



***The
Myth
of
Attention
Deficit
Disorder***

Thomas P. Millar



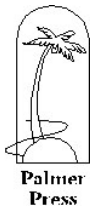
The Myth of Attention Deficit Disorder

Thomas Millar

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Chapter One

Who Is Doing the Labeling?

From the analysis of triplicate prescriptions, where publication of such doctor prescribing data is permitted, the finding is that most prescriptions for Ritalin are being written by pediatricians and family physicians. However, in many cases, the diagnosis has already been made by some teacher who has simply checked items on the Attention Deficit Hyperactivity Disorder checklist.

The teacher often tells the parents something like this: “Your child has ADHD. You should go to your doctor and get him on Ritalin right away. I have three boys in my class on the drug, and they don’t give me trouble anymore. Ritalin does wonders.”

Sometimes the urgency of this teacher referral is reinforced with hints of special class placement or even suspension if the parents do not cooperate. This kind of pressure is illegal in the United States. A federal judge has ruled that pressuring parents to put their child on drugs is not a reasonable thing for schools to be doing. That educators would attempt to do this suggests to me that they have grown hazy about their professional competence, the limits of their mandate, and the ethics of their profession. (See “Judge Says New Hampshire Can’t Order Ritalin Use,” *Boston Globe*, 8 August 1991.)

Many doctors, however, simply go along with these teacher diagnoses and recommendations. “If I don’t give them the drug some other doctor will,” is the common excuse. This argument is not, by any standards, a reasonable rationale for prescribing a powerful drug. I think most doctors know that.

In some communities a few doctors have become known as the local ADHD gurus. These do the bulk of the medicating. A recent study out of Michigan investigated their triplicate prescription program and established that half the Ritalin prescriptions written by pediatricians were written by 5 percent of registered doctors. Here in British Columbia, at the direction of the Health Minister, the College of Pharmacists has decreed that doctor prescribing habits will remain secret. (See *Vancouver Province*, 2 June 1996.) If that were not so I think we would soon learn that here in Canada too, only a few doctors are responsible for our epidemic of ADHD. (See Rapley, MD, Gardiner, JC, Jetton, JR, Houang, RT, “The Use of Methylphenidate in Michigan,” *Arch Pediatr Adolesc Med* June 1995 (149/6): 675-79.)

That a few doctors are doing most of the prescribing is more important than a lay person might realize. Doctors who prescribe much Ritalin maintain that they are midstream practitioners. If legally challenged for giving a child Ritalin without proper indication, as is happening more frequently now, such a doctor may feel he or she can defend this action by calling it standard practice in the community. However, if it could be shown that only a few doctors are doing most of the prescribing, this defense would no longer hold water.

What Is a Parent to Do?

Since these kinds of diagnostic and prescriptive abuses are now widespread, what is a parent with a child with behavior problems to do? Here is my advice.

If you, as a parent, need to take your child to a physician for diagnosis and treatment of behavior difficulties, know that you have the right to expect a proper assessment from your doctor. If you don't receive an assessment that includes the following four things, my advice is to seek another opinion.

- You have a right to expect your physician will do a full evaluation of the child. This includes taking a complete history of his or her birth, development, physical health and behavioral difficulties. Secondly the doctor should interview the child to assess his or her behavioral style. Both of these are essential to make a proper diagnosis. This is not a twenty minute procedure. In my child psychiatry practice it took two hours to do such an evaluation, along with a follow up interview to explain my findings and recommendations to the parents.
- Your doctor should inform the parents that ADHD is a controversial diagnosis, and, in the minds of many experienced clinicians, not a proper diagnosis at all. One way might be to provide “pro” literature such as supplied by organizations like “Children and Adults with Attention-Deficit/Hyperactivity Disorder” (CHADD) supply, and “con” literature such as this book, and allow you to come to your own conclusion.
- Your doctor should inform you that Ritalin is a powerful drug with side effects, that has no understood mode of therapeutic action, has a considerable street presence, and, like other Schedule II stimulants, can lead to dependency and abuse.
- Finally the doctor should include in his or her management of your child's behavioral problems a program of guidance to promote any delayed psychological growth in the child through effective parenting.

With respect to guidance to parents, even the ADHD enthusiasts agree that such steps should form part of any treatment program for children diagnosed with ADHD. However, nine times out of ten, no effective help is offered.

There are two reasons for this. Once Ritalin has been prescribed and the child's behavior settles down, the motivation for the parents to seek, and the doctor to provide, such parenting guidance tends to disappear. Secondly, most family doctors and pediatricians have neither the competence nor the time to conduct such guidance. The serious fact is that, once Ritalin has been described, the likelihood of the child receiving the retraining that is his or her greatest need is sharply reduced.

Do most children diagnosed ADHD today go through the careful assessment I have described? The evidence is that they do not. Many, many children are being dropped into the ADHD bin after a cursory study and then given Ritalin by a physician largely unfamiliar with the drug's side effects and habit forming potential. Indeed, one of our local ADHD gurus has said that taking Ritalin is no worse than taking aspirin. Which should make one wonder why aspirin isn't also a street drug? Ritalin is.

Why do parents go along with shoddy diagnoses, careless labeling, and off-the-cuff prescribing? Some, knowing that the ADHD category appears in the vaunted *Diagnostic and Statistical Manual* of the American Psychiatric Association, assume that, emanating from such an august body, ADHD cannot be anything but a proper diagnosis.

Such persons may be surprised to hear that many experienced clinicians hold a very different view. I am going to devote a short chapter to presenting some of these dissenting views. The doctors involved are experienced clinicians, not just ivory tower professors. I urge the lay reader, and any doctor braving these pages, to give their views due consideration.

Chapter Two

A Minority Opinion

Do most doctors agree that Attention Deficit Hyperactivity Disorder is a proper diagnosis? Only in America. There the general view is that it is only mavericks who disagree. However, outside of Canada and the United States, very few doctors make the diagnosis at all. On the European continent they won't touch it with a ten foot stethoscope.

Furthermore, in America, there are many senior clinicians who question the validity of the ADD/ADHD category. Some, like me, have been doing so for over a decade now. Though this questioning has appeared in the medical literature, it is only lately that this concern has begun to reach the public.

As far back as 1976 Shrag and Divorky, in their book *The Myth of the Hyperactive Child*, trace the origin of the diagnosis to advertising campaigns run by drug companies which manufacture cures for such behavioral disorders. They say that with ADD the cure preceded the ailment. As we shall see later, this approach is a most unusual way for a new medical diagnosis to emerge. (See Shrag and Divorky, *The Myth of the Hyperactive Child*, New York: Pantheon, 1976.)

Weinberg and Bromberg, contributing to a consensus article entitled "The Professor's Opinion," have stated unequivocally that "the diagnostic category ADHD is a myth." Offering another opinion in the same article, Golden says: "Even if the condition exists, it is probably much less common than is diagnosed in practice." (See Weinberg and Bromberg, "An Analysis of the Legal Issues Surrounding the Forced Use of Ritalin: Protecting the Child's Right to 'Just Say No'," *New England Law Review*, 27, 1173+.)

