do it without them. Because the meds are honestly just great, I still miss the feeling they gave me. But still, I just wouldn't do it again. I can't find a way out of this dilemma. (Student J, a 33-year-old PhD student)

This dilemma she faced about enjoying the effects of the psychostimulant medications but feeling like her achievements and success did not belong to her holds Student J from using psychostimulant medications in a continuous way. In the case of students with ADHD identities, we have seen that this ambivalence and doubt towards medication use is partially resolved through their belief that they could not have done it without the help of the medications and that the medications are not magic pills that give them capabilities beyond their own potentials. When the ADHD identity is missing, as in the case of Student J, we see that feelings of uncertainty linger in the student's experience with psychostimulant medications.

Interestingly, Student J's thoughts about the inner workings of the human body also stood in contrary to other accounts of illness that depict illness as genetic and / or an irreparable dysfunction or deficit. She argued that the human brain is just like a muscle, and that all parts of it could be strengthened and or reprogrammed through regular exercise:

> The chemicals in the psychostimulants work because they activate certain receptors in the brain and cause it to release certain chemicals. And for example, by swimming I can cause a wonderful dopamine release in my brain. Sure, receiving psychological help or even using medication is necessary sometimes, but I think you can just train your brain to do certain things, it's just like a muscle. My swimming provides me with all the energy and motivation I had while I was using psychostimulants because I trained my brain. I come back home from swimming and I can study for hours, I feel really strong. (Student J, a 33-year-old PhD student)

Her understanding of the human brain and illness pushes her away from the narrative of the ADHD identity, as she sees the problems that are caused by ADHD as solvable through sheer will and training. Thus, she has a difficult time coming to terms with her use of psychostimulant medications, because her grounds for justification and rationalization of drug use are removed.

3.3. Accommodating Psychostimulant Use in Everyday Life

As mentioned in the previous chapters, in the sociology literature the issue of prescription psychostimulant use is exclusively studied in reference to "compliance". Compliance refers to the overlapping of individuals' practices of pharmaceutical use with the medical professionals' advice. (Conrad, 1985) Meaning, it serves as the yardstick that is used to decide whether or not the practices of psychostimulant medication use fit into a medical framework. According to the rational drug use paradigm, individuals' practices of pharmaceutical use could be either categorized as medical use or non-medical use/misuse/abuse, depending on if they have a legitimate prescription for the medication and to their compliance with the drug regimen. In the case of psychostimulant medication use, compliance involves using the medication only for the treatment of ADHD, and following the directions of use given by the medical professional, without making any adjustments in terms of frequency of usage or dosage. The rational drug use paradigm dictates that unless compliance is achieved, the medication will not produce therapeutic effects and the potential for abuse will increase.

The medical perspective is not able to explain the stages that the individuals go through before coming to the point where they become regular users of prescription psychostimulant medications. The medical perspective overlooks three main points in psychostimulant medication use: i) the initial stages where individuals recognize certain difficulties they experience as "troubles" requiring an external intervention, ii) how individuals get their hands on prescription stimulants via their immediate social circles, and iii) how the concept of the psychostimulant medication use is introduced along with how the knowledge of effective and safe practices of psychostimulant use is communicated within a network of users. In the previous chapter I focused on the

first two neglected areas, and this section will focus on the third by discussing different ways in which students engage in practices that accommodate psychostimulant medication use.

As these medications help their users manage performance related tasks and difficulties, most of the students I interviewed had used these medications during the academic semester. As discussed in the previous section, for some students these medications become a routine part of their life, while for others the domain of use is limited to specific tasks like taking exams or meeting deadlines. Assuming the identity of a person with ADHD determines the chances of these medications being used continuously by the student. For instance, those who developed an ADHD identity could not abandon psychostimulant use as they wished, while who those had not often quit using the medication upon running into issues with side effects or supply.

Despite their differences, what applies to almost all the student in my sample is that the way an individual is going to use psychostimulant medications is not fully determined from the beginning by their interaction with medical professionals. The students' subsequent use of prescription stimulants does not follow the medically sanctioned path, because there are various other things to consider. The logic of psychostimulant use goes against the compliance framework, and it goes against the medical paradigm that the medication is prescribed for the treatment of the disorder. According to the compliance framework, the patient has to follow the medical professional's suggestions; while in reality, they occasionally depart from the medical professional's orders. Different practices of medication use are created by the patients. Different practices of medication use are usually learned through peer-network, forums where others' experiences are shared online, and trial-and-error methods.

There are a number of reasons for individuals to engage in accommodating practices of psychostimulant use. First, they might feel that their psychostimulants do not provide as strong an effect as their previous uses. Not being able to get the desired effect from the medication pushes individuals into reconsidering their ways of consuming psychostimulant medications. Secondly, individuals' expectations from the medication changes according to the tasks they are going to perform while on

medication. To complete a short study session in the evening, the individual may prefer to use a lower dosage or an immediate-release (IR) medication. Contrarily, when the user is taking an exam which lasts long hours, then he or she might find it more sensible to go with an extended-release (ER) tablet. The third main reason that individuals feel the need of adjusting their way of use is managing the side effects. The fourth reason is that some of the students feel like the medical professionals do not really understand what dosage or what sort of psychostimulant they need. They feel like they are not adequately informed. They have occasionally encountered unexpected situations where they need to take initiative and self-regulate their own use.

3.3.1. Optimizing the Psychostimulant Medication Usage

3.3.1.1. Adjusting the type and dosage of the medication according to the task at hand

One of the main ways that the students customize their psychostimulant medication usage is by taking into consideration the type and duration of the task they want to accomplish when they are under the effect of the medication. Studying for an exam for 6 hours and taking an exam for 90 minutes are fundamentally different tasks that prompt the students to make different decisions regarding the type of medication they use and the time of day they take the medication. While it takes about 30 to 45 minutes for immediate-release medications like Ritalin to take effect, extended-release medications like Concerta reach their peak effectiveness within 6 to 10 hours. This makes the former more preferable in an exam setting, while the latter is more often used to stay productive during the entire day.

As mentioned in a previous section, Student G uses prescription stimulants in strategic moments such as taking important exams. He stated that he prefers to use immediate-release medications before entering the exam to stay awake and focus for the duration of the test. During our interview, he recalled a specific instance where he was about to take an important exam but he did not have any immediate-release medication at his disposal. This led him to taking an extended-release medication he had at hand, but modifying the pill to try and convert it into an immediate-release psychostimulant:

> Yeah I broke the pill in half, and identified the half that contained the quick release, immediately active portion of the drug. I had heard about this method from a friend and seen it mentioned on the internet, so I decided to do it because I needed it to kick in immediately, before the exam started. But I don't usually prefer to take Concerta because of this, I mostly use Ritalin. I would just adjust its dosage to suit the exam. (Student G, a 27-year-old Master's student)

Student G's medication taking practices show us two things: First, individuals' choice of psychostimulant type changes according to the context of use. They may choose different release forms for studying or for taking exams. There is no general rule of conduct, though. It depends on the individuals' interpretation of how well they perform while they are on these different types of psychostimulants. Secondly, individuals customize their psychostimulant so that the medication fits their expectations. This may look like a simple adjustment of dosage, or a more dramatic customization as in the case of Student G.

Student G also mentioned that the knowledge of how to use these psychostimulant medications is circulated in friend groups. He and a friend of his frequently discussed their preferred ways of usage and gave each other feedback on new methods they tried: We would often talk about how can you make the meds more effective, how it affected each of us, how our experiments with dosage turned out. We would give each other feedback on how different types and dosages of meds worked in different instances.

> There's this flow of information between us where we inform each other about different ways of usage. It's not like a prescription of what to do and what not to do, but a sharing of information about our experiences. (Student G, a 27-year-old Master's student)

Through this sharing of knowledge, the students involved gain a better understanding of which types and dosages of medication pair best with which activities and settings. They adjust and customize their use based on the context they find themselves in, and they base their decisions on the shared experiences of others.

Student B, on the other hand, used psychostimulant medications to increase her concentration while she was studying, which prompted her to switch from Ritalin to Concerta:

> I started to realize that Ritalin was not that suitable to my lifestyle or needs. I was taking a really large number of classes that semester. I would wake up to go to a morning class, and take a Ritalin before the class but it wouldn't kick in until the lecture was halfway done. Its effect would last for the second half of the class and the break I had until my second class of the day, but it would have completely faded by the time I had to sit in that second class or study in the evening. That's why I convinced my psychiatrist to switch to a medication with an extended duration of effectiveness. (Student B, a 28-year-old Master's student)

Unlike Student G, who required the medication to give him an immediate boost that only had to last for a couple of hours, Student B needed her medication to carry her through the multiple classes she was taking in the day, as well as the study sessions she was doing in the evening. After doing research and talking to friends, she realized that using the other common type of psychostimulant medication (ER types) would be the best option for her.

