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Developing non-toxic approaches to helping children who could be diagnosed with ADHD and their families: Reflections of a UK clinician.

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The number of children diagnosed with attention deficit hyperactivity disorder (ADHD) and prescribed stimulant medication has increased dramatically in the Western world in the last couple of decades. This article reflects on my experience as a consultant child and adolescent psychiatrist working in the United Kingdom. I examine how local dynamics result in ADHD becoming a part of the local and common culture linguistically, conceptually, and clinically resulting in this new category of childhood. I review the literature concerning the safety and efficacy of using stimulants in children. I argue that effective non-medication-centred approaches are available and that their efficacy requires us to first dispense with the notion that a medical condition called ADHD exists. Finally, I discuss how using a multiple perspective approach has enabled me to help children who could be diagnosed with ADHD and their families without recourse to medication.

Something strange has been happening to children in Western society in the past couple of decades. The diagnosis of attention deficit hyperactivity disorder (ADHD) has reached epidemic proportions, particularly amongst boys in North America. The diagnosis is usually made by a child psychiatrist or paediatrician with advocates of the diagnosis claiming that children who present with what the diagnoser considers to be over-activity, poor concentration and impulsivity are suffering from a medical condition which needs treatment with medication. The main medications used for children with a diagnosis of ADHD are stimulants such as Ritalin, whose chemical properties are virtually indistinguishable from the street drugs speed and cocaine. Boys are four to ten times more likely to receive the diagnosis and stimulants than girls (Zachary, 1997) with children as young as two being diagnosed and prescribed stimulants in increasing numbers (Zito et al, 2000). By 1996 over 6% of school aged boys in America were taking stimulant medication (Olfson et al, 2002) with more recent surveys showing that in some schools in the United States over 17% of boys have the diagnosis and are taking stimulant medication (Le Fever et al, 1999). In the UK prescriptions for stimulants have increased from 6,000 in 1994 to over 150,000 by 1999 (Department of Health, 1999) suggesting that in the UK we are rapidly catching up with the US.

The current ADHD and stimulant prescription epidemic can be understood as being caused by socio-cultural and political factors (Timimi, 2002, Carey, 2002; Diller, 1998, DeGrandpre, 1999). It is very much a culture bound syndrome as this epidemic is almost exclusive to Western societies.

In the UK, the local dynamics that have set an epidemic in motion go something like this- Schools struggling with being under-resourced, using labour intensive 'modern' educational methods are under pressure to demonstrate ever improving academic achievement in their pupils, with ever less politically acceptable methods for behavioural control of children. John, One of their more distractible and boisterous children, gets a diagnosis of ADHD and starts taking Ritalin. He is no longer a big problem; he does as he is told. The school has saved money, instead of having to provide extra input for his 'special needs', the teachers realize that John has a medical disorder and now that it's being treated he is, as far as they are concerned, fine. John's teacher realizes that John's friend Paul seems to be similarly distractible and boisterous. She meets

with Paul's parents and tells them that she wonders if Paul too has this ADHD and advises them to see their general practitioner. Paul gets referred to a consultant and he too gets an ADHD diagnosis and starts taking Ritalin. Soon other teachers have started identifying children in their classes like John and Paul. A year down the line John's old pattern of behavior seems to be returning. Teachers wonder if it could be due to the treatment for his medical condition (ADHD) not being adequate. The school writes a letter to John's consultant and his dose of Ritalin is increased. Soon Paul's dose also goes up.

Meanwhile John's consultant has attended a couple of drug company sponsored seminars, has been contacted by a drug company representative and has been given parent and teacher information booklets by this representative (The booklets describe ADHD as being caused by an inherited chemical imbalance in the brain and have pretty pictures of nerve cell synapses to show exactly what's going-on in ADHD brains). This literature now goes into local circulation and other parents contact their doctor expressing concern that their child may have ADHD. A local parents' support group is set up and they join a national consumer pressure group (who organize yearly conferences with drug company financial help). The local paper interviews the parent's group who talk about 'hidden disabilities', how for years they struggled but no one recognized the psychiatric problem their children had and so forth. By now ADHD is firmly established in local culture with economically and politically powerful groups (drug companies, doctors, teachers) having had a major, but often unacknowledged impact on a local communities conception concerning the nature of childhood. A new category of childhood has emerged- that of the ADHD child.

Below I present the results of an audit I did on the children I inherited in the last three years who were diagnosed with ADHD and prescribed a stimulant at the time I took over their care. One of the most obvious impacts of the ADHD diagnosis on the previous professional's views about these children that I inherited was the almost complete lack of attention to context. Thus I saw children who were missing their absent father; I saw parental discord; I saw children from failing schools that were under special measures; I saw depressed mothers who were not coping; I saw families with poor support networks; I saw children with attachment issues; I saw adopted/fostered children who were used to rejection; I saw children who couldn't grieve for a lost relative; I saw very bright children who used their intelligence to get round a system; I saw frightened parents whose children knew what buttons push; I saw frightened teachers who were unsure how to handle the boys in their classes; I saw tired and worn out teachers who'd had enough of teaching; and so on.