In yet a third "Professor's Opinion" in the same issue, Levine comments that "at a time when professionals contend with a perceived epidemic of ADHD it is indeed ironic that such a low level of agreement regarding the conditions identity as a discrete entity, its precise manifestations, its mechanisms, and its diagnostic criteria exists."

Despite these grave dissents, ADHD has grown like topsy. The diagnosis has become a waste basket into which any misbehaving child can be tossed.

Some children proved not to fit too well into that basket. How did the American Psychiatric Association deal with this? Since the children wouldn't fit the category, they refitted the category to accommodate the children.

In each new version of the *Diagnostic and Statistical Manual* they modified to criteria by which the diagnosis was made. So it is the *DSM III* criteria are not the same as those in *DSM IIIR*. Nor are these the same as *DSM IV*. With checklist diagnoses it's easy to alter the criteria. You just change the questions on the checklist.

As the Attention Deficit waste basket became the repository of all these variegated fruits and vegetables, the American Psychiatric Association decided to divide their big basket into a lot of

little baskets. Never at a loss for nomenclature, the committee gave each of these little baskets its own name. Here's the current roll call of those baskets:

- Plain vanilla ADHD
- ADHD Combined Type
- ADHD Predominantly Hyperactive-Impulsive Type
- ADHD Predominantly Inattentive Type
- ADHD Not Otherwise Specified Type.

You know what will be probably show up in *DSM V*, don't you?

ADHD Normal Child Type

If, despite this wide choice of baskets to choose from, some children still show bits and pieces of other disorders, these are explained away by calling them co-morbid conditions. It is clear that Attention Deficit Hyperactivity Disorder has become a one size fits all diagnosis -- which makes it a win-win situation for lazy doctors and a lose-lose situation for lively kids.

The committee members at the American Psychiatric Association, the group responsible for these categories, should realize that all this patching up is losing its capacity to obfuscate. As it becomes less politically incorrect to do so, more and more doctors are emerging from their storm cellars to express some doubts about the situation. All these doctors dare do so far is to agree that Ritalin is being over-prescribed. However, sooner or later it's bound to occur to them that faulty prescribing is a result of faulty diagnosing, and they may be ready for the next step in their understanding.

To understand this situation properly we need now to take a short look at the history that led to the creation of this label and ultimately to its explosion, like a super-nova, upon the innocent heads of North American parents and children.

Chapter Three

Post-Freudian Angst

Until Sigmund Freud came along, psychiatric conditions had been classified in purely descriptive terms. Some were named for a single symptom such as the various phobias. Claustrophobia, a fear of closed places, and Agoraphobia, a fear of open places, are examples of such single symptoms.

Later, these conditions began to be named in general descriptive terms such as Behavior Disorder or Neurosis. This change came about because psychiatry was in the same primitive state of understanding as general medicine had been before Harvey discovered how the blood circulated.

Consider this, for example. Prior to Harvey's discovery of blood circulation, there was a diagnosis called "dropsy" which consisted of two main symptoms commonly seen together, shortness of breath and swelling of the ankles. Once Harvey had spelled out how the circulation worked, doctors were able to understand how these two symptoms could be related to heart failure in one instance, to renal failure in another, and to starvation in yet a third. Once the organizing principle had emerged, one diagnosis became three, each of which provided a much clearer line to treatment than did the descriptive label "dropsy."

Medical diagnosis has always marched along a continuum which has description at one end and cause -- or as we physicians call it, etiology -- at the other. The journey often multi-stepped and protracted, and it never ends.

Psychiatry has needed a Harvey to discover and explain some fundamental principle of mental function which could take us deeper into the heart of the psychological disabilities behind the symptoms our patients displayed. When Freud came along many thought psychiatry had found that principle.

Freud constructed a coherent system of psychological function and malfunction, based on three fundamental notions. The first of these was called the *libido theory of psychosexual development*. This was the notion that the child passed through phases during infancy when his or her psychological needs were dominated by oral, anal, or oedipal events, each of which phases might, or might not, be successfully navigated. The second fundamental notion was that these significant events of early childhood were pushed out of awareness by an active process Freud called *repression*. The third fundamental notion was that there was an *unconscious* mind where these developmental triumphs and traumas *remained*, and where they were capable of affecting the adult's behavioral choices. Putting these three ideas together, Freud came up with the instinctual conflict theory of neurosis.

Just as Harvey's principle had changed the concept of blood circulation, Freud's led to many new diagnoses. These were called dynamic diagnoses since they purported to explain how the

symptoms were related to the underlying instinctual conflict. The names of many of these diagnoses reflected underlying oral, anal, or oedipal psychopathology.

For example, the school phobia child was seen to have displaced his unresolved castration anxiety onto some aspect of the school. By avoiding school he was actually protecting his psychological cojones.

When it came to treatment, the rationale became as follows: recover the repressed early conflict from the unconscious, vent the attached emotion, and forever free patients from its tyranny. Given Freud's underlying premises, it all made perfect sense.

The fact that the treatment didn't actually work was overlooked in the burgeoning enthusiasm. Soon everybody who was *au courant* was rushing to take part in the best parlor game to come along since charades. It was easy to diagnose your neighbor's refusal to lend you his lawn mower as a manifestation of his anal retentive personality. It was just as easy to see your wife's distaste for your late nights as repressed emotional angst about her father. And it was not just naive intellectuals, cab drivers, and bartenders who played this game. Novelists, playwrights, movie makers – everyone got into the act.

With the passage of time, things Freudian began to fall apart. The theoretical underpinnings of Freud's instinctual conflict theory of neurosis were, one by one, invalidated. Direct observation of developing children did not lead to a confirmation of Freud's libido stages. The notion of repression was discredited. The unconscious mind was seen to be a much different creature from the one Freud described. (I addressed this issue in "Some Observations Concerning Out of Awareness Mentation," in *Perspectives in Biology and Medicine* 33, 2 (Winter 1990).)

Though Freud's instinctual conflict theory of neurosis was discredited by all but a few die hard analysts, his contribution was, and remains, a considerable one. Freud opened an important door for psychiatrists. He taught us to look beyond symptoms into historical psychological events and he showed us how these events were in fact major determinants of our learned behavior.

Though psychoanalysis soon became defunct, dynamic psychiatry had come to stay. The new dimension to diagnosis was called psychosocial, which, viewed against where psychiatry had been prior to Freud, was change indeed.

Now we come to the angst bit.

The immediate post-Freudian era was not a good time to be a psychiatrist. The pendulum took a mighty swing. We psychiatrists soon found we had all been tarred with the oral-anal brush. People no longer saw us as wise and kindly men of great intelligence easily able to penetrate to the heart of bizarre syndromes such as those portrayed in the movies *Spellbound* and *Vertigo*.

Now psychiatrists were seen as some type of *Dr. Strangelove*, and our patients as feckless Woody Allen characters or spouse murderers working the Freudian con. Even our medical colleagues began looking at us with barely concealed misgivings.

That's when a small group of American Psychiatric Association gurus, in the best American tradition, rode to the rescue. Pulling wagon loads of concrete nomenclature, they galloped in and undertook to restore psychiatry's good name. Since the villain was a series of weird diagnoses that led to strange conclusions and haphazard predictions, these self-appointed Salvationists

decided to undertake a radical restructuring of diagnosis in psychiatry. (See a very interesting paper by Dr. Mitchell Wilson entitled “DSM III and the Transformation of American Psychiatry: A History” for more on this subject. It appeared in the *American Journal of Psychiatry* 150, 3 (March 1993).)

