Unravelling the Mysteries of ADHD

By Judith Deutsch M.S.W.,
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Part 1 – ADHD and Ritalin

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A series of articles on Attention Deficit and Hyperactivity Disorder, first published in Parent-to-Parent Magazine(now known as Barbara Burrows Parenting Magazine) follows. Author Judith Deutsch is a psychiatric social worker, graduate of the University of California, Berkeley and post-Masters training at Mount Zion Psychiatric Clinic. Mrs. Deutsch has a strong background in normal childhood and adolescent development and a particular expertise in helping children and adolescents resolve the underlying issues that lead to problems. In these series of articles on ADHD, Mrs. Deutsch shares her insight on one of the most common and complex difficulties facing parents, teachers and children today. She can be reached at (416) 929-8180. The first article appeared in Vol. 10 Issue 1. ©September 1996

As a psychotherapist, it is always hard to define the complexity and individuality of people, whether child or teenager or adult, with a diagnosis. To label children is especially difficult, for the very nature of childhood is "change." Even the most definable symptoms, like sleep problems for instance, come and go and change meaning at different stages. With sleep problems, a hard-to-settle infant is obviously different from a toddler with night fears, or from a school-age child with insomnia. When children have trouble sleeping, all sorts of possible reasons come to mind, whether it is considered a normal phase, or perhaps a reaction to illness, or that it could be a reaction to changes in routines, or that it is connected with various feelings like anxiety or excitement, and so on. Parents, without always being aware of it, often wonder about the reasons, about the causes of hard-to-understand behaviours. It would be very difficult to know how to help a child with a sleep disturbance, or with any problem, without knowing the full picture. Perhaps nowhere is it harder to pin a label than in the vast area of behaviours having to do with the capacity to pay attention and the capacity to maintain an appropriate activity level.

In this series of articles, we will try to look at and clarify both the common as well as worrisome aspects of attention deficit and hyperactivity problems. But before focusing on real children and their parents, it is helpful to know some facts about the diagnostic classification Attention Deficit Hyperactivity Disorder (ADHD) and about the medications most frequently used in the treatment of this disorder in North America. Robert Furman, M.D., has recently investigated and written about the concept ADHD as well as medication use. Initially a paediatrician, he is a child psychoanalyst, Director Emeritus of the Hanna Perkins School and the Cleveland Center for Research in Child Development.

Furman writes out of his concern that an epidemic number of children in the United States are diagnosed with such a serious disability and that the current treatment of choice is medication. Current estimates are that 2 million children are now receiving stimulant medication in the United States, 4.4% of the children in the 5-l7 year old age group. To have some perspective on this number, in contrast there are 6,000 children in Europe, with a comparable population, who are receiving psychostimulants. This means that in Europe, the drugs are being used less than four-tenths of one percent as often as in the United States. Neither Health Canada nor Ontario Ministry of Health had statistics on the use of Ritalin, but in Canada, medication is generally the first method of intervention, along with behaviour management strategies for home and school when children are diagnosed as having ADHD.

Exploring the differences between the U.S. and Europe led Dr. Furman to clarify some of the problems in both diagnosis and treatment.

He found that one source of the large number of children diagnosed as ADHD has to do with the vague way that ADHD is defined in the *DSM-IV* (*Diagnostic and Statistical Manual of the American Psychiatric Association*), a classification which eliminates the need to look into the history or causes of the behaviours. In other words, the diagnosis is based purely on description, but not the development, of current symptoms. As will become clear in summarizing Furman's findings, he contrasts a symptom-based approach to the alternative way of looking at the whole child. Looking at the whole child has to do with the complexity of the growing up process, getting to know both the child and his family and school environment, and exploring a child's current as well as earlier adjustment. With Furman, the child himself is an important part of the assessment process, namely, how a child understands himself and feels about his own problems.

The standard diagnostic tool used in Canada as well as the U.S. is the *DSM-IV.* In the *DSM-IV*, there is a list of nine behaviours having to do with attention, and nine having to do with activity; selection of any six characteristics of the eighteen confirms a diagnosis of ADHD. Furman writes: "All 18 symptoms are of a totally subjective nature, and each could be part of any number of psychiatric entities or be aspects of a perfectly normal child. Included are symptoms such as `makes careless mistakes', `fails to finish chores', `does not seem to listen when spoken to', `talks excessively', `has trouble waiting his turn'...Check-lists for the 18 symptoms can be filled out by parents and/or teachers and/or a physician, and can be tabulated by an untrained assistant." Moreover, an additional classification was added called '314.9 Attention Deficit/Hyperactivity Disorder Not Otherwise Specified" which states that a child can be diagnosed ADHD without the particular criteria being fully met. In practice, this means that any child, with any kind of behavior, can be

diagnosed ADHD. As Furman states, "scientifically, this seems an unusual diagnosis (l996a, p. 158). And as in the example of sleep problems, it seems unusual to think about symptoms without thinking about their causes and their reasons.