3.3.1.2. Adjusting the daily schedule and time of usage

Psychostimulant medication use requires individuals to arrange their daily routines. This was visible in Student B's narrative. Student B's decision to switch to Concerta came with its own set of adjustments that she needed to implement in her life.

> So I started taking Concerta instead, but Concerta as a drug makes you conform to its lifestyle rules much more than Ritalin does, it forces you to live according to its demands. For example, if I took it after 11 in the morning, I wouldn't be able to sleep at night, so I would have to wake up before 11 am. I had a really hard time waking up early in the morning, and that's one of the major benefits I experienced from using Concerta. It forced me to wake up early so that I could take my med, because if I didn't take it then I wouldn't be able to take it later in the day. (Student B, a 28-year-old Master's student)

This is just one way that students adjust their daily routines around their psychostimulant medication use. In this example, the characteristics of the medication - like the extended-release of the chemicals in the case of Concerta – implement certain restrictions on the individual's daily routine such as waking up or sleeping hours. The same sense of a forced routinization of daily life was present in the way Student M talked about his own psychostimulant medication use:

> When you start using it, it completely changes your daily routine. Like two years ago, I used to be someone who would exercise regularly, study at the library, take part in the student association I was enrolled in during the weekends. And the moment you step into the routine of the drug it's all gone, you can't exercise, you can't do anything else. The daily withdrawal of the drug makes you resistant to do anything else, I wouldn't even start watching a new TV show, I would just rewatch old ones I had seen before. It dictates everything in your life: the time you go to bed, the time you eat, what you eat and drink… (Student M, a 28-yar-old Master's student.)

According to his experiences, psychostimulant medications played a sizeable role in ordering his everyday life. Most notably, he had to plan and organize his daily activities around the spikes and falls of energy he had in different times of the day based on his medication usage. Even his most basic needs like sleep or food were organized around the timetable that was enforced by the psychostimulants.

Much like in the previous section, we see that the knowledge of how psychostimulant medications affect one's daily routines and how to adjust this routine is being shared within peer groups. Student L mentioned witnessing many conversations with his friends about the intense planning of daily life while the student is using psychostimulant medications:

> I saw this very often - the daily schedule is being planned in an extremely detailed way. I found it really strange at the time, like they would say "I'll take the meds at this time, by this time it'll start to fade away, but I have a second quiz exactly at that time, so I'll do this and that…" They would plan exactly when they would eat and what, they would know exactly when they would go to bed and sleep. (Student L, a 27-year-old undergraduate student)

3.3.2. Dealing with Undesirable Effects

All the students who have used psychostimulant medications in one way or another reported experiencing certain undesirable effects from their medication use. The most often reported effects included having difficulty sleeping, experiencing heightened levels of stress and anxiety, fixating on any given subject or activity, and a diminished appetite. One of the main findings that came out my research is that the undesirable effects that are perceived by the students greatly affect their continual use of psychostimulant medications. If the students feel like they cannot manage the

problems they experience around sleep and food consumption, deal with the anxiety they experience once the effects of the drug wears out, or come to terms with their fears of addiction; their chances of continuing to use psychostimulant medications greatly decrease. As Student D put it, "At one point you have to decide if you're going to deal with these effects or quit using the meds. I continue to use them because I figured out how to deal with them.".

The knowledge of how to manage these unwanted effects and the reassurance that these effects are temporary, reversible and manageable very often come from the social circle of the student who also use psychostimulant medications in their daily lives. As mentioned in a previous section, the existence of a peer-network that is engaged with psychostimulant use contributes greatly to the way the individual experiences their own psychostimulant medication use. In this section, I will go over the four most common undesirable effects I mentioned above and show the ways the students managed or failed to deal with these effects.

3.3.2.1. Sleep and insomnia

Experiencing difficulty sleeping and a low sleep quality was very common among my sample of students. Many students explained that due to the psychostimulant nature of these medications, taking them too far into the day caused them to have a difficult time going to sleep. The two most common ways of managing this issue was adjusting the type of psychostimulant medication (instant-release vs. extended-release) and / or the time of day that the medication was taken, and using other substances like alcohol, cigarettes, or marijuana to be able to sleep.

Student M described the cycle he found himself stuck in following his attempts to deal with the insomnia that came with his psychostimulant medication use in the following way:

> It changes from person to person, but it didn't let me sleep at all. I mean I could sleep with alcohol and cigarettes, but then something like this happens: Concerta is a pretty heavy substance, even the 36 mg version is really effective. So, when I took one at around noon, it took me 3 or 4 in the morning to be able

> to sleep, and that's with the help of alcohol and cigarettes. And when you sleep wasted like that, you wake up all messed up. It's impossible to be able to study like that. So then you take another Concerta, and the cycle repeats itself. (Student M, a 28-year-old Master's student)

His use of psychostimulant medications pushed him into a cycle of substance use, as he had to resort to alcohol and other substances to sleep and back to Concerta to manage the tiredness he experienced from the other substances.

3.3.2.2. Stress and anxiety

Heightened levels of stress, anxiety, irritation and other negative feelings were often experienced by students, especially once the initial effects of the psychostimulant medications started to wear off.

Student K reported experiencing negative feelings that were foreign to her following her psychostimulant medication use:

> I quit using because (…) I would get these strange feelings that I can't really describe, like I would either be extremely flat and emotionless, or experience the most extreme version of any emotion I felt. If I was sad, I would feel completely devastated, if I was offended by something I would react very strongly. I still feel the remnants of this today and I think it's because of the meds. I wasn't like this before I used them, and it was very strong during the time I actively used them. Now I feel it diminishing, but I still experience it. (Student K, a 21-year-old undergraduate student)

The disturbances she experienced to her emotional state by her psychostimulant medication use eventually resulted in her dropping them. This supports the premise that being able to manage and optimize the experience of prescription stimulants is required for the continuous use of psychostimulant medications. Additionally, the absence of a person that might voice alternative explanations for the negative experiences she was having or someone who may suggest a technique to deal with such emotions is a contributing factor for ending the prescription psychostimulant use. Her association of such feelings with the medication and being convinced that these are not reversible effects results put an end to her use, as she did not possess the knowledge or the support system necessary to deal with these difficulties.

Student F mentioned experiencing a "come down effect" following her use of Ritalin:

> Yeah, there's this thing called a come down effect, Ritalin especially results in you feeling extremely sad and worried. (…) So, I would often hit the bong to be able to deal with the depressive state Ritalin put me in, and that put me in a cycle of sorts. I spent a whole year like that, bouncing between Ritalin and the bong. (Student F, a 27-year-old Master's student)

Student F also expressed her discontent towards being stuck in this cycle which was initiated by her psychostimulant medication use and cited this dynamic as one of the main reasons for why she wishes to quit using psychostimulants as soon as she can.

3.3.2.3. Fixation

Another key point that requires the students' efforts to manage is the fact that psychostimulant medications can cause the person to become fixated at the "wrong" activities. Many students reported accidentally getting distracted and hyper-fixating at an irrelevant task like cleaning, consuming video content, or playing games when they took the psychostimulant to be able to study. The most common way of dealing with this issue was reported as being careful to clear out any distractions from the study space and setting up the actual material they were supposed to be engaged with before taking the medications.

> It can cause a strong fixation, a really obsessive fixation when you first take them. Like I would suddenly fixate on cleaning the kitchen, and I would not stop until every surface of the kitchen was completely spotless. So it was really important for me that I knew what I was going to do when I first took the medication, and that whatever I was going to work on was open on my computer, ready to go. (Student M, a 28-year-old Master's student)

Student M described that he became quite strict about properly preparing his mental and physical space before taking the medication in order to prevent accidental fixations on activities or subjects other than his intended activity of studying or writing. He also mentioned that both him and Student B try to stick to a library environment to minimize accidental fixations.

Student H experienced some fixation not on a particular activity, but on negative thoughts and feelings. Her strategy for dealing with this fixation involved focusing on the benefits she received from the medication:

> I remember getting heart palpitations and fixating on negative thoughts. (…) But this medication is my savior, I literally don't know how to focus on anything, I just can't concentrate. No matter how much these fixations bother me, I keep reminding myself that I need the meds, so I try not to focus on the negative obsessions. (Student H, a 28-year-old Master's student)

Here, we can see that her reliance and perceived dependence on the medication overwriting her discomfort at fixating on negative thoughts and feelings, allowing her to continue using the psychostimulants.