These doctors were determined to invent categories that were descriptive, medically based where possible, about which, they hoped, there could be no argument. Concrete description was in; etiology was out. As Robert Spitzer explained to a latter day critic, from the very beginning the task force was committed to a classification that avoided etiologic speculation. Thus, freshly equipped with sensible, straightforward categories, they reasoned, psychiatry would be restored to respect in the mainstream of medicine.

To develop their new diagnoses these doctors went back to what they considered to be first principles and spelled out the categories that would eventually make up the *Diagnostic and Statistical Manual III*. Spitzer’s lists had been born.

Not all psychiatrists were pleased with these efforts. Dr Theodore Lidz, a leading psychiatrist from New Haven, Connecticut, put it succinctly in a letter in the *American Journal of Psychiatry*, complaining that “they foisted *DSM III* on American Psychiatry despite strong opposition from many of the leaders in the field.”

DSM III constructs lists of symptoms, which in child psychiatry are usually behaviors, associated with a given diagnostic category. The manual then determines exactly how many of such behaviors need to be present for what period of time for the diagnosis to be made.

This entirely new approach to medical classification has become known as “checklist diagnosing.” With *DSM III* the checklist diagnosis is king. History taking and clinical interviewing now take a back seat. Sometimes, it seems, they have been kicked off the bus altogether.

The special appeal of checklist diagnosing is that it is easy. Teachers, parents, and in fact anyone who can read and owns a pencil can make the diagnosis merely by checking items and counting them up. Later in this book I shall include the ADHD checklist from *DSM III* and the reader can try his or her hand on the neighborhood children.

However, to name a category “Attention Deficit Disorder” does seem to suggest that the fourteen behaviors on the checklist result from a deficit in the individual’s capacity to sustain his or her attention, does it not? Is this approach not implying an etiology – an actual cause of a disease?

What if the committee members elected to call their category “Pervasive Fidgeting Disorder”? Fidgeting is, by their account, the most statistically significant of their fourteen behavioral items. If their diagnosis is truly descriptive, why not name it for its most consistent symptom?

These doctors ignored this obvious choice, however, and chose to call their category “Attention Deficit Disorder,” a term with clear etiological implications. Why did they do this?

The Real Reason for the DSMs

For the explanation of this discrepancy we need to go back to Shrag and Divorky's account of where the original diagnosis came from. As they point out in their book, "the cure preceded the ailment." The cure they are speaking of is the drug Ritalin.

Before ADD, Ritalin was being used for children who were showing what was then called "functional behavior problems." The term "functional" really means "we don't know the cause but think it's nothing organic."

Ritalin was seen to calm these children who exhibited "functional behavior problems." But, some nascent gurus reasoned, Ritalin is a stimulant! How could a drug which was a known stimulant calm children? Clearly some fancy footwork was going to be needed to put this plus two and minus two together and come out four. (The old maid's tale that coffee calms kids may have had something to do with the decision to experiment with stimulants for any calming properties they may contain.)

Not to worry. Clinical professors sharpen their teeth on challenges of this kind. The rationalization they constructed went like this. There has to be a brain center which enables the child to focus his or her attention on the environment, right? Let's call this the Attention Center. Ritalin stimulates this center, which leads the child to pay better attention. Now that the child is focusing better, he or she copes better and, consequently, the behavior improves. Q.E.D. and all that stuff that makes it all sound precise and logical!

The next step was obvious. Since Ritalin stimulates this Attention Center and the child gets better, that center must not have been doing its job before. That means the child's symptoms are caused by a deficit in his or her ability to attend. Voila! The child has an Attention Deficit Disorder!

You'd think, wouldn't you, that if a man rode too long on an intellectual merry-go-round like this, he'd get dizzy? The diagnosis Attention Deficit Disorder has to be the first occasion in medical history where a diagnosis was named for a purely speculative rationalization, constructed to account for an unexplained drug effect.

Despite their horror of etiological implications creeping into their diagnostic nomenclature, the DSM gurus took this illegitimate orphan in, lock, stock, and barrel. With undaunted faith, hope, and charity, they have foisted it on the rest of us for nearly a decade now. And many swallowed it, hook, line, and sinker. Though it is becoming increasingly clear the Attention Deficit diagnosis doesn't hold water, down at DSM HQ, they just change the checklist and keep on trucking.

So, let's now take a look at this famous checklist.

Chapter Four

Spitzer's List

Here are the fourteen behaviors listed on the ADHD checklist, quoted from the DSM.

“Diagnostic Criteria for 314.01 ADHD

Note: Consider a criterion met only if the behavior is considerably more frequent than that of most people of the same mental age. A disturbance of at least six months during which at least eight of the following are present:

1. often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to feelings of restlessness)
2. has difficulty remaining seated when required to do so
3. is easily distracted by extraneous stimuli
4. has difficulty awaiting turn in games or group situations
5. often blurts out answers to question before they have been completed
6. has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension) e.g., fails to finish chores
7. has difficulty sustaining attention in tasks or play activities
8. often shifts from one uncompleted activity to another
9. has difficulty playing quietly
10. often talks excessively
11. often interrupts or intrudes on others, e.g., butts into other children's games
12. often does not seem to listen to what is being said
13. often loses things necessary for task or activities at school or home (e.g., toys, pencils, books, assignments)
14. often engages in physically dangerous activities without considering possible consequences (not for the purposes of thrill seeking) e.g., runs into the street without looking

Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the *DSM-III-R* criteria for disruptive behavior disorders. Onset before age seven. Does not meet the criteria for a Pervasive Developmental disorder.”

That's it. Those are the fourteen items, of which your child only has to show eight. The symptoms need to show up before the child is seven years old, and should last for a period of six months for the child to qualify as ADHD. Wow!

We need to do some thinking about this list. Let me begin by drawing your attention to some details.

First, did you notice that eight of the fourteen items began with the word "often"? For example, "often loses," "often fidgets," "often blurts," etc.

Whose "often" did the developers of this diagnosis have in mind when they chose these eight items? A general practitioner who sees a few kids? A pediatrician who sees a lot of kids for common medical problems? A child psychiatrist who sees a lot of kids for behavior problems? An adult psychiatrist who wouldn't see a kid if his couch depended on it? How about a CHADD board member whose child is taking Ritalin?

What is required to answer the "often" question about a given behavior is experience and judgment. This is what parents pay a professional for: his or her experience in matters outside the normal person's own expertise.

A second point. Did you notice that, of the six questions that did not begin with often, five of them began with "has difficulty"?

How much "having difficulty" does it take to qualify for a check mark? Again, it is a matter of experience and judgment. Again, it comes down to who is doing the diagnosing and what his or her qualifications are for doing so. The process should take more than simply owning a pencil and being able to read, shouldn't it?

Checklist diagnosing totally ignores training and experience. In this checklist approach, a teacher's or day care worker's opinion could carry the same weight as that of a qualified neurologist or child psychiatrist. It is beyond comprehension to me that some parents would accept a diagnosis from someone without training or experience, based on a list of fourteen vague criteria, and use that information to put their child on drugs.

