Deconstructing ADHD: Mental Disorder or Social Construct?

Edited by
Eric Maisel

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Introduction

For those of you familiar with the concerns of those who have their doubts about the ethics, tactics, logic and legitimacy of what we might call the mental health establishment, you may already know all you need to know about psychiatry as a pseudoscience and a pseudo-medical specialty, about the differences between treating actual disorders and the mere collecting of "symptoms" into "symptom pictures" which then get affixed a convenient label, about what might rightly be called medication versus mere chemicals-with-powerful-effects, and so on. But even if you know all this, you may find it convenient to hear from many voices in one place. The Ethics International Press Critical Psychology and Critical Psychiatry series is one such place.

The first two volumes in this series, *Critiquing the Psychiatric Model* and *Humane Alternatives to the Psychiatric Model*, have now appeared. This volume, Deconstructing ADHD, is the third in the series. A fourth volume, on the so-called mental disorders of childhood (with a focus on autism), will appear in 2023. We hope that further volumes will appear and tackle important subjects like psychiatry and the law, the validity of psychological testing, the logic of psychotherapy as a pseudo-medical "expert" activity, etc.

Trying to explain why the concerns explored in these volumes should be located in the territory of "ethics" would take us down paths we do not need to travel, into the definitional morasses of how to get from "what is" to "what ought to be," whose values are being promoted, and, most basically, what do we mean by "ethical"? Let me just present a few basic points as to why the concerns presented in these volumes are ethical in nature:

- If you claim that you are doing medicine, as psychiatrists do (and, by extension, every other mental health practitioner who

"diagnoses and treats"), or suggest that you are doing medicine without actually making that claim, and you aren't doing medicine, that amounts to an ethical matter, wouldn't you say?

- If, as an answer to a question on a psychological test, I tell you that I prefer something, say that I like solitude, and then you repeat back to me that I prefer that something, just changing the wording and claiming, say, that I am an introvert, that is a linguistic transaction of a certain sort and not a test. What is being "tested" in that transaction? To the extent to which psychological tests are not genuine tests, or really nothing like tests at all, that is an ethical matter, wouldn't you say?

- If you claim that certain chemicals are "treating" a "disorder" but in fact they are just chemicals with powerful effects, with some of those effects perhaps sometimes desirable and many of those effects regularly undesirable, that is an ethical matter, wouldn't you say? It is not just a linguistic matter or a language game to call a chemical a "medication" when it isn't—it is also an ethical issue, yes?

- If I claim that I am "practicing psychotherapy" and that at the core of that activity is the "diagnosing and treating of mental disorders," and the whole construct is fishy, that is an ethical matter, wouldn't you say? If you are putting your psychological and emotional life in my hands, it would be nice if I knew something about the psychological and emotional life of human beings and had more in my arsenal than a symptom checklist, an ability to listen, and some rote questions, yes? To put the matter another way, if someone calls himself or herself an expert at something and isn't, that is an ethical matter, yes?

Society giving some certain people the right to electroshock you is an ethical matter. Society giving some certain people the right

to incarcerate you for your unusual but not illegal behaviors is an ethical matter. Society giving some certain people the right to label you with some psychiatric label because of your political views, as part of society's tactics of oppression, because you are a child and can't defend yourself from labeling (and the chemicals that will follow), and for other social and political motives, are ethical matters. So is society denying the relationship between poverty and "poor mental health," denying the relationship between oppression and "poor mental health," denying that circumstances matter when it comes to your mental health, and in countless other ways denying that the realities of your life matter to your emotional wellbeing.

There is much that is wrong with this picture and there is much that ought to change. "Ought" is a value word located squarely in the domain of ethics. If you agree that there is a lot that ought to change with respect to our mental health paradigms and practices, then you are agreeing that we are properly in the domain of ethics. We hope that the volumes in this series prove both provocative and helpful. We welcome feedback, we hope that you will perhaps promote these books in your networks, and we look forward to hearing from you if you think that you might like to contribute to a future volume, if you might perhaps like to take on the role of editor for a future volume, or if you might like to propose a future volume.

We are happy to train a lens on any aspect of psychology and psychiatry that deserves some scrutiny. Come join us in this worthy enterprise.

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ADHD, ODD, Pediatric Bipolar, Oh My!

Eric Maisel

In this volume, I've invited contributors to explore, critique, and deconstruct the so-called "mental disorder" known as ADHD. I think that this is a wonderful, valuable collection of chapters and I want to thank the book's contributors. Anyone who reads these chapters will come away with a new appreciation of the gravity of the dangers associated with the wanton labeling of children with the AHDH label. They will likewise be alerted to the dangers of placing these little patients, often as young as of pre-school age, on powerful chemicals with dubious positive effects and life-altering negative effects.