The extreme differences in the incidence of ADHD has to do in part with the much more specific way of diagnosing hyperactivity and attention problems in Europe. In England, the symptoms need to be identified as pervasive and severe and "relatively constant across all situations, including being visible to the diagnostician". The eminent researcher Michael Rutter, M.D., concluded that linking ADHD symptoms with minimal brain damage was "an uncertain hypothesis," a "neuromythology" (a neurological myth), and that nonpervasive symptoms (attention and activity problems that surfaced in some situations but not in others) were of no diagnostic significance (l996b, p. 136).

This is not to say that attention and hyperactivity problems are not of concern; however, it does indicate that a much more thorough assessment is indicated when considering such a serious psychiatric diagnosis. Furman continues with the important point that either "a normal child could be mislabelled or a distressed child could have no one seeking the origin of his or her distress" (p. l37-138).

Another striking difference between the U.S. and Europe has to do with government regulation of stimulant medication. The medications most used for ADHD are amphetamine derivatives -- Ritalin and its generic version, methylphenidate. On both sides of the Atlantic, these drugs are classified with opium, morphine, codeine, methadone, and amphetamine. The Substance Abuse Manual says regarding these substances: "The controlled substances in this schedule have a high abuse potential with severe psychic or physical dependence liability"(cited in l996b, p. 133). Control of the drug is tight in all the European countries, with the amount of the prescribed drug being highly restricted. In Sweden, prescriptions are allowed only by special license for research.

To conclude this introduction to the *Parent-to-Parent* series on ADHD, I include a longer quotation from Dr. Furman's (l996a, p. 159) well-informed letter as it touches on important considerations often overlooked when there is much pressure to quickly fix what seems like maladaptive behavior:

Proponents of the diagnosis of ADHD and its treatment with the psychostimulants always proclaim: "it works!' By this they mean that the drugs do suppress motor activity, and can do so rather promptly, sometimes dramatically. The implication is that children, no longer too active in the classroom, apparently attentive to their schoolwork, are progressing academically. The proponents do not like to discuss the fact that the motor activity of almost anyone can be suppressed by psychostimulants, that there is firm evidence that the drugs do not produce any long-term academic

improvement, and that the drugs may cause tics and interfere with growth. . . .Almost always missing, from any reports about the drugs are the children's responses to them, often very poignant ones, complaining of insomnia, loss of appetite, feeling estranged from themselves, feeling stigmatized with no one to turn to....Also not discussed or quickly dismissed is the danger of teaching children....to control themselves by drugs as an inappropriate preparation for coping with the stresses of adolescence without their turning to street drugs."

Of great concern is that children come to feel they have a lifelong deficiency in their brains caused by a neurochemical defect, a belief that has not been confirmed by research. Regarding medication, Dr. Gabrielle Weiss, a leading Canadian child psychiatrist concludes in her review article in "Child & Adolescent Psychiatry: A Comprehensive Textbook" (p554) that "we have expected too much from medication for a syndrome comprising such diverse and multiple behavioral, social, and cognitive deficits. For example, stimulants have been found not to benefit specific learning disabilities, and they cannot fill in the gaps of knowledge hyperactive children often have because of their inattention."

Lastly, Furman writes: *"Mention does have to be made of the abdication of responsibility possible with the diagnosis of "an illness in the child", presumably caused by some chemical deficiency in the brain. Parents are spared responsibility for their child's behaviour, the child is spared a type of responsibility for his own behaviour, teachers are spared responsibility for managing their classrooms, society is spared responsibility for the inadequate funding of schools that creates such large classroom sizes a teacher has problems coping with active children."*

One challenge is in the definition and diagnosis of Attention Deficit Hyper Activity Disorder. Children who exhibit behaviour commonly associated with ADHD can make life almost impossible for parents. Children themselves suffer when they cannot control their impulses. Using medication may help control and modify the behaviour and families generally experience relief as a result. However, using medication to treat the symptoms of such a complex problem as ADHD rarely helps children resolve the underlying difficulties that may have provoked the behaviours in the beginning.

Few parents would turn to a sleeping pill to help children sleep better. Instead, they would wonder what was making the child restless and try to find different ways to help the child feel settled so that he or she could sleep comfortably and naturally. In the same way, with careful investigation, it is possible to approach a child's impulsive, restless behaviour. The goal in the long run is not only to stop the troublesome behaviour, but to help the child feel comfortable and calm within himself, so the child regains control of his own body.