As Shakespeare might have put it, "*He who depends upon diagnoses such as these, swims with fins of lead.*"

ADHD Research

The problem of facile ADHD diagnosing is heightened by the fact that many millions of dollars are being spent on research intended to find the ultimate cause of the condition. Since this is clinical research, it involves comparing groups of children diagnosed with ADHD against normal children who haven't been so labeled.

In all of the research projects on ADHD, the subject group is diagnosed by the checklist. Since all fourteen of these items are matters of judgment, and all kinds of different people are making the judgments, the ADHD group they come up with is, scientifically speaking, insignificant. This means any differences observed between that group and the control group are also insignificant.

Despite this insignificance, whole careers have been built on ADHD research of this nature. Millions of dollars are being wasted in this fashion. But that is not the worst of it. Treatment is being justified on the basis of such flawed research. In the land of the blind the one-eyed man is king, even if he has a cloudy cataract.

But I'm not finished with this list yet. Look at the items again. Don't you think almost any child could, without stretching things, be labeled ADHD? Tragically, the diagnosis is pathetically over inclusive. Do you know any fidgety children who can't stay in their seat, or play quietly, who don't listen when you speak to them, or have difficulty following instructions? Don't most children blurt out answers, interrupt others, and chatter away?

Of course you do. Everybody does. Count them! That's eight symptoms everyone exhibits. That means that just about any child – and I don't care if he is your favorite nephew – qualifies for the diagnosis and will receive it, if he falls into the wrong hands.

Remember that the protocol says the symptoms must be present before the age of seven to make the diagnosis. Most every child, certainly those who are temperamentally energetic and intense, will show many of the behaviors on the list when they are of preschool age. It's normal for young children to have these "symptoms." So, the question then is, what do these behaviors really indicate?

Symptom or Adaptive Immaturity?

In my view, the significance of these so-called symptoms – and I prefer to call them behaviors – is entirely dependent on the age of the child. If I saw a four year old with these qualities, I would say to his or her mother, "this one's a handful! How about we get to work on those temper tantrums for a start?" And with good parenting, I would expect the tantrums to cease in matter of two or three weeks.

This approach to difficult behavior is normal child rearing consultation. No way should it be called treatment of symptoms, in either the mother or the child. The behaviors on the ADHD checklist, though they are called symptoms, are not symptoms in the way that a rash or a cough or a sore foot are symptoms. These behaviors are common, and they are normal in preschool children. When they are seen in older children, they are more appropriately called signs of immaturity.

It is important to draw this distinction. Getting over normal immaturity is a process that has a name. It is called growing up. No way is growing children up "treatment." Children do not grow up by having a label pasted on their medical folder and taking prescription drugs such as Ritalin.

Children grow up when they are parented properly: that is nurtured and trained in a fashion appropriate for their temperament. This is a subject I shall return to and spell out in more detail later.

Before I go on to a discussion of Ritalin and its effects, let me close this chapter with a quote from the *Drug Enforcement Agency Report – Methylphenidate, 1995*.

ADD has never been proven to be a disease or anything physical or biologic. Asked if it was or not, Paul Leber MD of the US Food and Drug Administration responded December 22, 1994 [stating] “that as yet no pathophysiology for the disorder has been delineated.” The Drug Enforcement Administration responded on October 25th, 1995 [stating] “We are also unaware that ADHD has been validated as a biologic/organic syndrome or disease.”

Despite such strong advice to the contrary, doctors go on making the diagnosis of ADHD and prescribing Ritalin, claiming that, “if I don’t do it, somebody else will.”

The next chapter is all about Ritalin, how it works, not why it works because nobody knows that. We shall also deal with Ritalin’s several varieties of side effects: mild, moderate, severe, and as yet unknown.

Chapter Five

No Worse than Aspirin?

The generic name of the drug known as Ritalin is methylphenidate. Everybody knows it as Ritalin because the manufacturer CIBA (now Novartis in Canada) has almost got the market cornered. You can ask them if you like, but they won't release their sales figures. Still, they did have enough in their kitty to donate nearly a million dollars to CHADD.

(Who or what is this CHADD I keep referring to? As mentioned earlier, CHADD is the acronym for Children and Adults with Attention Deficit Disorder, the principal parent-support group for Attention-Deficit/Hyperactivity Disorder. CHADD has over 20,000 members and 600 branches in the United States. The organization is expanding rapidly into Canada where many child psychiatrists serve on their boards. CHADD recruits members and distributes literature about the "disease" ADHD. They assisted in a drug company effort to get the national quota on the manufacture of methylphenidate (over seven tonnes in 1994) increased. They were concerned that a shortage might develop and leave parents and children high and dry.)

I have chosen to deal with the subject of this chapter in two parts. First, let's consider whether Ritalin actually works. Then, let's see if it is really no worse than aspirin, as some doctors say.

Does Ritalin Work?

As we shall see, the answer to this question depends on what you mean by "work." If you mean does it quiet children down, the consensus is that it does. About 80 percent of children who receive the drug experience this effect.

This is similar to saying aspirin helps headaches. It is important not to equate this settling down with a cure of the child's behavior problem. Let me cite an interesting study which will put this difference into perspective.

Granger et al, from the Department of Psychology of the University of California at Los Angeles report a study in which they enlisted ninety-six undergraduate college students to view and make judgments about videotaped play sessions. These were videos of two different ADHD boys playing an interaction game with three normal peers. One of the target boys was on Ritalin and one wasn't. (See Granger, DA, et al., Social Impressions of Methylphenidate Effects on Hyperactive Children's Peer Interactions," *Journal of Abnormal Child Psychology* 21: 67-81.)

The observations of these undergraduates were evaluated and more negative than positive behaviors were detected. The interesting thing is that the negative behaviors reported were strikingly different.

The negative ratings for the placebo child (the one not getting Ritalin) reported three behaviors:

- non-compliance
- aggression
- disruption.

The negative ratings for the Ritalin child also reported three behaviors:

- social inhibition
- passivity
- submissive behavior.

The question arises: When a child is reported to be better on Ritalin does “better” mean more compliant, less aggressive, and less disruptive?

I have no doubt that, for a teacher trying to run a classroom, these qualities equate with “better.” But are submissiveness, passivity, and social inhibition qualities we want to generate in children?

In another study, three covert antisocial behaviors were measured: stealing, destroying property, and cheating. Ritalin was found to reduce the incidence of the first two, but it increased the incidence of cheating. The authors speculate that this is because Ritalin enhances task involvement. (See Hinshaw, SP, Heller, T, and McHale, JP, “Covert Antisocial Behaviour in ADHD,” *Journal of Consulting Clinical Psychology* April 1992 (60/2): 274-81.)

What is the lesson for parents from these findings? When it is reported that a child is much improved on Ritalin, it is best to find out, if you can, exactly what the reporter means when he or she reports “improvement.” It may be simply calming. It may, however, involve changes you or I would not see as improvement.

Later, when I come to discussing my own retraining approach for children, you will see that Ritalin contributes little to promoting the adaptive growth of the child. The drug may calm the child, but it does not help change his or her behavior problems so that they eventually disappear in the way such behaviors normally do when children grow up.