In this opening chapter, I want to set the stage a little and give you a taste of this territory, the territory of the "mental disorders of childhood." This contemporary, dominant "mental disorders of childhood" paradigm is promulgated by the psychiatric profession (and, in turn, most helping professionals) and supported by mega-institutions like Big Pharma, academia, and mass media. What does this territory look like? Let's begin by picturing a child—an actual child, an actual person being his or her human self.

A child is already and really somebody. Children think, imagine, feel, dream, remember, hope, and hurt. They have that thing that we rarely talk about any more, a "personality," that unified, individual and recognizable amalgam of their original personality

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and their formed and forming personality. To conceptualize their anger, upsets, sadness, or high energy as "symptoms" of something, as opposed to natural differences or consequential reactions to life experiences, is both to do them a dramatic disservice and to do something fundamentally illegitimate. But that is what currently occurs without a second thought. Especially in America, but increasingly worldwide, the first line of approach to dealing with a child's thoughts, feelings, behaviors, and his or her very personality is to pull out a "symptom" checklist and begin to "diagnose." This is where the train runs right off the tracks.

Little Jane is likely not sad or anxious because she has "contracted" a so-called mental disorder. Rather, she is likely sad or anxious for *reasons*, reasons that might include that her parents are harming her, that she was born easier to startle than the next child, that she just failed an exam that she expected to pass, or that performing in public terrifies her. To leap from here to there—from seeing a sad or angry child to labeling her with a so-called mental disorder like pediatric bipolar disorder or oppositional defiant disorder is both mistaken and unfair.

How exactly should we conceptualize the journey that an infant takes from birth to suicidal thoughts at fourteen or anorexia at sixteen or drug addiction at eighteen or college failure at twenty? Is it the best way—or even useful—to say, as is so often said nowadays, that it is a "biopsychosocial" process? Where is the person in that way of conceptualizing things? Is it the best way—or useful or legitimate—to say, as is so often said today, that a child with these difficulties "has a mental disorder" requiring medication? Or are there better, truer ways to conceptualize growing up as human? Is our goal to silence children's complaints and engineer their behaviors so that they fall into line with certain norms and agendas? Or is it, one hopes, to facilitate their healthiest, happiest individual life journeys?

First of all, we are faced with the current ubiquitous procedure of instantly "diagnosing" based on so-called "symptom pictures," as if a disease is the culprit causing the child's problems. This is at the heart of the current psychiatric paradigm and where the dominant system's failure begins. Let's start there.

Squirming and anger are symptoms of what?

In real medicine, you use symptoms to help you discern a cause, which then helps you pick a treatment. You take fever, fatigue, swelling, and so on as indicators of, say, a particular virus, and then you attempt to deal with the virus. If you can't discern the cause or if you can't decide between two or more causes, you run more tests and, while you are trying to identify the cause, you indeed do things that you know or suspect are likely to help relieve the symptoms.

In the meantime, as you seriously look for the cause, you work to reduce the pain or bring down the fever. You are reducing the pain and bringing down the fever while you continue to investigate what is actually causing the fever and the pain. You do not focus all of your efforts on reducing the pain or on bringing down the fever and you don't just guess what the cause is, based solely on the symptoms. Rather, you continue your investigations. You are trying to figure out what is going on. In real medicine, *your job isn't merely to treat symptoms*.

One of our neighbors recently suffered from terrible stomach pains. For a long time, on the order of two months, no conclusive diagnosis could be reached among the four contenders vying as the cause of her affliction. Finally, it was conclusively determined that it was cancer located in a certain stomach valve. Treatment began immediately. All along, she was being given relief for her symptoms—relief for the pain, help with her inability to keep food down—while the cause

was being determined. Treatment for the actual affliction could only commence *once it was identified*. That is how real medicine works.

In the pseudo-medical specialty of "children's mental health," something very different goes on. There you take the report of a child's behavior—for example, that little Johnny pulled on the braids of the girl sitting in front of him—and for no reason that you can possibly justify, you call that a "symptom of a mental disorder." You collect several of these "symptoms of mental disorders"—often three, four or five are enough—and then you attach a "mental disorder" label to that "symptom picture." The label might sound like "oppositional defiant disorder," for instance, or "attention deficit hyperactivity disorder."

Once that label is provided, chemicals typically follow. Little and often no interest is shown in what is causing the behavior. Little and often no interest is shown in whether the behavior reflects something biological going on, something psychological going on, or something situational going on. Little and often no interest is shown in whether what is going on is congruent with this child's personality—rather like who she has always been—or is new, different, and incongruent. This suspiciously easy route of labeling-followed-by-chemicals is not medicine, no matter how many white coats are in evidence. It is behavioral engineering.