3.3.2.4.Food and diminished appetite

Having a diminished appetite and weight loss are some of the most commonly cited side effects of psychostimulant medications, and they showed up multiple times during the interviews I held. While the students who continued using the medications for extended periods of time came up with ways of dealing with their problems around eating, those who could not find ways around it discontinued their use of psychostimulants. One such example was Student C, who had concerns around the weight loss he experienced following his psychostimulant medication use:

> It killed my appetite and seriously decreased the amount of food I ate in a day. I knew that if I used it for an extended period of time, I would lose even more weight and I was worried that dropping to an even lower weight would affect my general health status. This is the major reason why I discontinued my use. (Student C, a 31-year-old PhD student)

In contrast to Student C, Student B continuously experimented with different ways of dealing with the issues she experienced around food and eating in order to be able to continue using the psychostimulants:

> When I took the meds, I would study as long as I possibly could, and completely ignore the fact that I had to eat. Which isn't the smartest thing to do, because the medication already leaves you exhausted. You know you're

> supposed to eat, but your stomach is upset and nothing feels good. I tried a lot of ways of dealing with it, sandwiches didn't work, hot meals didn't work… I finally landed on soups, as they were much easier to consume in that state. (…) Since sometimes it would be hours before I could have soup at school, I looked for some way I could snack during the day, during my study sessions. I remember searching for "Ritalin snacks" or "Concerta snacks" online to see if others had recommended snack foods. I saw someone suggesting fruits, so I started carrying around fruits with me every day. Otherwise, I would be completely wiped out by the end of the day. (Student B, a 28-year-old Master's student)

Because Student B saw psychostimulant medications as integral to her daily functioning, she remained resilient in the face of the difficulties she experienced around food, did research on ways of dealing with it, and ultimately landed on some solutions that helped her carry on using the psychostimulant medications.

3.3.2.5. Concluding Remarks

The above examples demonstrated some of the most commonly experienced undesirable mental and physical effects that come with the use of psychostimulant medications. The continuous use of psychostimulant medications rests on the student's ability of dealing with these effects. If the student cannot find their way around some of these issues, they render themselves unable to continue their use as the mental and physical ramifications of the medications outweigh the benefits they receive from their use of psychostimulants. I observed a correlation between the students' capabilities of dealing with the undesirable effects and the strength of their ADHD identities. Those who possess a strong, working ADHD identity rely on their psychostimulant medication use more heavily, and that causes them to be more motivated to keep trying to solve the issues they are experiencing with their medication use. On the other hand, those who practiced a more strategic style of psychostimulant medication use tend to try and bear the difficulties they are experiencing during their limited time of use, and then discontinue taking the medications because the undesirable effects affect their mental and physical health in a negative way.

3.4. Managing the Psychostimulant Medication Supply

The existing literature on psychostimulant medication use among university students tends to approach the question supply management from a rather limited point of view that separates medical use from non-medical use. There are an abundance of studies based on both qualitative and quantitative methodologies that explore how prescription stimulants are acquired in a university context. Within these studies, there is an apparent bias towards studying the illicit use of prescription stimulants, which is believed to produce more interesting qualitative results and it is viewed by the researchers as a more complicated and nuanced process. Scott Vrecko's study on non-medical use of prescription stimulants is one of the most cited texts presenting the argument that "the means through which non-medical users obtain their supply of medication are characterized by a significant degree of complexity and heterogeneity… compared to the simplicity of how Adderall is obtained when legally prescribed to a patient as therapeutic intervention" (Vrecko, 2015, p.302). He claims that,

> legitimately prescribed patients would generally proceed along a predictable pathway, taking a prescription obtained in the clinic to a pharmacy, where it would be exchanged for medication. In contrast, practices of drug acquisition among non-medical users of Adderall appear to be much less standardized, varying considerably in relation to the particular social and everyday circumstances in which individuals find themselves. (ibid.)

One point that stuck out to me during my research was the fact that "legitimately prescribed patients" did not have as easy and straightforward an experience during their encounters with the medical system in terms of securing a supply of psychostimulant medications. They face a variety of barriers due to the stigmatized nature of these medications, such as being perceived as "drug users" by pharmacists even if they have a legitimate prescription they are trying to fill. Many of my respondents who identify as legitimately having ADHD reported they had to engage in a number of strategies in order to obtain the medications they need to adequately function in their daily and academic lives. These strategies include actively trying to present a convincing case of having ADHD to a new psychiatrist they might be seeing, which is often written off as them faking / pretending to have ADHD to secure a drug supply.

I hold that applying these strategies does not make these students "non-medical" users. This dichotomous and binary way of thinking about medical and non-medical users causes a severe lack of rich data on the medical use experiences of psychostimulant medications. In this section, I will attempt to fill that this gap by discussing the nuanced experiences of medical users in managing their medication supplies. There are two domains in which these experiences take place: The psychiatrists' offices and the pharmacies.

3.4.1. Psychiatrists

Many of the students I interviewed who described themselves as having ADHD reported facing stigma from the psychiatrists they were seeing at the time of their usage of psychostimulant medications. Student H was diagnosed with ADHD and initially prescribed with an extended-release psychostimulant medication at a very young age. After years of use, she decided to discontinue using the extended-release medication because she felt that many of the critical exams and turning points in her life were behind her and she did not want to be on medication anymore. However, with the approaching deadline of her Master's thesis she started experiencing difficulties with concentrating and finishing her work in time, which prompted her to go to a psychiatrist once more, this time to get a prescription for an immediate-release psychostimulant medication. This is where she started experiencing supply-acquisition problems. Upon visiting the psychiatrist at her university's health center and explaining her story and situation, she felt unsupported and judged.

> I was working on my thesis all day without doing anything else and I was only getting done one fifth of what I was supposed to get done that day. It's not like I was doing anything else, all I did was sit in front of the computer and write my thesis but it just wasn't getting done. (…) The psychiatrist told me that I was trying to take the easy way out, and I repeatedly explained to them that I wasn't there begging for a medication because I loved using these drugs. This is a legitimate disorder, and I needed treatment for it. I don't want to use medication for it, but if I don't, I just can't do certain things, it's just impossible. But because they saw it as taking a shortcut or cheating, they said it wasn't necessary for me to use Ritalin. (Respondent H, 28-year-old woman, Master's student)

Here, we can see that even an individual who has been diagnosed with ADHD before starting primary school has a difficult time convincing the medical professional she is seeing about her needs for dealing with her disorder and daily tasks. This is far from being a singular example – the vast majority of my sample reported dealing with similar accusations of "trying to take the easy way out" or cheating from the medical professionals they were in contact with. This sort of response pushes students into developing certain strategies and techniques that help present a more agreeable and acceptable case to the psychiatrists, as exemplified by Student I's case. He was diagnosed with ADHD and prescribed psychostimulant medications, but once he ran out of his initial supply, he had a difficult time finding someone who would write him a new prescription. He had to go to multiple different psychiatrists to be able to renew his old prescription.

> So, I ran out of Ritalin, and went to a public hospital to renew my prescription. That was the first time I couldn't get a prescription, the psychiatrist just refused to write one. I told her that I was prescribed just recently, but she told me she wouldn't give me a prescription. And you can't really insist in those instances because then you risk being perceived as someone who is looking to abuse these drugs. For example, you're never supposed to say "I can't do without Ritalin", rather you should tell them it helps you study. You sort of need to sugar coat your problems to get a prescription. (Student I, a 40-year old PhD student.)

Student I gave numerous examples of his failed attempts of getting new prescriptions to continue using his psychostimulant medications. He mentioned that he has had to learn ways of properly explaining his feelings and difficulties to increase his chances of successfully obtaining a prescription.

Student M recalled several stories of his friends who have valid ADHD diagnoses having difficulty securing prescriptions, two of which unfolded in the following ways:

> It's really hard man, you have to get lucky. You need to go to the right psychiatrist at the right moment because these meds require a red prescription. For example, a friend of mine from the lab has ADHD and she cannot live her life without these medications. She's doing a PhD, and she's been using psychostimulants for the past two years. She has a diagnosis, she has a history of prescribed use, yet she was refused a prescription when she had to go to a different psychiatrist, where they told her they could not write her a

> prescription for Ritalin because it's so often abused. (…) Or another friend went to a public hospital and explained his situation, told the psychiatrist about how he couldn't focus on anything. The doctor asked about what he was doing, and then said he wouldn't be able to do any of the things he was doing if he truly had an attention deficiency. They sent him away with a prescription for an antidepressant instead. (Student M, a 28-year-old Master's student)

As these examples show, the narrative that medical users of psychostimulants do not necessarily have a straightforward and smooth experience with the first half of "taking a prescription obtained in the clinic to a pharmacy" (Vrecko, 2015, p.302). The very act of obtaining the prescription in question can be and often is challenging due to the popularized stories of psychostimulant substance abuse by students reinforcing the stigma that these medications are only used in non-medical ways.