Does Ritalin Have Side Effects?

According to the head of psychiatry at the Vancouver Children’s Hospital, Ritalin is not even as dangerous as aspirin. (See the report in the Vancouver/Lower Mainland area newspaper the *Tri-City News*, 26 August 1990.) Few advocates of the drug take so extreme a position as this. The fact is that Ritalin, like most drugs, has many known side effects. Some of them are rare; some of

them are common; and some of them just are a nuisance. Some of them are serious, and there are some equally serious possibilities that are as yet unclear.

Here is a short table of side effects originally published under the auspices of the US Department of Justice, Drug Enforcement Administration (DEA). The title of the publication is *Methylphenidate (A Background Paper) October 1995*, and it is available through the DEA.

ORGAN SYSTEM SIDE EFFECTS

Cardiovascular system

palpitation, tachycardia, increased blood pressure

Central nervous system

insomnia, psychosis, dizziness, headache irritability, Gilles de la Tourette's disease, tics

Gastrointestinal system

nausea, anorexia, dry mouth

Endometabolic system

weight loss, growth delay

Other systems

leukopenia, allergic sensitivity, anemia, blurred vision

The five most regularly reported effects are: insomnia, decreased appetite, stomachache, headache, and dizziness. When decreased appetite leads to weight loss, discontinuing the drug may be necessary. If the child avoids taking the drug late in the day insomnia can be reduced, but using night time sedatives along with Ritalin is neither a common nor a recommended practice.

Growth suppression has been reported in children receiving Ritalin a year or more, especially if the dose is high. Does growth bounce back when the drug is discontinued? Most findings indicate that it does, but some authors seem to be hedging a bit when they say not to give the drug during the child's time of "normal growth spurt." The fact is, these are the years when Ritalin is most often prescribed.

A less common but serious side effect has been identified by Lipkin, who reports that of 122 kids treated with Ritalin, nine percent developed tics, (repetitive contractions of functional muscle groups as in eye blinks, neck thrusts, or sniffs) and that these tics were "mostly transient." What in this connection does he mean by "mostly"?

One child in his series developed Gilles de la Tourette's syndrome, a chronic condition of multiple shifting body tics and occasional vocal symptoms which can become a very serious handicap, as any member of the National Gilles de la Tourette's Association can confirm. (See Lipkin, PH, Goldstein IJ, Adesman AR, "Tics and Dyskinesias Associated with Stimulant Treatment in Attention-Deficit Hyperactivity Disorder," *Archives of Pediatric and Adolescent Medicine*, 148:859-861, 1994.)

Reports of psychotic reactions are rare but have occurred. Leukopenia, caused by poisoning of the bone marrow, is equally rare. The only deaths from Ritalin that I have seen reported resulted when teen-agers crushed Ritalin pills and injected them intravenously. I have heard they some adolescents have now taken to snorting Ritalin. Who says it is not addictive?

Another issue medical papers rarely include in their discussion of the negative effects of Ritalin is the topic of how the children who take the drug feel about it. Though some doctors say that children don't even notice they are taking the drug, such doctors cannot have interviewed the children.

Children don't like taking Ritalin and they say so. Some hide their pills, other pouch them in their cheeks and spit them out later. School nurses have learned to stand over the children until they are sure the pill has been swallowed. Older children say things such as: "I hate taking Ritalin... When I take Ritalin nothing's fun anymore... When [you're] not on Ritalin you take in more... When not on it, life is greater... My dad [a doctor] says there are no side effects. It says there are, right here on the box... I don't like myself on Ritalin... It's totally not me. I become a false person."

These interview quotes are from the video documentary, *The Merrow Report ADD*, which was produced by South Carolina ETV in Columbia South Carolina. View it if you want some firsthand data.

Is Ritalin Addictive?

Now we come to the unanswered question most everybody is worried about. Does Ritalin set the child up for later substance abuse? Almost all of the literature put out by the various ADHD support groups, and even some physicians who promote Ritalin, say there is no reason to be concerned about later drug abuse. Here is a quote from a letter which expresses one opinion on this subject. In response to a column I had written, Derrick H Smith, a CHADD consultant and child psychiatrist, writes:

"A number of well controlled studies have also shown, contrary to Millar's opinion, that the use of methylphenidate [Ritalin] or other medication has not predisposed teen-agers to addiction and other drug problems." (See "Letters," *Vancouver Province*, 29 March 1996.)

I know of no such studies, and I have been keeping up with this literature. On the other side we have the following data: CIBA says that the long term effects of Ritalin are as yet unknown. The US Department of Justice, DEA Report of 1995, previously cited, has this to say on the subject:

a number of recent studies, drug abuse cases, and trends among adolescents from various sources indicate that methylphenidate use may be a risk factor for drug abuse.

In another part of this report the authors say, “children are abusing methylphenidate and abuse can lead to dependency and addiction.”

In his letter Smith goes on to recommend parents turn to CHADD for more accurate information than I provide about the subject. The DEA report has this to say about CHADD’s information for parents. “Of particular concern is that most of the ADHD literature prepared by CHADD and other groups and available to parents, does not address the abuse potential of methylphenidate.”

I am impressed that Ritalin has become a street drug, and it is often found to have been the entry drug to serious addictions such as to cocaine and heroin. I am of the opinion that giving kids Ritalin to improve their home and school behavior may help to make them more tractable, but at the same time it teaches them to look to drugs for the solution to life’s problems. Further, I believe Ritalin may habituate them and make them dependent.

The question that now arises is this. If ADHD is a nonsense diagnosis, as I say it is, what, then, is wrong with these children? If Ritalin is a “no no,” what is the right way to deal with the difficult behaviors these children exhibit? In the next chapter I shall outline my alternative to diagnosing them ADHD and treating them with stimulant drugs.

Since I have written two books for parents on the subject of child rearing, I will touch on this topic only lightly, and guide readers to these other books for more information. They are *The Omnipotent Child* and *Rearing the Preschool Child*, and information about both books can be found on the Palmer Press website at www.omnipotentchild.com.

Chapter Six

An Adaptive Approach

Many years of clinical practice led me to identify a group of children who had, among other qualities, a striking desire to be the boss in all situations; who felt that they should have not only the same rights as adults; and who believed they are of equal competence despite their young age. While these children were not omnipotent, they seemed to believe they were. I labeled their characteristics “the Omnipotent Child Syndrome.”

Here are the four components of the Omnipotent Child Syndrome:

- retained omnipotence illusion
- infantile egocentricity
- intolerance for normal unpleasure
- poor self esteem.

Let me describe these components briefly.

These children believe themselves omnipotent, and they say so. “You’re not the boss of me, I don’t have to do what you say,” is the theme song they sing every day.

They are as self-centered as the two year old who thinks the sun gets up when he does, follows him around all day, and goes to bed when he does. This makes these children a pain for other kids to play with and hard work for their family to live with.

They have very limited tolerance for life’s unpleasures. Disappointed, they cry. Frustrated, they scream. They cannot wait for satisfactions and cannot persist with tasks, so nothing gets done unless mother or teacher stands over them. Finally, despite their arrogance and braggadocio, self esteem is sorely lacking.