A child who loses his temper, argues with his parents, defies his parents' rules, and is spiteful and resentful is given, based on these four "symptoms," the pseudo-medical sounding label of "oppositional defiant disorder" and is put on chemicals to make him more obedient. This is not medicine. This is behavior control instituted to make the lives of adults easier. Why not start by asking little Johnny why he is angry and resentful? Why not step back to see if perhaps his family is in chaos? Why not look at his life and

not just his "symptoms"? Why presume that a child arguing with his parents is arguing because of some impossible-to-find medical condition? Isn't it more likely—by a longshot—that he is angry with them or angry with something? Isn't is sensible to suppose that he is acting out angrily because he is angry about some very real and meaningful problem in his life?

We don't know why little Johnny is acting the way that he is acting. But we do not believe that it is cause-less, and we do not really believe that it is the result of a medical condition. Certainly, we ought to test for genuine organic problems like brain damage or neurological damage that might cause explosive rage. But in the absence of such biological challenges, we are obliged to presume that little Johnny has everyday human reasons for his anger. Once you rule out brain damage and other possible biological causes of rage, your next step ought not to be to posit a made-up, invisible medical condition. Rather, it is to treat little Johnny like a human being with everyday human reasons for his anger and resentment.

One fact alone should prove the absurdity of considering these behaviors a pseudo-medical "mental disorder." Imagine for a second that I said to you that my not being able to see any symptoms of your cancer was proof that you had cancer. Wouldn't that statement astonish you and confound you? Or imagine that I said to you that my not being able to see a break in your bone on an x-ray was proof that you had a broken bone? Wouldn't you find that a pretty odd assertion? What is fascinating is that mental health service providers are often warned that they may not get to witness any of a child's "oppositional" behaviors because a child with this "disorder" is likely not to demonstrate any defiance except exclusively with his parents and teachers!

Unlike in real medicine, where the sore is visible both at home and in the examining room, with the behaviors associated with "oppositional

defiant disorder" those behaviors are likely only observable when little Johnny is *actually angry*, namely at school and at home. It is absurd but true that an indicator that you have the mental disorder of "oppositional defiant disorder" is that you do not display any signs of it when you are talking to someone you don't happen to hate. Seriously, shouldn't the fact that little Johnny is only angry around his parents suggest that little Johnny is angry with his parents?

Picture the odd thing a provider is doing here. He does not personally see any signs of little Johnny's oppositional defiant disorder. He takes not seeing them as further proof that little Johnny has an oppositional defiant disorder. He relies on reports of things that he has not observed for himself, things that are of course more logically signs of rebellion, protest, and anger than "symptoms of a mental disorder," and from those reports he "diagnoses" a pseudo-medical condition called a "mental disorder" and moves on to dispensing chemicals that act as a straitjacket in an attempt to control his behavior. He has not seen the "disorder," he has no tests for the "disorder," and he is basing his "diagnosis" in part on the fact that he has seen nothing of the "disorder"!

This is akin to the absurd claim made that proof of the presence of an attention deficit disorder is the fact that you do not display it when something interests you. Might it not be the case that you like to pay attention to things that interest you, like sports and videos games, and don't like to pay attention to things that don't interest you, like math class and your parents' dinner conversation? It is only through the looking glass that my interest in the things that interest me and that my failure to rage at someone who hasn't angered me are signs of some pseudo-medical "mental disorder."

There are many things we wish for little Johnny. We wish that he were having an easier time of it. We wish that he could stop his

raging, for his own sake, since he is making everyone around him dislike him. We wish we knew what was causing his difficulties so that we could offer him help at the same level as his difficulties. If he is raging because school is too difficult for him, we might offer one sort of help, say, a tutor. If he is raging because his parents are abusive alcoholics, we might offer another sort of help, in the form of a call to child protective services. If he is raging because he can't abide his parents' strict rules, we might offer another sort of help, like, for instance, a whole-family intervention. We absolutely wish that little Johnny were having an easier time of it and we would love to help him—but not by burdening him with an illegitimate label that potentially has negative effects on his identity and by prescribing him powerful chemicals.

If a child has a medical condition, treat the medical condition. If a child is angry with his parents, do not call that a medical condition. Labeling an angry child with the pseudo-medical sounding "mental disorder" label of "oppositional defiant disorder" may serve adult needs for peace and order. But it is not medicine and it is not right. Little Johnny is making it very difficult on the adults around him, who will naturally return the favor and make it very difficult on him, perpetuating a cycle of anger. But that he is making life hard for them is not the same thing as him being mentally ill.

We must stop saying that this little Johnny is suffering from a mental disorder or that he has a medical or pseudo-medical condition. It makes no sense on the face of it to believe that an angry child is angry because he has a disease. It makes much more sense to believe that he is angry because he is angry, just as you are angry when you are angry. Maybe little Johnny is a lot angrier than you are—but that he is angrier than you are doesn't turn his anger into a disease. It also doesn't make it a disease just because his anger is problematic. As a society, we may not be equipped to deal with all of our sad, anxious,

or angry children—but the answer to that shortcoming must not be to call them all diseased.

And what about pediatric bipolar disorder?