3.4.2. Pharmacists

Not only do students experience difficulties obtaining a prescription, they may also run into issues in filling their prescriptions at the pharmacy. Due to the perception of psychostimulant medications as "study drugs" and them being sold under a highly restrictive red prescription, many pharmacists are reluctant to sell these medications to students. A number of my respondents reported having difficult times at the pharmacies they went to have their prescriptions filled. Student M mentioned how he and Student B repeatedly had issues at the pharmacies they visited:

> [Student B] has a pharmacy that she knows, they order the medications specially for you, and that's how we managed to buy them at the end. Because if you go to any pharmacy in [a neighborhood with a large university student population] they treat you like you're there to buy drugs. It's so weird, I really can't understand their mentality. I mean I have been diagnosed and prescribed by a doctor, and I'm just there to buy the medication my doctor instructed me to buy. They don't carry the meds, they don't place an order for you, sometimes they don't sell it to you even if they have it in stock. It's really difficult to get your hands on them even if you have a legitimate prescription. (Student M, a 28-year-old Master's student)

The same sentiment was repeated by Student A:

> I can say this for certain, if you don't have a pharmacy that knows you personally, you're not getting your hands on these medications. Either they know you and trust you, or you get treated like you're a drug addict in search of a supply. It's so interesting they way you're treated while you're trying to fill a prescription. (Student A, a 28-year-old Master's student)

As these accounts demonstrate, the medical route of obtaining prescription psychostimulants is not exactly straightforward. The individual is pushed into finding a suitable pharmacy that is willing to place an order and keep stock of psychostimulant medications, developing a personal relationship with said pharmacy, establish trust with the employees. During this process, the student will likely be subjected to an array of unpleasant treatments and denied treatment. It can even develop into an argument, as it was in Student D's case:

> When I was first prescribed, I went to a bunch of pharmacies to try and find the medications and none of them had it in stock. I went into one of them after not having any luck with the previous ones, and just directly asked them if they had it in stock. They immediately got tense and started looking at each other, all nervous. One of them asked me if I had a prescription, and I said yes. Then he barked at me saying "Why didn't you say that in the first place", so it turned into an argument, and we started fighting. (Student D, a 25-year-old Master's student)

Although experiences such as the ones above are not universal among all individuals who are trying to purchase their prescribed medications, they are certainly common enough to challenge the idea that acquiring a supply of psychostimulant medications is uncomplicated in the case of students who follow a medical path.

3.5. Chapter Conclusion

> Some such troubles undergo long, complex transformations marked by increasingly serious problems and progressively more severe responses. With the multiplication and extension of response efforts, troubles tend to be elaborated, changed in form and content, deflating or escalating as new responses are attempted, the troublemaker responds to these responses and so forth. (Emerson, 2015, p.12)

As the above quotation from Emerson shows, troubles follow a complex trajectory where they can lead up to new troubles, escalate, or diminish over time. In this chapter,

I demonstrated that the diagnosis of the student as having ADHD and their initiation to psychostimulant medication use do not bring about the end of their troubles. Rather, they introduce a new set of troubles that need to be dealt with in order to continue psychostimulant medication use. These new troubles include the student feeling like they lost their authenticity, them not being able to own their achievements and success, and them feeling a loss of agency in the course of their lives. Emerson's approach is useful here, as he indicates that defining the trouble in particular ways does not end the discussion; rather, it is a continuous process where the trouble gets defined and this particular definition and bundle of responses lead the individual into modifying their conceptions of trouble.

This chapter was centered around techniques of dealing with these new, emerging troubles and it focused on three domains in particular: How the ADHD identity helps or hinders the psychostimulant use of the students, how the students engaged in practices that help them accommodate their psychostimulant usage in their daily lives, and how they manage their supplies of medication. By showing the ways in which students deal with these new problems, I have demonstrated that intrinsic responses do not fade out even when the official, extrinsic response is applied to a trouble. They are once again required when the official, medical categories like ADHD and official remedies like psychostimulant medication treatment fail to eradicate the problem. The students feel the need to return to their intrinsic responses in order to be able to accommodate psychostimulant usage and the ADHD identity in their everyday lives. In other words, the redefinition and reframing of the troubles do not cease once the trouble is placed in an official category, they simply continue to be reinterpreted and solved.

CHAPTER 4

CONCLUSION

The main question that guided my research was “How do university students from two high ranking universities in Turkey experience the use of psychostimulant medications as a response to the everyday and academic troubles they encounter?”. In order to respond to this question, I conducted 15 in-depth, semi-structured interviews with university students who had experience with using methylphenidate, which is sold under the brand names of Ritalin, Concerta and Medikinet in Turkey and used for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). The interviews were guided by four sets of questions: The students were asked about i) their initiation to psychostimulant medications, ii) their use experience and changes in their everyday lives after starting regular use of psychostimulant medications, iii) their peer network’s involvement in their psychostimulant use, and iv) their experiences in clinical sessions with medical professionals.

The qualitative data I obtained through the interviews was analyzed using Emerson’s conceptualization of “trouble”. Emerson and Messinger (1977) argue that “the transformation of a trouble into a designated form of deviance can be seen through the trouble's discussion in "informal" and then "official" realms” (Katz, 2015) Emerson shifted the focus from official categories of deviance to informal ones and showed how the informal troubles get recognized and assume concrete forms as a result of processes of interpretation and getting reaction. The individual will initially attempt to address their troubles through informal, intrinsic means. However, as these informal methods become exhausted and fail to correct the troubles, they will turn to official, extrinsic responses. It must be noted that intrinsic responses do not cease to be relevant with the shift to official responses. On the contrary, these informal responses remain important even when there is an official category in place, as the interpretation of troubles does

not stop there. These dynamics were clearly represented in my data, which lead me to organize my analysis into two thematic analysis chapters.

In the second chapter of this thesis (*Initiation to ADHD and Psychostimulant Use*) I focused on the ways in which students resort to intrinsic / informal responses in the face of everyday and academic troubles they encounter, and how these responses offer a significant contribution to the process of recognizing / making sense of the trouble in the first place. I first discussed the ways in which the students delay the recognition of their troubles as they attempt to generate intrinsic responses to them, such as normalization, externalization, and trivialization of the problems they are experiencing. Second, I explored how significant turning points in the lives of the students function as catalysts that push students towards extrinsic, official responses such as ADHD diagnoses and psychostimulant medication prescriptions. I argued that failing at significant moments showed up as a threat to the linearity of the student's life course, and thus appeared as turning points that may force the student into reinterpreting their troubles as serious ones that cannot be handled by intrinsic responses alone. Finally, I discussed the role that the immediate social circle and the peer-network of the student plays in their initiation to the category of ADHD and to psychostimulant medication use.

The third chapter (*Strategies for Ensuring Continual Use*), I focused on the processes that unfold after an extrinsic / official response has been applied to the trouble that is experienced by the student. As Emerson argues, the intrinsic / informal responses do not cease to be relevant with the shift to more extrinsic / official forms of response to troubles; and in this chapter I exemplified this dynamic through the troubles students face after having resorted to these sorts of responses. I argued that the act of getting diagnosed with ADHD and starting psychostimulant medication treatment is not the end of the student's troubles – rather, the introduction of an official medical category and a treatment plan in the form of psychostimulant medication use often brings about new sets of issues that need to be resolved. I showed that students once again turn to intrinsic, informal responses in order to deal with the issues that are brought about by the application of extrinsic, official responses. To do so, I first discussed the ways in which an ADHD identity contributes to the student's continual use of psychostimulant

medications. I showed that a working ADHD identity plays a crucial role in one's justification and rationalization of medication / drug use. One of the main findings here was that an ADHD identity or identifying experiences of academic difficulties with ADHD comes after individuals experience psychostimulant medication use and benefit from it, rather than the reverse being the case. Secondly, I explored the practices students engage in to be able to accommodate psychostimulant medication use in their everyday lives. I provided examples of the ways in which students customize their psychostimulant use and dealt with the undesirable effects that are caused by medication use. Finally, I discussed the processes by which students manage their medication supplies, with a focus on the students who follow a medical path to do so – which has been neglected in the existing literature on psychostimulant medication use among university students.

Due to the limited scope of this project, I have not been able to explore the role of performance in higher education to its full extent. The concept of performance remained as a subject that was only discussed with reference to individuals' experiences and reports: I have discussed underperformance within the context of formation of academic troubles, and mentioned underperformance as a problematic situation to which students respond by using psychostimulant medications. In other words, "performance" was taken for granted to a certain extent and only discussed using the students' self-reports and perceptions.