After many years I came to comprehend how they remained so infantile. What they lacked in their rearing was not love; it was effective training. Out of this understanding I devised methods to re-parent them. My book *The Omnipotent Child* describes these troubled children in detail. It explains how they got that way and provides programs of management by parents designed to get them back on the track to normal growth.

About the time I wrote my book, along came ADHD with its implied etiology, to wit that all these qualities in children were caused by some mysterious defect in the child’s capacity to sustain attention. Nobody wants to think they are responsible for their child’s problems and a checklist ADD/ADHD diagnosis says exactly that. ADHD says it’s not your fault, there’s something awry in your child’s brain. As a dissolver of parental guilt, the ADD/ADHD diagnosis has been truly effective. In every other way it has been desperately harmful.

But as I have argued in this book, ADHD is not a proper diagnosis. There are much better explanations for the checklist behaviors, explanations that lead to better parenting, not to drugs. Let me offer a few of those explanations.

An Adaptive Approach to the ADHD Checklist

The adaptive approach is based upon a particular view of humanity that needs to be made clear at the outset. The mature human is a person able to cope with himself or herself and the world. This means that within that human being, instinct, emotion, and reason are functioning in harmony. Such a person does not deny instincts, drives for food, sex, and security, but nor does that person indulge those to excess. This person is in touch with his or her emotions – love, anger, sadness and joy – but is not overwhelmed by them. This person is, in the end, governed by reason but not enchained by it.

The newborn baby is pure instinct. The toddler adds emotion to the mix. By the time the child begins kindergarten reason is making its presence felt. The early portion of this psychological growth is automatic, but increasingly adaptive growth comes to depend upon parental input. This parental input involves two things: loving the child and training the child. Both are essential, but it is the training part which is the main generator of adaptive growth.

The effect of nurturance is primarily upon satisfaction or contentment, while the effect of training is upon developing adaptive skill. A child may be well nurtured but poorly trained, or poorly nurtured and well trained. Or poorly both, or properly both. Each of these combinations generates a different result. Here is a chart I have constructed to illustrate how those inputs generally interact with one another.

PARENTING STYLES AND OUTCOMES

high nurture	low training	sunny – non coper
low nurture	high training	sullen – coper
high nurture	high training	sunny – coper
low nurture	low training	sullen – non coper

Children with behavioral problems generally fall in the first two of these categories. One of these, the sunny non-coper, is a good candidate for adaptive retraining through parental guidance. A child who has been emotionally neglected is a more difficult proposition. The longer the nurturance has been deferred, the more difficult it is to make up the loss.

Children who have been neither nurtured nor trained have found the world an ungiving place, and they are not motivated to learn to cope. The worst of these children are concerned with getting even. From this group come the destructive antisocial types, and also some of those people who seek pleasure in the only way that seems to work for them: substance abuse.

The sullen copers are a special case. They are not, in my experience, as common as they used to be. Harsh, unyielding parenting used to be common, I'm told. It is not common in North America today. Sullen copers cope with life, indeed they sometime achieve reasonable success, but they rarely find happiness. That die has probably been cast.

The sunny coper is, of course, the kind of child most of us are striving to rear. All it takes is parenting that is nurturing and discipline that is effective. Why, then, it is so hard to do? I think it is because rearing children is the most complex task life has to offer, and one way or another most of us parents fall a little short of our goals. But if we get reasonably close, that will just have to be good enough.

With the omnipotent child it is the training that has been ineffective, either because the parent doesn't know how to train, is too drained by complications of her or his own life, or has been given one of those high energy, intense kids whom any mother would have trouble rearing. This brings us to the most sorely neglected subject in child psychiatry. We cannot go on until we have paid some attention to the concept of temperament in humans.

What Is Temperament?

All people have different physical and temperamental qualities. The scientists who study this topic seem to be narrowing down the field to nine basic differences. In my work I have identified five common characteristics which seem most significant in the clinical setting of the child psychiatrist. When I take a history from a mother I am always trying, among other things, to get a picture of her child's temperament. The five main characteristics I see, in different degrees, are:

1. activity level: from high to low
2. intensity: from placid to fierce
3. rhythmicity: from regular to irregular
4. persistence: from butterfly to intent
5. mood: from sunny to moody

To illustrate this idea, let me give you an example of how temperament interacts with training as that has shown up in my practice.

There is a common stage of development that has, over time, acquired the name the "terrible twos." Sometime, usually in the latter part of the second year of life, a hitherto sunny child suddenly becomes cranky and demanding. Mother says yes; the child says no. Mother offers Wheaties; the child wants Cheerios. Battles-of-will start over nothing. Some encounters escalate to temper tantrums. At the same time, the child frequently becomes clingy and, for example, wants mother to stay at bedtime until the child is asleep.

Thus we see a “terrible twos’ triad”:

- battles of will
- temper tantrums
- separation anxiety.

In a series of twenty five children brought to me demonstrating this triad of behaviors in marked form, twenty-three were *temperamentally energetic and intense children*. Of the two children with milder temperamental characteristics, one mother was mentally ill and the other was a self-centered woman who could not find it in herself to train her child.

All children go through the psychological change these children were going through, a stage I call the omnipotence-devaluation phase of adaptive growth. In some children this phase passes almost unnoticed. In the temperamentally energetic and intense child it can hit like a tropical storm out of the Caribbean.

So, the first thing to understand is that some children are temperamentally difficult to steer through the normal phases of adaptive growth, and parents of these children are more likely to get into trouble. There is nothing wrong with the brains of these children.

Now we need to look at the phases of adaptive growth. In the first year, the child is getting his or her automatic equipment running reasonably well. In the second year, the child is first learning to feel his or her emotions and then to harness them. In the third year, the child becomes self aware and starts to bring reason into the equation, a process that continues until adulthood.

It is parental training that brings the child through this growth. Nurturance alone will not do the job. The notion that love is all it takes to grow children up is a pernicious and persistent misunderstanding that has produced a thousand books and misled a million parents. The authors of these books should be thrown into a vat of loving care and be allowed to soften to death.

The child with a behavior problem is stuck in the process of adaptive growth. Reason is having trouble assuming the chair in the board room of the mind. Before I examine the checklist in adaptive terms, let me illustrate my point by contrasting the one of the major adaptive competencies – tolerance for the normal unpleasures of life – with its corresponding adaptive weakness. Examples of “normal unpleasures” for children include getting dressed, going to bed on time, doing their homework, helping with the dishes, and so on.

TOLERANCE FOR NORMAL UNPLEASURE

The competence	The weakness
patience	impulsivity
persistence	distractibility
self control	lack of restraint

Babies have no tolerance for unpleasure, though some – the temperamentally energetic and intense ones – express their unhappiness more vigorously than others. Babies develop tolerance for unpleasure by repeatedly experiencing measured doses of the same, doses that are not so great as to overwhelm nor so minimal as to be invisible.

For example, an infant who has to wait for her bottle or who doesn't get picked up the moment she cries practices a little waiting. The toddler who is denied a cookie until after supper learns that mild hunger is not forever. The two year old goes to his room for four minutes for blowing his stack learns not to escalate his battles-of-will past a certain point. The three-year-old learns to get his pajamas on, or he gets no story. The preschool child gets a chip in her rude jar if she talks back to her sister. On and on the training goes, and step by step the child learns to tolerate greater doses of unpleasure.