What is it that psychiatry is really trying to say when it announces that a young child has pediatric or juvenile bipolar disorder? Have you ever been around a two-year-old or a three-year-old? Don't they sometimes rush from activity to activity? Don't they sometimes melt down and have ferocious tantrums? Don't they sometimes "suffer from excesses of energy"? Can't they sometimes become inconsolably sad? Aren't they sometimes willful and defiant? Yet all of these states and behaviors, as completely normal and ordinary as they are, are now deemed "symptoms of the mental disorder of juvenile bipolar disorder." Does this make any sense?

Stuart Kaplan, author of *Your Child Does Not Have Bipolar Disorder*, explained in Newsweek:

> I have been a child psychiatrist for nearly five decades and have seen diagnostic fads come and go. But I have never witnessed anything like the tidal wave of unwarranted enthusiasm for the diagnosis of bipolar disorder in children that now engulfs the public and the profession. Before 1995, bipolar disorder, once known as manic-depressive illness, was rarely diagnosed in children. Today, nearly one third of all children and adolescents discharged from child psychiatric hospitals are diagnosed with the disorder and medicated accordingly.
>
> I believe that there is no scientific evidence to support the belief that bipolar disorder surfaces in childhood. In fact, the opposite seems to be the case. The evidence against the existence of pediatric bipolar disorder is so strong that it's

> difficult to imagine how it has gained the endorsement of anyone in the scientific community. And the effect of this trendy thinking can have devastating consequences. Such children are regularly prescribed medications that are not effective in kids and have unwelcome side effects .

To call certain childhood behaviors "manic" is to do a particular disservice to bright, sensitive, creative kids. Such kids may be restless because they're bored and under-engaged or because they have a roving curiosity that makes them play with this toy for a minute, read that book for another half-minute, and rush around from activity to activity "as if" manic or hyperactive. If a child is bright, sensitive, and creative, he or she is at a much higher risk of one day receiving a juvenile bipolar disorder diagnosis.

I've worked with creative and performing artists as a therapist and a creativity coach for more than thirty years and their concerns interest me a lot. One of those concerns is this thing commonly called "mania." People who are creative and who think a lot are more prone to so-called mania than people who do not think a lot and who aren't creative. This fact, which is indeed a fact, should alert us to the possibility that mania is not some pseudo-medical condition or some brain abnormality but rather a function of the mental pressures put on individuals who use their brains and who rely on their brains.

That intelligent, creative and thoughtful people are the ones more regularly afflicted by the thing called mania is beyond question. Research shows, for example, a clear linkage between achieving top grades and "bipolar disorder" diagnoses, between scoring high on tests and "bipolar disorder" diagnoses, and between other, similar measures of mental accomplishment and a subsequent mental disorder diagnosis. For instance, one study involving 700,000 adults and reported in the *British Journal of Psychiatry* indicated that former

straight-A students were four times more likely to be "bipolar" (or "manic-depressive") than those who had achieved lower grades . Are these folks "more ill" than their C-average counterparts or are they perhaps putting their brains under considerably more pressure?

In another study, individuals who scored the highest on tests for "mathematical reasoning" were at a 12-times greater risk for "contracting bipolar disorder ." Similar studies underline the linkage between creativity and mania and we have thousands of years of anecdotal evidence to support the contention that smart and creative people often get manic (think of Virginia Woolf). Doesn't all this evidence suggest that enlisting your brain—say, to write a novel or to solve a riddle in theoretical physics—is a rather dangerous act, since it increases the pressure on a brain already pressured to deal with everyday matters like financial difficulties, psychological threats, or just finding your car keys?

"Manic-depression" and "bipolar disorder" are in quotation marks in the previous paragraphs because the current naming system used to describe "mental disorders" is weak and highly suspect. It leads to many odd, wrong-headed hypotheses, for example that "because you are bipolar you are creative" or that "perhaps mania accounts for the higher test scores." What is likely truer is that the greater a person's brain capacity and the greater a person's reliance on thinking, the greater his or her susceptibility to a racing brain. If you rev up your brain so as to think long and hard, why wouldn't your brain be inclined to then race—and maybe race out of control?

All of the characteristic "symptoms of mania" that we see in adults, including (apparently) high spirits, heightened sexual appetite, high arousal levels, high energy levels, sweating, pacing, sleeplessness and, at its severest, hallucinations, delusions of grandeur, paranoia, aggressiveness and wild, self-defeating plans, make perfect sense

when viewed from the perspective that some powerful pressure, likely existential in nature, has supercharged a brain already feverishly racing along. When that particular pressurized racing begins, the "symptoms of mania" naturally follow.

And don't children already have racing brains, a feverish fantasy life, imaginary playmates, wild schemes, and all too often trauma-induced "mind pressures"? Doesn't it make sense to conceptualize "mania" in children, when it really is something different from normal childhood curiosity and distractibility, as related to the way that the mind can be pressured, in children as well as adults, to race too wildly? If it is ever fair to call a child "manic," isn't this the direction in which we should look?