This conceptualization of performance is not unique to my research. I have come across a number of qualitative studies which took a similar route in explaining psychostimulant medication use. Although new studies are being carried out in different contexts, they all raise similar concerns and conceptualizations of performance and discuss it on the basis of individuals' experiences. Regardless of the contextual differences, performance expectations came out as the primary way of explaining psychostimulant medication use. I hold that this similarity between these studies arises out of their reliance on interviewees' accounts of how and why they use psychostimulant medications. As students encounter similar challenges (like taking exams, doing homework, applying to different programs, etc.) in their academic lives, they also end up reporting similar narratives of performance related problems. Thus,

psychostimulant medication use comes out as a shared response to performance difficulties. This shared perspective means that performance as a theme is singled out among other contextual factors, and it is taken as a one-dimensional concept.

Further studies on psychostimulant medication use would significantly benefit from contextualizing performance in a more nuanced way, and discovering specific conditions within which it became a problem for students. The contextual differences cannot be fully appreciated if the focus remains only on the individuals' experiences. In order to get a more complete snapshot, further studies would need to move their focus to the role of performance in higher education, in relation to specific employment structures. As mentioned in the contextual background on the sample of my research, performance anxiety is far from being a personal issue. It is rather the representation of broader social facts like employment structures or educational systems on an individual level. Thus, future studies would benefit from approaching the issue of performance and psychostimulant medication use from a point of view that takes into account these structural facts like employment opportunities and higher education infrastructures.

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APPENDICES

APPENDIX A. APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE

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Sayı: 28620816 /

13 KASIM 2020

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Barış MÜCEN

Danışmanlığını yaptığınız Mert ERTUBAY'ın ***"Yükseköğretimin Yönetimselleşmesi Psikostimülan İlaçların Üniversite Öğrencileri Arasında Kullanımı Örneği"*** araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve **336-ODTU-2020** protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız.

[redacted]
Prof. Dr. Mine MISIRLISOY

İAEK Başkanı

APPENDIX B. TURKISH SUMMARY / TÜRKÇE ÖZET

Son yıllarda özellikle Kuzey-Amerika bağlamında üniversite öğrencileri arasında psikostimülan ilaç kullanımında bir artış gözlemlenmiştir. Öncelikle Dikkat Eksikliği ve Hiperaktivite Bozukluğu (DEHB) tanısını almış kişilerin tedavisi için kullanılan bu ilaçların tıbbi kullanımının yanında, performans arttırma ya da rekreasyonel kullanım gibi çeşitli kullanımlarında da artış görülmüştür. DEHB dikkatsizlik ve/veya aşırı-hareketlilik/dürtüsellik belirtileri ile karakterize edilen nörogelişimsel bir bozukluktur (American Psychiatric Association, 2013) ve farmakolojik tedavi, DEHB için birinci basamak tedavi olarak kabul edilir (Durand-Rivera ve ark., 2015). Türkiye'de etken maddesi metilfenidat olan psikostimülan ilaçlar, Ritalin, Concerta ve Medikinet ticari isimleriyle DEHB tanısı almış kişilerce erişilebilir durumdadırlar. Türkiye'de bu ilaçların kullanımının kapsamını araştırmak için sınırlı sayıda çalışma yapılmıştır. Bu sebeple ilaç kullanımıyla ilgili belli başlıklara dair bilgimiz sınırlıdır. Örneğin, bu ilaçların Türkiye'de tıbbi amaç dışı tüketiminin yaygınlığı üzerine bir veri bulunmamaktadır. Üniversite öğrencileri arasında kullanımı üzerine de geniş çaplı bir araştırma mevcut değildir. Ancak yayınlanmış sınırlı sayıdaki çalışma, bu ilaçların kullanımında bir artış olduğunu göstermektedir. Öner ve ark. (2017), 2009-2013 yılları arasında yıllık psikostimülan ilaç kullanımının 2.18 kat arttığını belirtmiştir. Ancak bu araştırma sağlık veritabanına dayandığı için, veri sadece tıbbi kullanımı yansıtmaktadır. Ayrıca bu veriler yaş grubu veya eğitim düzeyine göre ayrılmamıştır. İstanbul'daki kontrollü reçeteli ilaçların kullanımına ilişkin bir başka çalışma ise, metilfenidat bazlı ilaçların çok kullanılan kontrollü reçeteli ilaçlardan biri olduğunu işaret etmektedir (Demircan ve ark., 2013). Çalışma, metilfenidatı da kapsayan psikanaleptik ilaç grubunun rapor edilen toplam 502.874 kontrollü reçeteli ilaç arasında en çok reçete edilen dördün ilaç grubu olduğunu göstermiştir. Başka bir deyişle, konuyla ilgili sınırlı araştırma ve verilere rağmen, psikostimülan ilaç kullanımının ulusal alanda alanda arttığı söylenebilir.

Bu ilaçların Kuzey Amerika ve Avrupa bağlamında kullanımını araştıran sosyoloji ve halk sağlığı literatürü, Türkiye'deki mevcut çalışmaların aksine, daha çok bu ilaçların tıbbi amaç dışındaki kullanımına odaklanmıştır. Bu çalışmalar, bireylerin psikostimülan ilaç kullanım nedenleri olarak, bireylerin bilişsel becerilerini geliştirme ve böylece akranları üzerinde rekabet avantajı kazanma gibi motivasyonlarını bildirmektedir. Bu çalışmalar psikostimülan ilaç kullanımı temel olarak bilişsel beceri artırma (cognitive enhancement) ve rekreasyonel amaçlı kullanım kategorileri üzerinden yaklaşmaktadır. Bu çalışmalar daha geniş çaplı nicel araştırmalara dayanırlar ve kullanım yaygınlığı oranını hesaplamaya çalışırlar. Bu çalışmalar, ilaçların hangi yaş gruplarınca, ne amaçlarla kullanıldığını ve artan kullanımın beraberinde getirdiği çeşitli ahlaki ve sağlık kaygıları işaret ederler. Bu çalışmalarda, "performans", öğrencileri ilacı kullanmaya iten birer motivasyon olarak değerlendirilir. Ancak performansı sadece bireyleri ilaç kullanımına yönlendiren bir faktör olarak görmek son derece sınırlı bir yaklaşım olarak kalır. Bu araştırma, ilaçların kişinin rekabetçi hislerle başvurduğu birer performans arttırıcı olarak tanımlayan diğer çalışmalardan ayrılır. Bu çalışmaların büyük bir kısmı, psikostimülan ilaç kullanımıyla ilişkili sağlık risklerini vurgulayan bir halk sağlığı perspektifini benimsemektedir. Diğer çalışmalar, tıbbi olmayan reçeteli uyarıcıların daha geniş kullanımının getirdiği etik ve sosyal hususları aydınlatmaktadır. Bu çalışmalar, öğrencilerin tıbbi olmayan psikostimülan kullanım alışkanlıkları ve yaygın kullanımın üreteceği sonuçları araştıran daha çok büyük ölçekli araştırma projelerine dayanmaktadır. Bu çalışmaların en önemli nedenlerinden biri, üniversite kampüslerinde psikostimulan kullanımının yaygınlığını tespit etmek ve artan kullanım oranlarını kontrol edebilmek için uygun önlemleri almaktır. Bu tür araştırmalar, stimülan kullanımının üniversite öğrencisi olmayan akranlarına kıyasla üniversite öğrencileri arasında daha yaygın olduğunu belirtmektedir (Bennett & Holloway, 2017). Bazı çalışmalar, araştırma sonuçlarında ilaç kullanımının öğrenci gruplarında daha yaygın çıkmasının sebebi olarak, öğrencilerin ulaşılabilir ve üzerinde araştırma yapılması kolay bir örneklem olması ile ilişkilendirir. Yani öğrenci gruplarındaki ilaç kullanımının aşırı temsil edilmesini metodolojik bir tercih üzerinden açıklar (Hupli, n.d.; Lopes ve diğerleri, 2015).