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Editor's Note: We have recently been informed that Dr. Robert Furman's letter published in *The Journal of Child Psychotherapy* has been translated into both Swedish and Danish. Parent-to-Parent Magazine sincerely thanks Dr. Robert Furman for his support, both in providing written material and in reviewing this article prior to publication.

Unravelling the Mysteries of ADHD
Part 2 – ADHD: Feelings and Hyperactivity

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Before moving on to discuss ADHD, the first article in this series for Barbara Burrows Parenting Magazine summed up the disquieting observations of several child psychiatrists. Their concerns about the overuse of Ritalin (generic name: methylphenidate) and the too broad and vague diagnostic category "ADHD" was echoed in a recent article in the Toronto Star (Saturday, September 7, l996) which again pointed out the very large number of children now being prescribed medication. The cover of a recent New Yorker Magazine (September 9, l996) shows a teacher, and on the blackboard is "Readin, Ritin, Ritalin." It seems to be in the air to think harder about this epidemic.

One problem with the ADHD diagnosis is that it is so inclusive, in that children whose behaviour ranges from normal to severely disturbed can all be diagnosed the same way.

Let us take an imaginary child as an example. Alan is a seven-year-old who often finds it difficult to sit still at school. At his desk, he appears to work for a few minutes and then stands up, sits down, stands up. At his desk he rolls his pencil back and forth and at times seems to pretend that it is a rocket. He often drops paper and pencil on the floor as he fidgets. During class time, he has a somewhat inscrutable look on his face -- it is hard to read his feelings or to imagine what he is focusing on. After 30 minutes work time he only has a stick-figure drawing on his paper.

Although Alan's "symptoms" fit many of the criteria for ADHD, it would be very difficult just from this description to know what his behaviour means. When children are not doing well at school, at home, or with friends, there is much pressure to *do* something. At present, "doing something" without taking the time to explore the full picture usually means medication. Medication aims at moderating behaviour, particularly emotions, and not determining in a precise way its underlying causes. Unfortunately there has been a great force and influence in our age to reduce and simplify; thereby overlooking **all** aspects of a child's feeling, thinking and acting and how important they are to take seriously. There is no simple way to separate the neurological from the psychological.

Over the last few decades, the pendulum has moved back and forth between placing blame on mothers vs. attributing everything to biochemistry. When mothers were blamed for all their children's problems, mothers often felt so badly that it was often hard to muster the emotional reserves to feel adequate enough to help their children. Now, with biochemical views about what makes children tick, biochemical solutions often make children feel that they are brain damaged and that their recovery does not have to do with their own efforts.

Both of these viewpoints simplify the child developmental process and provide unrealistically one-sided models about what happens inside people. A wealth of information from observation as well as from psychotherapeutic treatment indicates that psychological development is complicated from every angle. For instance, infant research shows that human infants are not blank screens, impinged upon by good or bad mothers, but that each infant brings to the world his own sensitivities and temperament and influences how his mother reacts to him. In terms of the brain, it is known that stress and psychological events can affect brain structure and function permanently. So even with regard to the brain, it is again a "chicken and egg" problem. Oliver Sacks, a well-known neurology author, writes: "Brain makes thought and thought makes brain."

One theme that will emerge in this series of articles on ADHD is the questionable practice of applying symptom-based diagnosis to ADHD. This means that it is not sufficient to look at a checklist of attitudes and behaviours. To make a diagnosis, that takes into consideration all possible reasons that the child could be having trouble, child experts gather information about the whole child -his outer and inner worlds, in the past and in the present. Importantly, this includes how a child understands himself and his problems. Before choosing a treatment, careful diagnosis provides clues about the causes of problematic behaviour -- weighing medical, psychological, and environmental contributions. At this point, I only wish to emphasize the importance of careful diagnosis. The range of underlying causes will be explored in other articles in this series.

Looking at the whole child means that parents and other adults, like teachers and doctors, need to bear with the frustration of not knowing in order to more fully explore and understand a child's problems. This may mean at times being able to bear one's own feelings of urgency and uncertainty before deciding upon a diagnosis and treatment. It also means being able to think not only of a child and his current situation and his earlier childhood, but thinking about one's own feelings as they have evolved in the process of caring for a child. It means involving the child himself in the assessment process and taking seriously how a child understands himself.

So with this introduction, and a focus on the whole child as the preferred method of diagnostic practice, one possible place to start in helping unravel the mysteries of ADHD is the subject of feelings. Knowing about feelings may seem "soft" and "unscientific," but actually, feelings are a very important part of knowing and thinking and especially important when considering ADHD.