Instead, in cultures dominated by the psychiatric model, the illegitimate "diagnosing" shortcut is taken and a label is affixed.

Just consider the extent to which diagnosing children with juvenile or pediatric bipolar disorder is largely an American phenomenon. Do we have more "bipolar children" in the United States? Or are we simply labeling more of our children? Peter Parry, Stephen Allison, and Tarun Bastiampillai explained in *Lancet*, in an article entitled "Reification of the paediatric bipolar hypothesis in the USA":

So why did the paediatric bipolar disorder diagnostic epidemic occur and remain mostly confined to the USA? Among more than a thousand, mostly American, articles about paediatric bipolar disorder, a few US psychiatrists and paediatricians have been vocal critics. They noted that diagnostic criteria for paediatric bipolar disorder deviate from strict DSM criteria, symptom-checklist approaches to diagnosis did not account for developmental and contextual factors, trauma and detachment disruption were overlooked, the pharmaceutical industry collaborated with key opinion leaders and researchers of paediatric

bipolar disorder, and that the US health system often mandates more serious diagnoses in order to provide reimbursement, which fosters diagnostic upcoding …

A systematic literature review of articles about paediatric bipolar disorder published from 1995 to 2010 noted almost no mention of the terms 'attachment,' 'neglect,' or 'maltreatment,' and very few mentions of the terms 'trauma,' 'PTSD,' 'physical abuse,' or 'sexual abuse,' and few mentions of the terms 'verbal abuse' or 'emotional abuse' in paediatric bipolar disorder research cohorts. In an era of dominant pharmaceutical industry funding and marketing, the presumption of biomedical causes for DSM disorders filled the aetiological space .

If the "mania" part of "juvenile bipolar" is a problematic construct, so also is the "depression" part. Might not any of the following cause the thing commonly called "depression"?

- A child gets a string of bad grades and begins to feel hopeless about his chances at school.

- A child is being bullied by a sibling, learns over time that he can't come to his parents with his complaints or his pain, and feels helpless in his own home.

- A child grows up scrutinized at every turn by a stay-at-home parent who expects nothing less than perfection.

- A child is forced to live in a chaotic environment filled with marital discord, broken promises, and a lack of privacy.

- A child begins to see life as unfair and a cheat and sours on life itself.

- A child receives no permission to do any of the things that he or she actually enjoys doing and lives a life of rules and chores.

- A child has his or her efforts criticized and ridiculed in cruel and shaming ways.

- Etc.

There are countless possible non-medical, non-biological reasons for a child's despair. But despite this obvious truth, these reasons are rarely on a psychiatrist's radar. And they ought to be. It really isn't very honest to use "depression" as a pseudo-medical collection word to collect all sorts of states and behaviors, like boredom, recklessness, irritability, alcohol abuse, anger, etc. To say that a child is "depressed" when he is actually and obviously irritable and angry is to make a linguistic leap that is exactly as illegitimate as saying that you are "depressed" when you are in fact irritable and angry.

Like the other "mental disorders of childhood," the construct of juvenile bipolar disorder is extremely shaky and suspicious. A much better case could be made for severe ups and downs being caused not by faulty wiring nor by any biological malfunctioning but rather by the way plummeting naturally follows a brain's failed attempt to find good answers to life's challenges. A brain races off in search of answers—this is the "mania" part. The answers prove insufficient—despair follows. Whether this is what is actually going on or not, it has a logic to it that the construct of "bipolar" does not.

The penalty for squirming

Then, of course, there is ADHD, the subject of this volume.

The most common "mental disorder" to anoint a child with nowadays is "attention deficit hyperactivity disorder." This is the "diagnosis" you get if you squirm. This so-called diagnosis comes in different flavors—you can be "predominantly impulsive," "predominantly

inattentive," and so on. What most typically follows one of these diagnoses is "treatment" in the form of powerful stimulant chemicals, very similar in molecular structure to cocaine, with serious side effects and negative livelong consequences, including the risk of addiction.

Imagine a little Bobby who squirms at school, squirms at church, squirms at home, squirms in his good clothes, squirms when given chores, squirms when he's told to sit down and chat with his aunt Rose, squirms … a lot. But what if you lived on a huge farm, it was always perpetual summer with no mandatory schooling requirements, and you didn't need to see little Bobby from morning until night? What would little Bobby be then? Would he still have the mental disorder of "ADHD"? Or would he just be happy?

Wouldn't little Bobby zip in and out, make himself a sandwich, put a band-aide on his skinned knee, take a shower once a week or once a month, change his clothes after he fell in the pond, complain once a day about being bored, and be completely a boy? No one would be having any problems, neither little Bobby nor his parents. Where did the "ADHD" go? Where did the "mental disorder" go? Well, try sitting him down at the dinner table or in a pew at church and then it would miraculously reappear. Imagine a disease only appearing at the dinner table, at school, or in church! What sort of disease is that?