Medikalleşme literatürü ise, bu ilaçların kullanımını araştıran bir başka sosyolojik yaklaşımdır. Medikalleşme kavramı, önceden tıbbi bir anlam ve önemi olmayan çeşitli durumların, zaman içerisinde tıbbi bir durum olarak değerlendirilip o duruma uygun tedavi yaklaşımları geliştirilme sürecini tarif eder. Medikalleşme yaklaşımına göre bu ilaçların kullanımındaki artış, artan DEHB vakaları ile beraber gerçekleşmiştir. O halde medikalleşme yaklaşımı, artan ilaç kullanımını bireylerce ilacın akademik avantaj sağlayan bir performans arttırıcı olarak değerlendirilmesine bağlamaz. Bu yaklaşım daha ziyade DEHB tanısına odaklanır ve bu tanının meşru bir bozukluk kategorisi olarak ne noktada ortaya çıktığını inceler. Psikostimülan ilaçlar, DEHB tanısının meşru bir bozukluk kategorisi olarak tanınması ve zaman içerisinde popülerleşmesi üzerinden değerlendirilir. Bu başlık altındaki temel tartışmalardan bir diğeri ise, DEHB kategorisinin tanı kriterlerinin zaman içerisinde farklı durumları ve yaş gruplarını kapsayacak şekilde genişlemesidir. Örneğin, Amerikan Psikiyatri Birliği'nin yayınladığı Ruhsal Bozuklukların Tanısal ve İstatistiksel El Kitabı'nda (Diagnostic and Statistical Manual of Mental Disorders-IV, 1994) yer alan değişiklikler sonucunda, sadece çocukların değil yetişkinlerin de DEHB tanısı alabileceği ileri sürülmüştür. Dikkatsizlik belirtilerinin, aşırı hareketlilik ve dürtüsellik belirtileri olmaksızın, tanının konulabilmesi için yeterli Kabul edilmesi, tanının yetişkin gruplarına uygulanabilmesini beraberinde getirmiştir. Burada temel argüman, tanısal kriterlerin genişlemesi sonucunda farklı yaş gruplarına tanı konulabilir olması ve dolayısıyla bu ilaçların daha geniş bir kitle tarafında bilinir ve kullanılır hale gelmesi ve beraberinde bu ilaçların popülerleşmesidir. Bunun sonucunda çeşitli kullanım şekilleri ortaya çıkar. Bireyler, kendilerinin tanı konması için gereken belirti gösterdiklerini düşünüp bu ilaçları kullanabilir ya da sadece bu ilacın belli faaliyetleri kolaylaştırdığını görüp, reçetesi olan bir kimseden bu ilaçları temin edip kullanabilirler. Farklı kullanım şekillerinin, DEHB kategorisinin yaygınlaşmasına bağlı olarak ortaya çıktığı düşünülür. Bir diğer deyişle medikalleşme yaklaşımı, DEHB kategorisi ve buna bağlı olarak ilaç kullanımının yaygınlaşmasını, gündelik hayatın tıbbi kurum ve profesyonellerce medikal bilginin alanına taşınması üzerinden tartışır. Gündelik hayat bir ölçüde teknik bilginin sahasına taşınır ve gündelik davranışlar ve problem, tıbbi ve teknik bilginin denetimi altına girer.

Medikalleşme yaklaşımının tek başına açıklayamadığı temel nokta, neden bazı davranışların diğerlerine göre daha çok medikalleştiğidir. Bu tezin de tartıştığı üzere, öğrencilerin sınav ve benzeri önemli anlarda akademik performanslarını yetersiz bulmaları deneyimi, kendilerine yönelik medikal bir problem şüphesi uyandırır. Düşük performans deneyimin medikalleşmesi, medikalleşme yaklaşımlarının önerdiği üzere bizatihi tıbbi kurum ve profesyonellerin otorite alanın genişlemesi ile açıklanamaz. Hangi deneyimlerin medikalleştiği, daha doğrusu hangi deneyimlere teknik ve bilimsel yaklaşımlarca bir "sorun" olarak bakılıp bir çözüm getirilmeye çalışılması, ancak toplumsal bağlam incelenerek anlaşılabilir.

Bu noktada, DEHB tanısı yoluyla üniversite öğrencilerinin akademik performansının medikalleşmesi, sadece tanı kriterlerinin genişlemesi, tıbbi otorite alanın genişlemesi ya da daha fazla insanın tanı şüphesi yaşaması ile değil, performansın önemli bir problem haline geldiği toplumsal bağlam üzerinden yaşanmasıdır. Ayrıca durum büyük ölçekli çalışmalar ve halk sağlığı çalışmalarında da belirtildiği gibi, kişilerin rekabetçi bir motivasyon ile bu tür ilaçlardan faydalanması arayışı ile de açıklanamaz. Bu tez, psikostimülan ilaç kullanan öğrencilerin açıklamalarından faydalanarak, bu fenomeni toplumsal bir bağlamda değerlendirmeyi amaçlamaktadır. Performans, tıbbileştirilen bir alan veya bireysel bir motivasyondan ziyade, kişilerin akademik çabalarını sorgulamasına ve problematize etmesine sebebiyet veren bir mekanizma olarak değerlendirilmiştir. Bu mekanizmanın yerleşik olduğu toplumsal ve tarihsel bağlam ise, günümüz Türkiye'sinde yükseköğretim kurumlarının daralan istihdam sağlama olanağının ve buna bağlı olarak bu kurumlara öğrenciler tarafında atfedilen anlamın değişmesidir. İstihdam beklentileri ve yükseköğretim arasındaki makas arttıkça bu kurumlar gelecek güvencesi veren yapılar olmaktan ziyade, çok sayıda öğrencinin sınırlı bir fırsat için rekabet halinde olduğu bir arenaya dönüşmektedir. Üniversite öğrencilerinin 6 yaş üstü nüfusa oranı 2008'den 2019 yılına kadar %8,9 artmıştır. Buna bağlı olarak lisansüstü öğrencilerin 6 yaş üstü nüfusa oranı %0,5'ten %1,8'e yükselmiştir. Artan üniversite sayısı (güncel olarak 129 devlet üniversitesi ve 75 özel üniversite mevcuttur) ve kontenjanlar ile beraber, üniversite sayısı 10 milyonu aşmıştır. Buradaki sorun, artan üniversite mezunu nüfusun istihdamda bir karşılığı bulunmamaktadır. Üniversite mezunu insan sayısındaki artış, istihdamdaki üniversite mezunu sayısından iki kat daha hızlı artmaktadır. Artan üniversite mezunu sayısı, artan

genç istihdamı anlamına gelmemektedir. Bunun üzerine, genç nüfusun mevcut ekonomik krizden en çok etkilenen gruplardan biri olduğu da göz önünde bulundurulursa, rekabet ortamında performans göstermek, geleceğe dair güvence sağlayacak tek strateji olarak görülmektedir. Bu bağlamda yaşanan performans kaygısı, diğer çalışmaların yer aldığı Kuzey Amerika ya da Batı Avrupa bağlamlarından temel olarak farklıdır. Yukarıda bahsedilen istihdam ve eğitim arasındaki dengesizlik benzeri yapısal sorunların oluşturduğu risk, bireylerin kendilerine güvence yaratma girişimleri sonucunda bireyselleşmiş birer risk olurlar. Performans kaygısı, işsizlik ve güvencesizlik riski ile baş etme sorumluluğunun bireye aktarıldığı bir bağlamda gerçekleşir.

Bu tez, saha araştırması sonucu elde edilen nitel verilere dayanarak, psikostimülan kullanımı bireylerin kendi akademik performanslarında sorun bulması ve bu soruna yönelik yanıt oluşturması bağlamında değerlendirmektedir. Bu çalışma için, psikostimülan ilaçları kullanım tecrübesi olan üniversite öğrencileri ile 15 yarı yapılandırılmış derinlemesine mülakat yapıldı. Mülakatlar 2021 yılında yapıldı ve ortalama 90 dakika sürdü. Mülakatların 3'ü yüz yüze, 12'si ise Zoom üzerinden gerçekleştirildi. Ses kayıtları kelimesi kelimesine deşifre edildi ve daha sonra MAXQDA'de tematik olarak kodlandı. Ankete katılanların anonimliğini korumak için, öğrencilere A'dan O'ya kadar takma adlar verilmiştir ve tanımlayıcı ayrıntılardan bazıları değiştirilmiştir. Mülakatlar Türkçe yapılmıştır ve seçilen alıntılar orijinallerinden tercüme edilmiş versiyonlarıdır.

Mülakatlar önceden belirlenmiş dört soru seti etrafında hazırlanmıştır: Katılımcılara i) psikostimulan ilaçlara başlama deneyimleri, ii) psikostimülan ilaçları düzenli kullanmaya başladıktan sonra kullanım deneyimleri ve günlük yaşamlarındaki değişiklikler, iii) akran ağlarının ilaç kullanım deneyimi üzerine etkisi ve iv) psikiyatrlar ile klinik seanslarda yaşadıkları deneyimler üzerinden sorular yöneltilmiştir.