Feelings do not just "happen" or emerge from the most primitive reptilian part of the brain. To know one's feelings, to be able to bear them and make cause-and-effect connections with regard to where feelings come from, is an acquisition

that begins in early childhood and only achieves some stability by early school age. All through life, knowing one's feelings is often hard work. And when people cannot gauge their own feelings and use them as signals, it is hard to think and evaluate. As adults, we can all probably identify times when we feel vague unease and confusion and then the relief of being able to think clearly when we define our feelings.

What do feelings have to do with ADHD? The accomplishment of being able to sit still in school and attend to learning is based to a great extent on being able to experience a wide range of feelings in ways that are not overwhelming, in ways that free up the mind to think. In the example of Alan, it would be hard for adults, and perhaps hard for Alan himself, to know what he is feeling -- his expression was "inscrutable".

One possibility is that his fidgety behaviour and restlessness is a physical way of being anxious and worried...like when people have palpitations when they are nervous. Or perhaps his activity was a way to divert himself from the painful awareness of feeling incapable and inferior...his activity protected him from uncomfortable feelings. When feelings are not understood, it is not possible to tackle problems or to know what is realistic. Also, if Alan does not know what he feels, he is missing an important part of who he is.

The vignette about Alan suggests that there can be a relation between activity and feelings. "Activity" per se is the very stuff of childhood. Visiting a playground will easily remind people of how children are so active, busy, and noisy. It is a different world from the adult world. How children develop their inner tools -- that is, being able to channel their energy, to feel calm enough to learn about themselves and their world -- is a major psychological task of childhood. How activity is related to emotions and to thinking is a central issue in child development. Hopefully, exploring the meaning of activity in the next article and how it becomes channelled, will shed light on how this process occurs, how it can become derailed, and directions for getting back on track.

At the outset, then, there are no simple answers to ADHD. As it is currently diagnosed, so much can be included in this category, including children with virtually no symptoms whatsoever (DSM 314.9 Attention Deficit/Hyperactivity Disorder Not Otherwise Specified, a new category of ADHD in which there are no specific symptoms). Nor is it possible to touch on the most current thinking. Several thousand articles are published each year -- 7000 between l977 and l980, and the rate increases. To again quote from Dr. Gabrielle Weiss from the standard text in child psychiatry: ADHD "is now the most intensively studied syndrome in child psychiatry and possibly also the most controversial" (p.544).

I will close the second of this series of articles on ADHD with a quote from Erna Furman, a child psychoanalyst who explains such important concepts

in such understandable ways. About feelings, she writes: "As long as we have the ability to be aware of them and to bear them, they tell us correctly what goes on in our own bodies and minds, what other people's motivations and behaviours are about, how we relate with them and with the world around us. They enable us to experience and appreciate all the satisfactions and dissatisfactions, to know what we like and don't like, and they guide our thoughts and actions accordingly." (p.353 Helping Young Children Grow: "I Never Knew Parents Did So Much", IUP l987).1

Weiss, Gabrielle.(l996). Attention Deficit Hyperactivity Disorder, in *Child and Adolescent Psychiatry: A Comprehensive Textbook*, ed. M. Lewis. Second Edition. Baltimore: Williams and Wilkins. p. 544-563.

Unravelling the Mysteries of ADHD – Part 3 – Assessing Hyperactivity

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In the first two articles of this series on ADHD, I explored the large discrepancy in medication use between Europe and North America, suggesting that there is cause for concern about the over-medication of children. Questions were also raised about symptom-based diagnosis in which children are often said to be ADHD on the basis of limited knowledge of their difficulties. In making diagnoses and treatment plans, it is well to gather information about a child's whole range of functioning in both the past and the present and to explore the nature of the family and school environments. In this third article, I will present thoughts about activity and hyperactivity and how activity may be connected with feeling and thinking. It is essential to know about normal activity throughout childhood before making judgements about abnormality. The next article in this series will be about Attention. The present article does not touch on "impulsivity", disruptive behaviours that have more aggressive or sexual qualities.

At one point in the popular movie *Forrest Gump,* a film about a very good-hearted man of limited intelligence, Forrest ran for over three years. Was this activity or hyperactivity? Did it interfere with his day-to-day ability to function, or was it an adaptive solution for him at the time? These questions can partially be answered because we know some significant facts about Forrest's past. As a child Forrest had been in leg braces so that his mobility was highly restricted during a normally very active part of childhood. His first incident of running was very dramatic. His only child friend, Jenny, screamed "Run, Forrest" when bullies tried to attack him. In the process of running clumsily from his attackers, his leg braces fell off and he ran with increasing speed and agility, a highly effective "flight" reaction to danger. Later, running stood Forrest in good stead and even enabled him to perform heroic wartime acts and stunning athletic feats.