The "problem" would of course return the second you tried to impose unnatural constraints on little Bobby's energy. Try to have him sit still during a sermon in church—now you have a problem. Try to have him sit still at an authoritarian, rule-burdened dinner table—"eat your peas first, sit up straight, stop fidgeting"—and you have a problem. Try to have him not climb on something that looks promising to climb. Then you would have a problem. Have you ever seen a child NOT climb on things that were there to be climbed on? Asserting your

stubborn desire to climb on everything you encounter may well get you into hot water but it should not get you a mental disorder label.

We shouldn't label children with non-existent "mental disorders." This is oppressive. Oppression of this sort goes on all the time. The psychologist David Walker, a consultant to the Fourteen Tribes & Bands of the Yakama Indian Nation since 2000, explained to me in an interview I conducted with him:

Attention Deficit Hyperactivity Disorder (ADHD) is the new way to label American Indian children as 'feeble-minded.' Tuning out and misbehaving in relation to the stultifying, manualized, test-anxiety ridden public education system is entirely understandable, and that's where ADHD kids are often first 'detected.' If one looks at the social amnesia of today's mental health system, you'll soon discover that current ideas and concepts have many historical echoes. There's little attention given to the fact that newer ideas in Western mental health are often merely updated language.

For example, during the height of the American Indian boarding school era in the 1930s and 1940s, the term 'feeble-minded' was used to describe children considered 'morally defective' as a result of being too active or impulsive, nonconformist, inattentive, or rebellious. In this way, such children were maligned and segregated from whatever limited opportunities were available to others considered to be their superiors.

When we look at today's public education system in the U.S., which has continued to fail Native children, we find the current epidemic ADHD diagnosis began in Indian Country in the late 1990s. It is only in the last ten years that the high rate of U.S. ADHD diagnosis in other children has even begun to catch up. The fact that Native children remain more than twice as likely to end up in special education classrooms than children from other ethnic backgrounds speaks

to the continuity of historical segregation and their stigmatizing as uneducable by the U.S. mental health system. ADHD, therefore, continues a process that 'feeble-mindedness' began .

Family therapist Marilyn Wedge, author of *A Disease Called Childhood: Why ADHD Became an American Epidemic*, explained to me:

As a child therapist since 1987, I have seen an alarming increase in children being diagnosed with mental disorders and prescribed psychiatric drugs. For more than 25 years, I have helped children by using safe and effective family and school interventions. I have successfully treated all kinds of childhood problems--attention and focusing issues, school misbehavior, distractibility, anxiety, oppositional behavior and sadness--without ever referring them for psychiatric medication.

In 1987, when I started my practice, less than 3 percent of American children were diagnosed with what was then called ADD. By 2016, the number increased by 300 percent. Today, 12 percent of our children are diagnosed with what is now called ADHD. When I researched ADHD in other advanced countries, I found that the rates of diagnosis have remained relatively low. In France and Finland, for example, the number is 1 percent or less. If ADHD were a true biological disorder of the brain, why is the rate of diagnosis so much higher in America than it is abroad? Or is it a matter of perception—of how children and childhood are viewed in various cultures ?

Should a child learn to be orderly in school? Yes, for the sake of civil society. But that is a very different matter from whether a child should receive a mental disorder diagnosis for not being orderly in school. There the answer is no. The issue of "being orderly in school" is not a medical one. That little Bobby is squirming is not a reason to label him with a "mental disorder" label, place him on the equivalent of street drugs, and set him up for a lifetime battle with addiction.

It is easy to get lost in the weeds and argue the pros and cons of each "mental disorder of childhood" diagnosis and each chemical "treatment." Is this so-called diagnosis more legitimate than that one? Is this so-called treatment more effective or less harmful than that one? These micro-analyses have their place. But we want to make sure not to miss the forest for the weeds. The fundamental question is, "Is the current model at all legitimate?" Is it right or fair to say that an angry child, a sad child, a boisterous child, or a frightened child is, just by virtue of being angry, sad, boisterous, or frightened, mentally disordered? That is the claim that psychiatry and its collaborators are making. I hope that sounds suspicious on the face of it.

The Emperor's New Clothes: Where ADHD Gets a Real Dressing Down

Thomas Armstrong

Most people are familiar with the fairy tale classic ''The Emperor's New Clothes,'' by Hans Christian Andersen.[1] It tells the story of an entire kingdom being duped by a couple of charlatans who convince the people that the clothes they are making for the king are the most beautiful ever made, when in fact there is nothing at all in their looms.

According to these two hoaxers, anyone who failed to see and appreciate what wonderful clothes they'd made were either stupid or unfit for their position in the kingdom. Naturally, people were afraid to admit that they saw nothing at all, including the king, because they didn't want to be considered idiots or lose their position in the kingdom.