Let us take a look at Spitzer's list in these terms. For openers, ask yourself: if a child has difficulty remaining seated, could it be he hasn't been trained to tolerate life's normal unpleasures, like sitting still for a while in the classroom? Is it still reasonable to say there must be something wrong in his brain?

Similarly, if a child is easily distracted by extraneous stimuli, do we need to postulate that there is an attention center in the brain and that something has gone wrong with it? If a child has difficulty waiting his or her turn in games, would it not be more reasonable to look at how well that child has been trained in patience before jumping to the conclusion that his or her frontal lobes are to blame?

How do you train a child to be more patient and persistent? You set up a program to deal with one item of that child's impatient impulsive agenda. One at a time is the best way to go.

Suppose your five year old is always getting down from the dinner table and having to be fetched. She isn't being provocative. Something just catches her eye and away she goes.

"Listen, Anna," you tell her. "You know I expect you to come to the dinner table and stay there until excused. But you are always leaving and having to be fetched back. I am therefore starting a get down from the table program just for you."

"Oh yeah," says Anna. "Dad gets down too."

"Rarely and with good reason."

"I got good reasons."

"Not good enough. Now here's the deal. If I see your bottom getting restless or you start from your seat, I am going to say 'Don't get down Anna, and you better settle right back. If you don't and I have to fetch you back, you are going to get a chip in a "get down from the table" jar.

"Cool," responds Anna.

"When you get three chips in your jar you get a punishment."

"What punishment?"

“No Lego for one day.”

“I’ll play with something else.”

Okay, but it won’t be Lego.”

You follow this program, and at the first meal she will get three chips and a punishment, then she will be two chips toward the next punishment before she sticks in her seat for the rest of the meal. Next dinner time, just like penalties in hockey, she starts period two with two chips already in the jar. After about four days she only gets down once or twice, and after two weeks she lifts his bottom, changes her mind, and bitches about stupid jars.

What has happened here? More than getting Anna to stay at the table. She still gets the impulse to leave but she controls it. Isn’t that what we were trying to do, increase impulse control?

Take a quick look at the rest of the items on the ADHD checklist and see if you don’t see a large component of intolerance for tedium in most of them.

Egocentricity

What about the second cardinal characteristic of the Omnipotent Child Syndrome: retained egocentricity?

The newborn doesn’t know where his body ends and the world begins, so how can his view of things be anything but totally egocentric? The toddler plays hide and seek by standing in the corner and covering her eyes. She assumes that if she can’t see you, you can’t see her. Many four-year-olds believe that when they go to bed, it’s night for the rest of the world. You can’t get much more egocentric than this, can you?

Once the child is on his feet and into his mother’s world, his mother begins to train him out of this egocentricity. By requiring that he sometimes accommodate to her, mother teaches the child he is not the center of the family but a member of it: that he is not the sun, merely one of the planets.

How does a mother teach such a thing as this? By loving him to pieces? No way! She does it by showing him she is a person with rights and on this occasion he better do some of the accommodating if he wants to ride his trike tomorrow.

This kind of input not only dispels egocentricity but also requires the child cope with the unpleasure of not getting to do his thing the moment he wants to. Adaptive development proceeds.

ADHD behavior number ten – often talks excessively – is a good example of egocentric behavior, isn’t it? There, sitting at the table with him, is his mother, mouth open, waiting to get her say, and his sister who has given up on ever getting her say.

The loving thing may be to let this child rattle on, smile, and try to look as if you cared. The training thing to do is set a limit on the oratory. If necessary, parents can use an egg timer to lay out for the child the two-way nature of interpersonal communication. If that doesn’t work, maybe

four minutes, judiciously applied, of conversing with the wall of his room will help. But guard your egg timer! Once the child figures out what's going on, that device is liable to disappear.

Look over the ADHD checklist again and see if you cannot detect bits and pieces of infantile egocentricity floating around a lot of those behaviors.

Retained Infantile Omnipotence

The third area of adaptive incompetence, the retention of the omnipotent illusion, is revealed more as an attitude which affects behavior than as a specific incompetence for interpersonal function. However the characteristic is just as crippling.

Where does this omnipotent attitude come from? It is a normal part of infancy. When the baby hollers and the bottle comes, the baby puts two and two together and concludes yelling is what makes bottles come. In time this generalizes to "things happen because I will them to happen." Mothers go along with until their child is on his or her feet and into things. Then mothers begin to say a few "no's". Toddlers do not take kindly to these "no's" and, if they have an intense and energetic temperament, they fight back. These no/yes exchanges escalate to battles-of-will and temper tantrums. Now the terrible twos are off the launching pad.

It is essential that the terrible twos are worked through, and it is training, not love, which works them through. I describe how this is accomplished, in clinical detail, in my professional paper "An Adaptive Approach to Primary Prevention in Child Psychiatry," (*Perspectives in Biology and Medicine* 38, 2 (Winter 1995) and for parents in *The Omnipotent Child and Rearing the Preschool Child*.

When this phase is not successfully worked through, the child continues to try to impose his will upon those around him. He says things like "You're not the boss of me. I don't have to do what you say" or, "It's my room I'll keep it dirty if I want." He believes he should enjoy all the prerogatives adults enjoy. "Why should I go to bed you're not going to bed?"

The omnipotent child truly thinks he is as competent as any grown up. One nine-year-old child I met in my practice once gave me a list of all the adult things he was capable of doing, including driving a car. "I can steer. I know where the gas is. I know to brake." He ended his long winded declaration by saying "I can do anything adults can do."

He paused. "Except adultery."

I asked him what adultery was.

"You know," he replied. "Filling out income tax forms and all that junk."

Clearly his omnipotence is illusory.

Consider again, if you will, the fourteen behaviors inscribed on the *DSM III* tablets. Mature children may want to indulge themselves in some of these behaviors – after all, they are still children – but they don't indulge themselves. Because they know it is not allowed. "Not allowed by whom?" the literate omnipotent child asks. "The teacher?! She's not the boss of me."

Implicit in all the behaviors on the list is a lack of respect for authority, the respect that normal children hold and which makes them try to come up to what the world expects of them.

What to do about omnipotence? When you set up a program such as stay in your seat, or don't interrupt, the child either obeys or disobeys. When the child obeys, he or she is accepting your right to make rules, which means surrendering the illusion of omnipotence a mite. When the child disobeys he or she gets a punishment. This says, "I'm the mother, you're the child. Get used to it." That reality also does wonders to disillusion omnipotence.

Adaptive growth is all of a piece. Training addressed to one cardinal characteristic affects them all. Of course Ritalin does too. Except when you stop dispensing the Ritalin, you're back at square one.

Self Esteem

Self esteem is not an adaptive competence. It is a result of the development of well developed adaptive competence. Whenever a parent sets a limit or communicates an expectation to her child she is training him. When the child copes with the expectation, he masters a little piece of living in the world. We call this coping. An accumulation of coping becomes mastery. Mastery is accompanied by a good feeling, which accumulates over time. The feeling combines confidence and a feeling of worth. Together these feelings help to build the child's self esteem.