However, when Forrest began his three-year run, he did not know why he was running and he was not able to stop. His mother had recently died. The night before his run he had his first sexual experience, and it was with his childhood friend Jenny. She had left him during the night, and we can guess that Forrest woke up feeling abandoned, desolate, and perhaps confused and sexually frustrated. The only thoughts that Forrest reveals is that he *had* to run and that he thought all the time about Jenny. Could Forrest's running be his characteristic biological reaction to tension, his genetic programming, not needing further exploration? We can ask, though, why it happened at that

particular time. Was it a way of warding off uncomfortable thoughts -- a body action way to flee from painful feelings? or could it have been a way of holding on to Jenny in his thoughts in that she was the one who had often told him to run for self-protection? could it also be a release of his newly stirred up sexual feelings? and is there any significance of the enforced passivity imposed on him by his leg braces in earlier childhood -- did this make it more likely for him to seek active body solutions like running? We can only make "diagnostic" guesses and ask questions about his running, but we cannot know with certainty unless we explore with Forrest himself his own thoughts and feelings.

Activity then could be many things. According to the psychiatric diagnosis of ADHD (Attention Deficit Hyperactivity Disorder), the hyperactivity needs to be pervasive and cause impairment in two or more settings and to be present for at least six months. For Forrest Gump, his three years of running certainly *impaired* his normal daily functioning, but in some ways it was followed by greater emotional depth. This is not to say that hyperactivity always contributes to health and growth, but it may represent a struggle to master and communicate. It is important to look beyond the surface of a symptom before simply trying to eradicate it.

During the first five years, physical activity is a fundamental feature of childhood. It is not until Grade One that there is an expectation that children sit still and think for extended periods of time. One of the central tasks of these early years is to channel physical activity and energy into thinking and feeling. Parents are familiar with the admonition "Use your words" (instead of your actions). Teachers and parents alike work again and again with children to help them learn to use words to tell what they experience on the inside instead of simply moving to action. After Forrest Gump's long run, he is able to think and talk about his loving feelings and he expresses pain about his own limited intelligence. Instead of running for a long time, he sits on a park bench for a very long time talking about his life, finally moving his listener to tears.

Hyperactivity and Temperament

To understand hyperactivity in a school-age child, to have some perspective about what it means and how energy gets channelled, it is necessary to know something about earlier childhood. Activity makes its appearance at the beginning of human life. Even when a baby is in utero, a mother can get some sense of who her baby is by his or her activity level. Paediatrician T. Berry Brazelton wrote a classic book called *Infants and Mothers* about three kinds of infants based on their activity levels and temperaments, showing that there is such a wide range of differences from the beginning, and also showing how mothers adapt to their own particular kind of baby. One baby was born hyperactive. Brazelton describes how a mother had to try many ways of calming her *hype*ractive newborn baby in order for him to feed and to help him

focus his attention. His mother found that swaddling him and rocking him vigorously helped to contain his uncontrolled movements so that he could master the tasks at this first stage of development. For example, with too much random activity, this baby would not have been calm enough to eat when he was hungry -- hunger and discomfort could escalate, eventually interfering with his ability to use his mother as a source of soothing and comfort. A *hypo*active (under-active) baby, on the other hand, had to be stimulated in gentle ways. Her mother had to frustrate her by placing toys just beyond her reach, allowing her to fuss and motivating her to be more active, to move by herself to reach her toys. Without enough muscular development, a child might have more difficulty mastering the tasks of the toddler stage -- taking pleasure in being separate and independent from mother. This quiet baby's fine motor manipulation (her finger movement) was advanced and she used it as an outlet much like other babies use their large motor achievements.

Hyperactivity: A Reaction to Stress

To complicate matters, already in the first year, *hypo*activity and *hyper*activity can be a ***reaction*** to stress, for all kinds of babies. When too much is going on, when a baby is overstimulated either because the environment or his own inner physical feelings are too intense, babies can become agitated, unfocused, and hyperactive. Their environment needs to be geared to what they are able to take in. For Forrest Gump, his long run came at a time when there was too much in his environment (the loss of his mother and of Jenny) and perhaps too much inside him (his new sexual feelings). Because of his limited ability to think, he was not able to think through and emotionally absorb what had happened to him. Even at the very earliest age, babies show us that they need a certain degree of calmness and body self-control in order to be able to make use of their other capacities -- to feed, to look around, to take in what they hear and see and touch.