Araştırmaya ilk olarak, psikostimülanların üniversite öğrencileri arasında akademik performansa yardımcı birer madde olarak ne şekilde kullandığını sorgulayarak başladım. Başlangıçta, ilaçların akademik zorluklar ile baş etme stratejisi olarak nasıl

deneyimlendiği üzerinde durdum. Ancak, ilk iki mülakatı tamamladıktan sonra, psikostimülan kullanma deneyiminin önemli bir bölümünün DEHB tanısı ile şekillendiğini anladım. Bu beni, mülakatların geri kalanına DEHB'yi psikostimülan ilaç kullanımı anlatılarının önemli bir parçası olarak görmeye sevk etti. DEHB tanısının bireylerin önemli akademik anlardaki performansları ile ilişkisini görmek, DEHB'yi tıbbi açıklamasının dışında, bireylerin yaşam bağlamı içinde düşünmek ilaç kullanımının farklı boyutlarını tartışmaya olanak sağladı. Görüşmeler sırasındaki temel amacım, öğrencilerin psikostimulan ilaç kullanımı ve DEHB'nin tanı deneyimlerini anlamaktı. Çalışmada, DEHB kategorisine karşı sosyal-inşacı bir yaklaşım kullanıldı.

Mülakatlar için başlangıçta az sayıda katılımcıya ulaşıldı ve onlardan psikostimülan ilaç kullanan arkadaşlarına ve tanıdıklarına ulaşmaları istenildi. Kartopu örnekleme yöntemi kullanıldı. Bunu çalışmaya sağladığı avantajlardan biri, ilaç kullanımı ve bu ilaçların tedariki üzerine bulunan bilginin akran ağları arasında paylaşımını görmekti. Başkalarının kullanım uygulamalarına tanık olan arkadaşlarla görüşmek, bilgi ve psikostimülanlar anlamının akran ağlarında nasıl dolaştığını anlamama yardımcı oldu. Ankete katılan 15 kişiden 10'u kartopu örneklemesi ile bulunurken, geri kalan 5'ine ise öğrencilerin sosyal medya platformlarında kullandıkları gruplar üzerinden çağrı oluşturularak ulaşıldı. Katılımcıları seçme kriterleri en az 3 aylık psikostimülan ilaç kullanımını içeriyordu. Ancak araştırma esnasında, ilaç kullanımını üç ay içerisinde sonlandıran katılımcıların da deneyimini öğrenmenin faydalı olacağını düşünmem sebebiyle başlangıç kriterlerime uymayan iki katılımcıyı daha çalışmaya dahil etme kararı verdim.

Katılımcıların tamamı, görüşmelerin yapıldığı tarihte yükseköğretim programına kayıtlı öğrencilerdi. Örneklemi 7 doktora öğrencisi, 5 yüksek lisans öğrencisi ve 3 lisans öğrencisi oluşturmuştur. 15 öğrenciden 14'ünün DEHB tanısı ve ilaç için reçetesi bulunmaktadır. Katılımcıların yaşları 22 ile 40 arasında değişmekte olup, öğrenci örnekleminde 8 kadın ve 7 erkek bulunmaktadır.

Görüşmeler yoluyla elde ettiğim nitel veriler, Emerson'un “sorun” kavramsallaştırması kullanılarak analiz edildi. Emerson ve Messinger (1977), “bir sorunun spesifik bir

kategori ile etiketlenmesinin, sorunun öncelikle "resmi olmayan", enformel tepkiler ile karşılaşıp bu tepkilerin yetersiz kaldığı noktalarda ve "resmi" alanlara taşınıp üçüncü partiler tarafından yanıtlanması sürecini anlatmaktadır (Katz, 2015). Emerson, odağı "sorunun" resmi kategorilerce çerçevelenmesinden önceki süreçlere kaydırır. Bu tezde "sorun" olarak tanımlanan durum, bireylerin deneyimlediği çeşitli akademik zorluklardır. Tezde bireylerin zorluk deneyimlerinin bir etkileşim süreci içerisinde ne yollar ile DEHB tanısı ile tıbbi alanda resmi bir kategori ile tanımlandığı incelenmektedir.

Tezin analiz bölümünde akademik zorlukların bireyler tarafından, bireylerin eğitim süreçlerinin hangi noktalarında DEHB işareti olarak fark edildiği sorgulanmıştır. Bunun için Emerson ve Messinger'in (1977) "sorun" kavramı kullanılmıştır. Bu kavramla beraber bir rahatsızlık deneyimi olarak beliren bireysel sorunların, hastalık kategorisi ile tarif edilen spesifik bir probleme dönüşmesi süreci incelenmiştir. Bireylerin farklı aşamalarda yaşadıkları sorunları, önceleri ne tür stratejiler yoluyla geçiştirdikleri öğrenilmiştir. Burada nitel veri sonucunda ortaya üç tema çıkmıştır. Bunlar dışsallaştırma, normalleştirme ve basitleştirmedir. Yaşanan akademik sorunlar en başta bu üç strateji üzerinden göz ardı edilmiş ama sorunların devam etmesi ve bu stratejilerin yetersiz kalması üzerine kişilerin akademik probleme farklı yanıtlar uygulama arayışına girdikleri görülmüştür. Dışsallaştırma, bireyin yaşadığı akademik problemin kaynağının dış bir faktöre konumlandırılması davranışını açıklar. Burada düşük akademik performans, daha genel bir sürecin, örneğin eğitim sistemindeki bozukluğun, ya da daha tekil bir örnek ile öğreticinin yetersiz olması gibi nedenlerle açıklanır. Dışsallaştırma stratejisi sonucunda, kişi yaşadığı sorunu dışarıya konumlandırır ve değiştirebileceği bir durum olmadığını kanıksar. İkinci strateji olan normalleştime ise bireyin akademik zorluk deneyimini evrensel bir deneyim olarak görmesidir. Normalleştirme, herkesin bir ölçüde bu zorluğu yaşadığına olan inancını ifade eder. Normalleştirmenin sonucunda ise yaşanan akademik zorluk evrensel bir deneyim olarak kabul edildiği için kişi kendi performansını ayrı bir durum olarak değerlendirip sorunlaştırmaz. Dolayısıyla kendine yönelik bir değişiklik gösterme, veya yetersizlik deneyimi üzerine çözüm arama davranışını geliştirmez. Üçüncü temada ise basitleştirme stratejisi işlenmiştir. Bu stratejiye ile beraber de yaşanan

sorun, farklı yollar izlenerek giderilebilir basit bir problem olarak değerlendirilir. Yaşanan soruna karşı gündelik önlemler almanın sorunu giderebileceğine inanılır.

Bu üç tema, bireyin yaşanılan sorun ya da akademik zorluk deneyimine yönelik net ve açık önlemler uygulamasını geciktirmesi ve bireylerin bu deneyimleri ayrı birer sorun olarak yaklaşmasını engelleyen stratejiler olma noktasında ortaklaşır. Bu temalar yaşanılan zorluğun muğlak birer rahatsızlık deneyiminin ötesine geçmesini engeller. Emerons'a göre bireysel zorluklar başkalarına açılıp farklı önlemler uygulanarak yanıtlanmadıkça spesifik bir kategorisi içerisinde tanımlanmazlar. Sorunun bir spesifik bir kategori içerisinde çerçevelenmesi ve isimlendirilmesi, süreç boyunca uygulanan gündelik yanıt ve stratejilerin, sorun deneyimini ortadan kaldırma konusunda yetersiz kalmasını takip eder.

Bireysel zorluk deneyimlerinin veya "sorunların", bireylerin kendileri tarafından ya da yakın çevreleri içerisinde zorluk deneyimlerine karşı çeşitli önlemler almaları sonucunda zorluk deneyimlerinin daha spesifik, somut bir hastalık kategorisine dönüştüğü incelenmiştir. Bireyler başlangıçta "sorunları" enformel, kendi kaynaklarına dayandırdıkları yöntemler ile çözmeye çalışmaktadır. Ancak, bu informal yöntemler tükenip sorunları giderilmedikçe, bireyler resmi, dışsal yanıtlara yönelmektedirler. Bu dinamikler verilerimde iki tematik analiz bölümü üzerinden değerlendirildi.