The omnipotent child has poor self esteem because he or she rarely copes. This child's has not learned to cope and so has never constructed a sense of self esteem. The child has not developed this sense either because his or her parents lacked parenting skills or the child was temperamentally hard to rear. Both of these issues can be dealt with and techniques are described in *The Omnipotent Child* and *Rearing the Preschool Child*.

I hope that I have demonstrated my principal intention in writing this book: to show parents that it is necessary to think long and hard before allowing anybody to label their child ADHD and put him or her on Ritalin. All that is left to do is point the way, in the hope that it is not too late to change course, to where we seem to be going with this ADHD nonsense, as I do in Chapter Seven. And maybe to puncture some medical egos with a little satirical humor, as I try to do in Chapter Eight.

Chapter Seven

Post ADHD Angst

I have, I hope, made it clear that ADHD is a mythical diagnosis, invented by doctors who, perhaps, hoped that by so doing, they would restore an embattled profession to respect in the eyes of the general public. They made an expedient choice, not a scientific one. The ironic thing is that, instead of accomplishing their end, these doctors have provided the public with yet another reason to mistrust psychiatry. It was ever thus. The people had figured Freud out long before the Freudians got the message. The analysts just soldiered on until they became more of a laughing stock than some of them deserved to be. And, while they were figuring that all out, many people bought into a lot of useless treatment, and expensive training.

This time the situation is worse because the victims are children, and there are so many more of them. Must we wait until a whole generation of ADHD/Ritalin youth explode upon the social scene before the professionals get the message? Or are they here already?

Already it is recognized that Ritalin is being grossly over-prescribed. Soon people everywhere will begin to question the competence of the doctors who have been responsible for tossing out Ritalin prescriptions like confetti at a wedding. I wouldn't be surprised if deceived parents took to the courts in large numbers. My advice to doctors is this. Take a complete history. Do a proper clinical examination of the children, as persons, not just as small bodies. Never prescribe Ritalin, or, if you must, at least not until a determined attempt to solve the problem through remedial parenting has been tried and has failed. That action you can defend.

This brings us to where the child-rearing buck always stops, on the kitchen table where parents meet to shuffle their daily worries into some kind of scale of urgency. I know that it is comforting to believe your child's behavior problems are not your fault. That's what the ADHD diagnosis sells, isn't it, that it's not the parents' fault? That, and a quick fix treatment that zonks children but doesn't do a thing about their growing up problems.

My advice to parents is this. Forget whose fault it is. Dump the Ritalin into the toilet. Wade into your child rearing responsibilities. Ask yourself, "who does that boy think he is, trying to make the rules and copping out on his responsibilities?" Don't clobber him. Just make sure he treats you, and his brother, and his sister, like human beings, or that he pays the price.

Re-rearing a difficult child is hard, but it is not impossible. There are ways, and they work. Don't blame yourself. Just get in there and pitch. The society you build will be theirs to live in. Help make it better for them, and them better for it.

The last chapter of this little book is optional reading. If you have a cat, or if you just enjoy when people poke a bit of fun people who overstep the bounds of logic, it might be your cup of tea.

Chapter Eight

Attention Deficit Hyperactivity Disorder in Cats*

By Felix M Furball DC, MP, BS
(Contribution by Invitation)

It is a year now since the Canadian Domestic Feline Treatment Association published its ground breaking *Diagnostic and Statistical Manual, First Edition*. However, the category that promises to bring a revolution to cat care has yet to receive the attention it deserves. (See annual report of Mouser Pharmaceuticals Ltd, the leading manufacturer of pharmaceuticals for cats).

Attention Deficit Hyperactive Disorder in Domestic Felines

This condition, whose etiology has been overwhelmingly suggested by the analysis of over 4,000 cat scans by qualified observers, is diagnosed by the following criteria.

Diagnostic Criteria

A disturbance of a least three months during which four of the following are present:

1. Attention frequently wanders when owner is talking to the cat. Loses eye contact.
2. Frequently has difficulty following through on instructions, to wit, getting off the sofa on command.
3. Frequently interrupts or intrudes to wit, sits down in middle of the newspaper while owner is reading it and will not leave until removed. Or walks across or sits upon keyboard while owner is working at the computer.
4. Is easily distracted by extraneous stimuli such as a mouse running across the floor.
5. Can't wait his turn, to wit, often blurts out meows when owner is in the middle of a conversation with others.
6. Has frequent spells of gratuitous hyperactivity i.e., gallops from one end of the hall and back again for no apparent reason.
7. Engages in physically dangerous activities without considering possible consequences, i.e., walking along edge of the roof.
8. Doesn't absorb what is being said, i.e., frequently repeats forbidden activities such as getting on the sofa despite reinforced reminders.

That's all there is to it. It's a diagnosis that anyone with a pencil and a piece of paper can make.

ADHD(C) is a long overdue advance in scientific knowledge. Too long have cat owners been unfairly criticized for their cat-rearing skills. They will be relieved to learn that it is not their fault, that there is something wrong in their cat's brain to account for the difficulties. No longer need owners feel obligated to take one of those cat parenting courses, nor to pay for extensive psychotherapy from the many psychologists specializing in cat problems.

Furthermore, there is a medication that works wonders for ADHD(C). Its brand name is Catalin. It is manufactured by Mouser Pharmaceuticals Ltd and comes in liquid form. All one does is add one drop per kilo to the cat's food. This dose may be doubled or tripled if necessary.

Like all medications, Catalin has occasional side effects, none of which appear to be serious. Indeed it has been said by some that Catalin is no worse than aspirin. However, rare as they be, these side effects need to be mentioned. The occasional cat will develop insomnia. If the cat's nap time diminishes below ten hours a day it might be a good idea to reduce the dosage.

Tics have been observed in a few cases, including rolling of the eyes, intermittent flicking of the ears, spasmodic jerking of the tail, and occasional vocal tics. Gilles de la Bobcat's disease occurs but is very rare.

The clinical concern is to differentiate rabies. There have been two cases where the cat's fur has changed color, settling in time to a not unpleasant lilac shade. It is not yet known if this change will be passed on to the offspring. The cause of this is, at this time, unknown.

The therapeutic effects of Catalin are striking. Many an owner has reported how much easier to live with their cat has become. "I hardly know she's there," one owner of a previously very hyperactive cat reported. "Every day he walks about exploring the house as though it were all new to him. Occasionally he bumps into the furniture or falls down the stairs, but this is a small price to pay for the peace Catalin has brought to our household."

If you have a cat that you think might be suffering for ADHD(C), get out your pad and pencil and go through the checklist. If you come up with four items, your cat has got it. If you find you need help working through the checklist, consult your local public school. Most up-to-date schools have at least one teacher trained to make the diagnosis. Of course she can't give you a prescription, but she can certainly tell you where to go to get one.

Another source of assistance is CADD. CADD stands for Cats with Attention Deficit Disorder. There is probably a branch in your area. If not, you can start one. Funding is available through Mouser Pharmaceuticals. Write for a brochure.

So all you cat owners, there is no need to feel guilty anymore. It's not your fault. It's all in your cat's brain. No longer is there any need to have your day ruined by an uncooperative cat. Use Catalin as directed and your troubles will be over.

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