So, the king put on the set of invisible ''clothes'' they had prepared for him, and walked (stark naked) in a royal procession before his adoring subjects. Everyone thought the ''clothes'' were the most magnificent they'd ever seen, except for one lone child, who said: ''But he doesn't have anything on!'' Nevertheless, the king and his subjects became more determined than ever to continue with this absurd charade.

I sometimes feel like this child when I confront the ADHD worldview. I look around and see how virtually everyone, including

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[1] Hans Christian Andersen, *Andersen's Fairy Tales*, New York: New American Library, 1966, pp. 65-71.

physicians, scientists, politicians, teachers, parents, psychologists, entrepreneurs, and others, agrees that ADHD is a real psychiatric disorder. I've just never been able to see the ''clothes'' adorning the ADHD belief system. This doubt goes as far back as 1972 for me, when I wrote my first college paper on ''hyperkinetic'' children, which is what people were calling it back then. Since that time, I've seen the idea of ADHD gather force until now it has become the most common mental disorder for children, and the intervention used most often to treat it—psychoactive medications—is expected to fuel a $24.9 billion industry by 2025.[2] In my book *The Myth of the ADHD Child*, I compare ADHD to the science fiction entity known as ''the Blob'' which flows over people, houses, and communities and gets bigger and more destructive as it gathers force.[3]

The reason for this huge disparity between a point of view embraced by most authorities in the mental health field, and my own views on the subject, has to do I believe with the distinction that the Russian-British philosopher Isaiah Berlin made between the hedgehog and the fox. Quoting the ancient Greek poet Archilochus--''The fox knows many things, but the hedgehog knows one big thing''-- Berlin noted a tendency in intellectual traditions to entertain either a pluralist or a monist perspective.[4]

Let's be clear: I am looking at the *same* objective phenomena as all the ADHD advocates: hyperactivity, impulsivity, distractibility and their subordinate and associated behaviors. I have to say this because when people read my work on the subject, some of them seem to

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[2] Grand View Research, Press Release, ''ADHD Market Size Worth $24.9 Billion By 2025,'' retrieved from https://www.grandviewresearch.com/press-release/global-attention-deficit-hyperactivity-disorder-adhd-market.

[3] Thomas Armstrong, *The Myth of the ADHD Child: 101 Ways to Improve Your Child's Behavior and Attention Span without Drugs, Labels, or Coercion*, New York: Tarcher/Perigee, 2017, p. 3

[4] Isaiah Berlin, *The Hedgehog and the Fox*, Chicago: Elephant Paperbacks, 1993.

think that I believe these symptoms don't exist. What are you, crazy? I'd have to be an alien on a strange planet to hold such a belief. I worked with these kids for several years in special education classes, so I have no illusions about the symptoms. The key difference in our perspectives is that ADHD promoters see these symptoms as due to this ''one big thing,'' which is essentially ADHD as a fixed entity, while I apply many different perspectives to account for these same behaviors. In the rest of this chapter, I'd like to go through several of these points of view.

Developmental perspective: We don't let kids be kids anymore

Every baby displays most of the symptoms of ADHD. Over time, however, the nervous system matures, and we develop the ability to focus for longer and longer periods of time, to restrain our impulses, and gain control over our motoric movements. But kids do this at different rates, and it turns out that kids diagnosed with ADHD mature later than typically developing kids. In fact, research suggests that the brains of ADHD-labeled youngsters develop two to three years *later* than so-called normal kids.[5]

I saw this all the time in my work as a special educator: these kids acted like much younger children. Is that such bad thing? In the opinion of many people these days, yes, it is a bad thing, because we're now expecting kindergartners to do things that first and second graders used to do. In one study, in 1998, thirty-one percent

[5] See, for example, P. Shaw, K. Eckstrand, W. Sharp, J.L. Rapoport, et al. Attention-deficit/hyperactivity disorder is characterized by a delay in cortical maturation, PNAS, December 4, 2007, 104(49), pp. 19649-19654; and Seunggyun Ha, Hyekyoung Lee, Yoori Choi, Hyejin Kang, et al., Maturational delay and asymmetric information flow of brain connectivity in SHR model of ADHD revealed by topological analysis of metabolic networks, *Scientific Reports*, 2020, 10, Article number: 3197.

of teachers believed children in kindergarten should learn to read; by 2010 this figure had skyrocketed to eighty percent.[6]

So, here you have children being pushed to do tasks that are developmentally inappropriate for *all* kids, and on top of that, you have those kids who have developmental delay have an even a harder time catching up, which creates stress-related symptoms of ADHD in addition to their natural playfulness being regarded as part of their diagnosis.

A study published in the *New England Journal of Medicine* revealed that rates of diagnosis and treatment of ADHD are higher among children born in August than among children born in September, in states with a September 1 cutoff for kindergarten entry.[7] So the youngest children in any kindergarten class are at risk for being labeled with ADHD purely on the basis of their age. In this situation, it makes no sense to postulate an ADHD entity being responsible for the child's symptoms. Instead, we need to use a developmental paradigm (kids grow up at different rates) to make sense of these symptoms.