Activity as a Way of Thinking

Hyperactivity, then, can be a child's biologically given temperament, or it can be a reaction to stress. For all young children, physical action is also the way children think. This is called "sensorimotor intelligence." For the young baby and toddler, doing things and acting upon the world is the earliest kind of intelligence. A very young child does not know in his mind that the ball is under the couch....the young child is totally reliant on his senses and if he cannot see the ball, it no longer exists. Gradually, and at first accidentally, a young child discovers that his actions can make the ball re-appear --- if he actually sees the ball rolling under the couch, he can pursue it and find it with his own actions. Young children experiment over and over again with actions involving their muscles to figure out the nature of the world and of themselves. With time, children learn to experiment with ideas inside their mind and do not actually have to experiment with actions as

much. The transition from sensorimotor thinking to mental thinking is a challenging task. Some teachers, realizing that this is not well established in the early school years, structure school time so that there are frequent outlets for physical activity and projects involving "doing," not just "thinking." Many children are first diagnosed ADHD by early grade school teachers because of the children's difficulties in settling down to do seat work.

Hyperactivity: A Way of Expressing Feelings

A final consideration is that hyperactivity may be an expression of particular emotions. Young babies do not at first have emotional feelings that are connected with causes -- they can cry but in their minds they do not know they are tired, or hungry, angry or distressed. For the young child, emotions are discharged in action and in physical body feelings. Feelings like excitement, joy, and distress are expressed through physical activity -- by flexed outstretched arms and legs, by circular and repetitive arm or leg movements. Sometimes physical activities can be totally suppressed because of feelings, such as when a baby withdraws or falls asleep at times of stress.

It is one of the major tasks of early childhood, accomplished with a great deal of help from parents and caretakers, to learn to channel physical activity into thoughts and feelings. It is tempting to reduce all hyperactivity to a simple formula. However, when meanings become clear, it can be quite remarkable to see how putting feelings into words and making causal connections can have an immediate effect on a child's activity level. For example, early on in therapy one child had a great deal of difficulty coming into the office but then became very agitated when it was time to leave, pulling out toys and speedily running around the office. Once his therapist said, "part of you wants to stay here and part of you wants to go," and he immediately calmed down and was henceforth able to talk about he felt about leaving instead of running around.

Hyperactivity: Assessment

Throughout life, some kinds of emotional feelings and thoughts remain rooted in *body* feeling and *body* action. Love and sexuality is the most notable one. Watching athletes rehearse their moves as they prepare for an event, such as when Olympic gymnasts or the *Cool Runnings* bobsled team mime in miniature their next moves, is another example of how action itself can remain a way of figuring things out, just as it was for the very young child. One of the worries about hyperactivity is that if there is so much body action, then there is not time or the ability to think. Sorting out what the activity/hyperactivity is about is important because children need to be able to use all their faculties and to be themselves with all their senses and feelings. When a child is having trouble, it is often so difficult to pause, to contain one's own anxieties and guilt, and to calmly bear with the

uncertainty of not immediately knowing what to do. In this article I have touched upon the subject of activity as it first appears in early development and how it remains with us throughout life. Assessing whether activity is excessive, figuring out its effect on a child and how it came about, takes time and careful consideration. As professionals, it is so very important that we give children more than a hyperactive response when trying to understand what could make a child extraordinarily active.

Unravelling the Mysteries of ADHD
Part 4 - ADHD: Paying Attention

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Children who appear too active or inattentive at school are often diagnosed as having a psychiatric disorder called ADHD (Attention Deficit Hyperactivity Disorder, formerly ADD) and then treated with Ritalin (methylphenidate) or related drugs. In three previous articles in *Parent-to-Parent*, I wrote about how the diagnostic category is vague and includes children across the diagnostic spectrum, from "normal" to "severely disturbed". I also discussed some of the reasons leading to the overuse of medication.

Children are often referred for assessment and diagnosed ADHD because of attention problems at school. What is often noticed is that a child is not paying attention to school tasks. The child may be distractible or behind in schoolwork. There can be innumerable reasons for inattention, but the "checklist approach" to diagnosis does not search for the *reasons* or *causes*. The checklist questions have to do with the signs and characteristics of inattention, but overlooked is what a child is thinking about when he or she is not paying attention.

Being able to pay attention is quite a mature feat for the young school-age child. It means that a child has learned how to be alone even during times of frustration. It means that a child can put a number of feelings aside momentarily and choose to pay attention, and it means that he or she can work without the immediate rewards of approval or encouragement from others. Working at repetitive or routine tasks also means working at times without the personal rewards and pleasures of discovery and mastery. In paper-and-pencil task, the child has moved from doing to thinking; as I wrote in the last article on activity, doing, or action, is the main way that younger children learn. Being able to work in a group, to focus on the task at hand, means that a child has to some degree mastered difficult and complex social feelings such as competitiveness and being left out.