Akademik zorluk deneyiminin medikalleşmesi noktasında en önemli aşama, yaşanılan zorluğun yaşam süreçlerinde bir aksaklığa sebebiyet verme endişesidir. Bu endişe üzerinden, zorluk deneyimi sıradan, geçiştirilebilir muğlak bir durum olmaktan çıkar, çözülmesi gereken bir problem olarak tanımlanır. Yaşam süreçlerinde, birer dönüm noktasını temsil eden anlarda yaşanan akademik zorluk veya yetersizlik deneyimi, kişiyi durum için önlem almaya yönlendirir. Önceden de ifade edildiği üzere, yaşamın lineer bir devamlılık içinde yapılandırıldığı inancı ve yaşamdaki bir sonraki aşamaya geçişin mezuniyet, doktora yeterlilik sınavı, final sınavları, tez süreci veya üniversite sınavı gibi kritik anlar içinde gösterilen performansa dayandırılması, yaşanılan akademik zorluğu basit geçiştirilebilir bir deneyimden ziyade, kişinin yaşamının sonraki aşamalarını etkileyen ve yaşam fırsatlarını kısıtlayan bir engele dönüştürür.

Bu noktada, akademik zorluk deneyimi ya da düşük performans algısı, kişiyi yaşadığı zorluğu daha net bir şekilde tanımlama ihtiyacını sokar. Tezde bu aşamalar başarısızlık algısı, sınav ve mezuniyet alt başlıkları üzerinden incelenmiştir. Yaşanılan zorluğun, yaşam sürecini değiştirecek bir risk olarak algılanması sonucunda, bireyler zorluğu gidermek adına başka yanıtlar ararlar. Medikalleşme süreci, yaşanılan zorluğun teknik bir sorun olarak çerçevelenmesini ifade eder. Yani medikalleşme, yaşanılan akademik zorluğun kişinin yaşam sürecini aksatma riski ile ilişkilendirmesi sonucunda ortaya çıkan bir süreçtir. Zorluk medikal bir durumun işareti olarak çerçevelendiği noktada, ilaç tedavisi bir çözüm yolu olarak belirir. Bu çalışmanın da dikkat çektiği üzere, medikalleşme her zaman bir medikal profesyonelin önerisi veya sorunu fark etmesi üzerinden gerçekleşmez. İkinci bölümün sonunda belirtildiği üzere, akran ağları bireye DEHB tanısının ve bu ilaçların tanıtılmasında önemli bir rol oynar. Akran ağları üzerinden ilaç ve tanı bilgisi yaygınlaşır. Kişiler kullanan başka insanların deneyimlerini öğrenerek, kendi yaşadıkları zorluk deneyiminin de medikal bir kökeni olacağı şüphesi duyabilir. Ayrıca, bir akranın kişinin zorluk deneyimini, aslında medikal kökeni olan bir durum olarak yorumlayıp kişiyi doktora gitmesi konusunda uyarması da medikalleşmenin gerçekleşebileceği başka bir yoldur. Akran ağları ayrıca, kişinin bu tür ilaçların kullanımı konusunda duyduğu şüpheleri giderme noktasında da etkindir.

Üçüncü bölümde ise (Sürekli Kullanımı Mümkün Kılan Stratejiler), bireylerin yaşadıkları akademik zorluk deneyimini DEHB tanısı üzerinden çerçeveleyip psikostimülan kullanımı ile gidermeye çalışmaları sonrasındaki sürece odaklanıldı.
Emerson ifade ettiği şekliyle yaşanılan durumun dışsal/resmi bir yanıt uygulandıktan sonra ortaya çıkan süreçler incelendi. Emerson'un da belirttiği gibi, "sorun" ya da zorluk deneyimi, resmi kategorilere referansla anlamlandırıldığında, yani bir akademik zorluk deneyimi kişinin DEHB tanısı ile açıklandığında dahi, kişi zorluk deneyimi için bireysel kaynaklarına başvurmaya devam eder. Bu bölümde, bireylerin DEHB tanısı alıp psikostimülan ilaç kullanımına başlaması beraberinde gelen sorunlara değinildi. Burada vurgulanan nokta, DEHB tanısının ve ilaç tedavisinin, bireyin yaşadığı zorluk deneyimini bir ölçüde yanıtlasa da başka sorunlara kapı araladığını vurguladım. Zorluk deneyiminin resmi bir kategori ile çerçevelenmesinin ve ilaç tedavisi uygulanmasının, o sorunu tümüyle sonlandırmadığı, aksine kişinin baş

etmesi gereken başka zorluk deneyimlerine sebep olduğu tartışıldı. DEHB tanısı alma ve psikostimülan ilaç tedavisine başlama eyleminin öğrencinin sorunlarının sonu olmadığını savundum - daha ziyade, resmi bir tıbbi kategorinin ve psikostimülan ilaç kullanımı şeklinde bir tedavi planının tanıtılması genellikle çözülmesi gereken yeni bir dizi sorunu beraberinde getirir. Öğrencilerin dışsal, resmi yanıtların uygulanmasıyla ortaya çıkan sorunlarla başa çıkmak için bir kez daha içsel, resmi olmayan yanıtlara yöneldiklerini gösterdim. Bunu yapmak için önce DEHB kimliğinin öğrencinin psikostimülan ilaçlarını sürekli kullanımına nasıl katkıda bulunduğunu tartıştım. DEHB kimliği oluşturabilmenin, kişinin ilaç kullanımının gerekçelendirilmesinde ve rasyonelleştirilmesinde önemli bir rol oynadığını gösterdim. Buradaki ana bulgulardan biri, DEHB kimliğinin teşhis beraberinde değil de düzenli ilaç kullanımı sonucunda, yani ilacın etkin bir şekilde kişiye zorluklarla baş etme olanağı sağlaması sonucunda oluşmasıdır.

İkinci olarak, öğrencilerin psikostimülan ilaç kullanımına günlük yaşamlarında uyum sağlayabilmek için yaptıkları uygulamaları araştırdım. Öğrencilerin psikostimülan kullanımlarını farklılaştırma yollarına örnekler verdim ve ilaç kullanımının neden olduğu istenmeyen etkiler ile baş etme yollarını araştırdım. Son olarak, üniversite öğrencileri arasında psikostimülan ilaç kullanımına ilişkin mevcut literatürde ihmal edilen bir grup olan tıbbi yollar ile ilaç kullanan öğrenci grubuna odaklanarak, bu örneklem içerisinde ilaç kaynaklarının nasıl yönetildiğini tartıştım.

Bu projenin sınırlı kapsamı nedeniyle, yüksek öğretimde performansın rolü geniş bir şekilde tartışılmamıştır. Literatürde de performans kavramı sadece bireylerin deneyimlerine odaklanılarak tartışılan bir konu olarak kaldı. Bu çalışmada da performans daha çok akademik sıkıntıların oluşumu bağlamında ele alındı ve düşük performansı öğrencilerin psikostimülan ilaç kullanımı ile nasıl yanıt verdiği durumu incelendi. Başka bir deyişle, “performans” bir dereceye kadar verili kabul edilmiş ve sadece öğrencilerin öz-bildirimleri ve algıları üzerinden tartışılmıştır.

Performansın bu kavramsallaştırılması sadece bu araştırmaya özgü değildir. Psikostimülan ilaç kullanımını açıklamada benzer bir yol izleyen bir dizi nitel araştırma mevcut. Her ne kadar farklı bağlamlarda yeni çalışmalar yapılsa da, hepsi

benzer performans kavramsallaştırmalarını gündeme getirmekte ve bunu bireylerin deneyimleri temelinde tartışmaktadır. Bağlamsal farklılık göz ardı edilerek performans beklentileri psikostimülan ilaç kullanımının temel açıklaması olarak sunulmuştur. Bu çalışmalar arasındaki benzerliğin, araştırmaların katılımcıların psikostimülan ilaçları nasıl ve neden kullandıklarına ilişkin açıklamalarına dayandırmasından kaynaklandığını düşünüyorum. Öğrenciler akademik hayatlarında benzer zorluklarla (sınavlara girmek, ödev yapmak, farklı programlara başvurmak vb.) karşılaştıkça, performansla ilgili problemlerini benzer anlatılar üzerinden aktarırlar. Böylece psikostimülan ilaç kullanımı, performans konusunda yaşanan sorunlara ortak bir yanıt olarak ortaya çıkmaktadır. Bu bakış açısı, bir tema olarak performansın diğer bağlamsal faktörler arasında sıyrılıp tek boyutlu bir kavram olarak ele alınmasına sebep olur. Psikostimülan ilaç kullanımına ilişkin ileride yapılacak çalışmalar, performansın ne tür koşullarda bir probleme dönüştüğünü gösterebilmek için bu kavramı bağlamsallaştırmalıdırlar. Yalnızca bireylerin deneyimlerine odaklanıldığında bağlamsal farklılıklar göz ardı edilmiş olur. Çalışmaya bağlamı daha iyi dahil edebilmek için ileride yapılacak çalışmalar performansı, eğitim, istihdam yapısı ve bireylerin deneyimleri arasında ilişkiyi göz önünde bulundurarak incelemedirler.

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