Media studies perspective: Mass media is rewiring our kids' brains

There's no question that the culture has speeded up in the past fifty years, due in large part to the radical changes that have occurred in media over that same time period, including advances in television,

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[6] Daphna Bassok, Scott Latham, and Anna Rorem, ''Is Kindergarten the New First Grade?'' AERA Open [a publication of the American Educational Research Association], January 2016, retrieved from http://ero.sagepub.com/content/2/1/2332858415616358.

[7] Timothy J. Layton, Michael L. Barnett, Tanner R. Hicks, and Anupam B. Jena, Attention Deficit–Hyperactivity Disorder and Month of School Enrollment, *New England Journal of Medicine*, November 29, 2018, 379, pp. 2122-2130.

movies, computer technology, video games, the Internet, chat rooms and social networks, streaming entertainment, and more. The result has been a shortened attention span for all of us (one study conducted by Microsoft determined that the average attention span had declined from 12 seconds in 2000 to 8 seconds in 2015, which is shorter than the attention span of a goldfish!).[8]

Is it any wonder that we have a malady called ''attention deficit disorder,'' emerging during this explosion in the growth of mass media? We're learning more and more about the impact of media on the brain, and there's a growing concern that among the many changes that media exposure makes to the brain, interference with proper dopamine transmission is a major issue.

We have three primary dopamine pathways in our brain that are sensitive to rewards from the outside world. When a reward is delivered (e.g. a ''hit'' in a video game, a ''like'' on Facebook, a ''ding'' from a smart phone, a ''jolt'' from a violent TV program or movie), these dopamine pathways are activated and become ''wired'' as the stimulation persists.[9] However, over time these pathways become habituated to the old stimuli (''been there, done that!'') and ever higher levels of stimulation are required to achieve the same effect.

Advertisers and media game designers exploit these vital neuro-pathways, and try to make their latest products even more arousing. Over time, this can result in dopamine exhaustion and a situation where the individual who feels a craving for rewards seeks higher

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[8] Kevin McSpadden, You Now Have a Shorter Attention Span Than a Goldfish, *Time Magazine*, May 13, 2015, retrieved from https://time.com/3858309/attention-spans-goldfish/.

[9] See, for example, Trevor Haynes, Dopamine, Smartphones & You: A Battle for Your Time, *Science in the News*, Harvard University, May 1, 2018, retrieved from https://sitn.hms.harvard.edu/flash/2018/dopamine-smartphones-battle-time/.

and higher levels of stimulation.[10] This is where ADHD comes in: those stimulus-seeking behaviors are indistinguishable from the holy trinity of ADHD symptoms: hyperactivity, impulsivity, and distractibility. Several recent studies have confirmed the link between media use and ADHD behaviors.[11] Fifty years ago, Canadian professor and media futurist Marshall McLuhan spoke of a generation of kids whose worldview would no longer be based on plodding, one-step-at-a-time thinking, but rather on instantaneous flashes of immediate sensory data.[12] This time seems to have come. But at what cost?

Ecological perspective: Kids need more time playing outdoors in the sun

With the advent of the environmental movement in the 1970's, people began to think of ''ecology'' in terms of recycling their garbage and fighting pollution in their communities. However, ecology means much more than that. In terms of this chapter, the word ecology has to do with the sum total of environmental influences in which a child or adult finds herself and the effects they have on her behavior and wellbeing.[13] While this takes in a wide range of components (including the media issues reported above), in this section I'd like to focus on three ecological components: nature, sunlight, and play.

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[10] See Robert Kubey and Mihaly Csikszentmihalyi, Television Addiction is No Mere Metaphor, *Scientific American*, March, 2002, 286(2), pp. 74-80; The evolution of the concept of habituation in psychology is discussed in Richard F. Thompson, Habituation: *A History, Neurobiology of Learning and Memory*, September, 2009, 92(2), pp. 127–134.

[11] See, for example, I.Beyens, Patti M. Valkenburg, and Jessica Taylor Piotrowski, Screen media use and ADHD-related behaviors: Four decades of research. *PNAS*, October 1, 2018, 115 (40), pp. 9875-9881; and Sanne W. C. Nikkelen, Patti M. Valkenburg, Mariette Huizinga, and Brad J Bushman, Media Use and ADHD-Related Behaviors in Children and Adolescents: A Meta-Analysis, *Developmental Psychology*, July 2014, 5(9), pp. 2228-2241

[12] See, for example, Marshall McLuhan and Lewis Lapham, *Understanding Media: The Extensions of Man*, Cambridge, MA: MIT Press, 1994.

[13] See Urie Bronfenbrener, *The Ecology of Human Development*, Cambridge, MA: Harvard University Press, 1981.