Listening to and noticing what a child is doing during times of inattentiveness can help both adult and child to better understand themselves. Understanding a child often involves a readiness to consider the nature of children's thoughts and feelings, a readiness to re-enter their "magical" world. Children and adults may at times face the same tasks, but they do it with a different mindset and with different feelings. For children, fantasy and reality are still not firmly differentiated and their beliefs can easily be misunderstood or overlooked.

One young child would not look at the airplane when his parents took off for a vacation. He would not pay "attention".

Adults might guess that he was feeling badly about his parents leaving. The little boy himself explained that he would not look because the plane was getting smaller. In his child's mind, he thought that the plane and his parents were becoming smaller and smaller as the plane became more distant. He did not yet securely know that objects appear smaller with distance. His strong worries and his immature understanding of spatial relationships interfered with his ability to look, to think, to "attend". When his caretaker helpfully explained that his parents and the plane were still the same size, he could then think about his parents' departure in a more rational way.

Being hyperactive or being inattentive is not necessarily harmful. When children are very young, even in their first year, being "hyperactive" or being "attention deficit" can actually be a basic way that a child can provide himself with a "stimulus barrier", a buffer or a shield, to an overstimulating or understimulating environment. Babies may withdraw into sleep or become physically active, when there is too much, or not enough, going on. These behaviors can help a child maintain a sense of inner equilibrium, even protecting him from experiences of disruptive panic. Adults and children may still use this kind of self-protection. During a very scary part of "Jurassic Park", several school-age girls withdrew their attention from the movie and started to chat with each other and share their snacks, obviously blocking out the overstimulating movie. Others may urgently request a washroom or snack break.

There are as many reasons for inattention as there are children. Glossing over these various reasons and treating the attention problems with Ritalin is comparable to treating all fevers in the same way. Being able to pay attention is without doubt a fundamentally important task. Not only does it help children feel good when they accomplish various skills, but being truly attentive helps children feel more themselves, for it takes the ability to be attentive in order to be able to have all one's thoughts and feelings. Also in this age of overstimulation, when children are exposed to so many inappropriate sights and sounds on T.V., radio, and in real life, the ability to sustain attention through reading offers children the opportunity to enter an unusually safe, child-centered world. I have known many children who somehow find their way to helpful, appropriate, and engaging books , an option often not available in the electronic media.

Being attentive to children's emotional and thinking states is often difficult for adults. "Pay attention!" is all too often a demand or a command from child to adult, or from adult to child It is difficult enough to listen to one's own worries or concerns, much less to put oneself in someone else's shoes. Perhaps hardest of all is to recognize those feelings of smallness and helplessness and confusion that one experienced as a child. Paying attention to each child as an individual, attending to his or her own *reasons* for not being able to pay attention, takes time and calmness. It does not help

when adults also feel pressured and pushed into premature decisions about diagnosis and treatment.

Unravelling the Mysteries of ADHD
Part 5 - Treatment

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In four previous articles I have written for Parent-to-Parent Magazine, I have challenged the prevailing overuse of medication and the checklist approach to the diagnosis of ADHD. Referring to the research of Robert Furman, M.D. from the Cleveland Centre for Research in Child Development, I described the current epidemic number of children in North America receiving stimulant medication: current estimates are that 2 million children are now receiving medication in the United States, 4.4% of the children in the 5-17 year old group. The rate of children on medication in Europe is .6% (6,000 children) that of North America. I outlined in that article how the amphetamine derivatives used to treat ADHD are classified with other addictive drugs, and that regulations for prescribing these drugs are, by contrast with North America, extremely tight in Europe. Also in previous articles I explored the nature of hyperactivity and attention, and how they appear and function in the overall development of children and adults.

The main thread of these articles is that diagnosing and treating children is complicated. In child mental health, the checklist approach to diagnosis, and the widespread use of medication, are recent phenomena of the 90's. Over the last few decades, there have been two divergent modes of diagnosis of psychological and behavioral difficulties: one focuses on symptoms and the other focuses on their underlying causes. ADHD is a symptom-based diagnosis. The diagnosis ADHD itself has been challenged by many experts. The eminent British psychiatrist/researcher Michael Rutter, M.D., has concluded that linking ADHD symptoms with minimal brain damage was "an uncertain hypothesis, a `neuromythology' (a neurological myth), and that nonpervasive symptoms (attention and activity problems that surfaced in some situations but not in others) were of no diagnostic significance."

To clarify the diagnostic and treatment problem then, the way we see ADHD can be compared with the way we think about a fever. With a symptom-based approach, the fever itself is identified as the problem to be treated and eliminated. On the other hand, a fever can be looked at as a sign of an underlying disorder that may or may not need medication. To complicate matters, the absence of a fever can be of diagnostic importance when there are other indications of a disease process. From this point of view, the presence of a symptom in itself does not provide necessary information about the nature of the problem or about its treatment.

Looking at underlying causes means

that diagnosis is a more lengthy process than compiling a checklist and that treatments will vary depending on the nature of the underlying problem. This does not mean that there are always deep-seated problems. In other articles in this series, I touched on the "normal" adaptive aspects of activity and the difficulties in differentiating activity from hyperactivity: activity in itself is an important way of learning and figuring out and remains so throughout life, so it may or may not be pathological in terms of a child's overall functioning. In children, symptoms are not necessarily indications of the kind of interference requiring treatment. Symptoms often appear when children face new tasks, such as a sleep disturbance appearing before going to school for the first time.

What then are the alternate methods of diagnosis, other than the checklist approach which now so frequently leads to a diagnosis of ADHD and pharmaceutical treatment? When do children need a more extensive assessment and when do they need other modes of help? What other methods have proved effective in helping children with hyperactivity and attention problems?

Clearly there are no simple answers. Perhaps a place to start is to consider that whoever is involved with the assessment needs to be willing to be open-minded about the whole picture. This means that teachers, doctors, psychotherapists, parents, and the child all need to be willing to think and analyze the problem in as full a way as possible. Gabrielle Weiss, a leading Canadian child psychiatrist who wrote the review article on ADHD for the standard textbook in child psychiatry, concludes that we have expected too much from medication for a syndrome comprising such diverse and multiple behavioural, social, and cognitive deficits," that these difficulties require a range of treatment interventions (p. 554).

Whether the presenting problems are around school learning difficulties, or social immaturity and inappropriate behavior at home or school, the specialists who are consulted need to know about a child's early history as well as his current functioning. Parents are the most knowledgeable about a child's past, but often children themselves provide their own crucially important perspective about significant formative situations in their own lives. For example, young children may venture information about scary misunderstandings of hospital experiences. Or ordinary life experiences like moving or pregnancy may have special significance to an individual child. Or news events overheard on T.V. may lead to particular confusions and anxiety that may not be readily apparent to a child's caretakers.

Children also need to be listened to in order to assess their current level of functioning --- parents and teachers may notice that a child does not use words but only agitated actions to express frustration, nervousness, or excitement; the child himself might reveal in an individual interview that he does have words, but that like very

small children, he still feels words are magical -- the child might magically believe that a bad thought can actually cause harm to others so that thinking and talking become unsafe endeavors. "Diagnosing" then becomes a way of understanding the child. Treating this child would mean explaining that words are not magical, that people can think whatever they want inside their own heads and that these thoughts are also private and secret --- treatment here involves helping the child feel safe with words, safe enough to think and not act out.

Diagnosis can take a long time. Knowing about a child, about his past and current family, school, and community environments, and about his medical background, means gathering much information. Various specialities have their own modes of assessment, at times involving educational, psychological, and neurological tests. Parents can ask specialists about their own professional backgrounds. Parents can ask what kind of diagnosis is used -- a) symptom-based, or b) broader exploration of all areas of functioning to establish some sense of underlying causes. Parents can ask whether the assessor treats children with methods other than medication and whether the assessor has a background in both normal and abnormal child development.

Deciding whether to assess a child is often subjective. One view expressed in this series is that currently there is an over-diagnosis of ADHD. Perhaps a useful guideline for parents and teachers is to consider whether a child's overall movement forwards is blocked or impaired, whether the difficulties are pervasive or specific to particular situations.

Treatment itself is based upon diagnosis. When hyperactivity and attention problems seem to interfere mainly with learning, individual tutoring within the context of a clear and uncritical relationship helps children focus on their own shifts in attention and enables them to take responsibility for their own work. It becomes less threatening to be self-reflective when children do not feel stigmatized and when they do not mistakenly believe that they have a brain disorder. Individual psychotherapy, also provided within the context of a clear and uncritical relationship, helps children and their parents to understand why attention is diverted and to understand what is actually occupying a child's mind. Children can be involved in a verbal therapeutic process in which they can come to understand and have greater control over their own difficulties.

To conclude this five-part series, I will quote again from Dr. Furman's article: "Mention does have to be made of the abdication of responsibility possible with the diagnosis of "an illness in the child", presumably caused by some chemical deficiency in the brain. Parents are spared responsibility for their child's behaviour, the child is spared a type of responsibility for his own behaviour, teachers are spared responsibility for managing their classrooms, society is spared

responsibility for the inadequate funding of schools that creates such large classroom sizes a teacher has problems coping with active children."

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