I seriously wondered why we doctors get paid so much. For what? If we've lost the ability to work with and take account of even the most basic 'barn door' obvious psychosocial issues, how, as consultants, could we be expected to deal competently with complexity and common but subtle problems that arise in interpersonal family life? These children were now on toxic addictive drugs, whilst the problems arising from their psychosocial context had yet to be tackled. What sort of medicine is this?

Concerns about stimulants

The few long-term studies that have been conducted suggest that stimulants do not result in any long-term improvement in either behavioral or academic achievement (Weis et al, 1975, Rie et al, 1976, Charles and Schain, 1981, Gadow, 1983, Hetchman et al, 1984, Klein and Mannuzza, 1991). A recent meta-analysis of randomised controlled trials of methylphenidate found that the trials were of poor quality, there was strong evidence of publication bias, short term effects were inconsistent across different rating scales, side effects were frequent and problematic and long-term effects beyond 4 weeks of treatment were not demonstrated (Schachter et al, 2001). Despite the lack of evidence for any long -term effectiveness, Ritalin is usually prescribed continuously for 7, 8 or more years, with children as young as 2 years being prescribed the drug in increasing numbers despite the manufacturers licence stating that it should not be prescribed to children under six (Zito et al, 2000, Baldwin and Anderson, 2000).

The dogma from ADHD priests, stating that Ritalin is a safe drug with few harmful side effects, couldn't be further from the truth. Troublesome and frequently reported side effects include poor appetite, weight loss, growth suppression, insomnia, depression, irritability, confusion, mood swings, obsessive compulsive behaviors, psychosis, explosive violent behavior, personality change, lowered self-esteem, loss of creativity, disinterest, a flattening of the emotions which, when observed, looks like a zombie-like state, stomach ache, headaches, movement disorders, tachycardia, pituitary dysfunction and dizziness (Barkley et al, 1990, Breggin, 1999, 2002, Cherland and Fitzpatrick, 1999, Adrian, 2001, Cramond, 1994). Ritalin may also have long term adverse effects in as many as one third of those treated, including subtle cognitive effects such as perseveration, preoccupations, sombreness and deterioration in performance on complex cognitive tasks (Solanto and Wender, 1989, Sprague and Sleator, 1977). Animal studies have found that taking stimulants can cause long lasting changes in the brain biochemistry of rats (Breggin, 1999, 2001, Moll et al, 2001, Sproson et al., 2001, Robinson and Kolb, 2001). Stimulants are powerful amphetamine like drugs with potentially addictive properties that can be crushed and snorted to produce a high and that may lead to further substance abuse in later life (Heyman, 1994, Volkow et al, 1995, Lambert and Hartsough, 1998). Withdrawal states (known as the rebound effect, which manifests in increased excitability, activity, talkativeness, irritability and insomnia) are seen when the last dose of the day is wearing off or when the drug is withdrawn suddenly (Barkley et al, 1990, Breggin, 2002). In addition, children become tolerant to a stimulant's effect resulting in gradually increasing doses being given as years on a stimulant clock-up.

More difficult to assess is the possible socio-cultural effects such widespread use of stimulants in children may have. Doctors may be unwittingly convincing children to control and manage themselves using medication, a pattern that may carry on into adulthood as the preferred or only way to cope with life's stresses.

In North America concern has been voiced about ADHD being diagnosed more frequently amongst children from families of low socio-economic status leading some authors to conclude that Ritalin is being misused as a drug for social control of children from disadvantaged communities (McGuinness, 1989, Kohn, 1989). The dynamics of Ritalin prescription in North America have changed in recent years however, with the majority of those who get the prescription coming from white middle class families (Olfson et al, 2002) where parent's fears about their children's education is the driving force. The anxiety is that if their children don't get into college or university, they are "sunk". Thus parents and the middle class teachers of their children are converting this anxiety into requests for the perceived performance enhancing properties of stimulants. With more children in classrooms taking stimulants many parents end up feeling their child is at a disadvantage if they don't (Diller, 1998). This dynamic is reflected in the trend where stimulants are being prescribed to large numbers children without first making a diagnosis of ADHD (Wasserman et al, 1999, Angold et al, 2000). In the UK, the place of stimulants is less established in popular culture than in the US, thus the dynamic is still very much that of social control of predominantly working class children.

Thus Ritalin remains a controversial drug for reasons that go well beyond its side effects. These are issues that should be discussed with all parents trying to make the difficult decision of whether or not to agree for their children to take a stimulant, yet this is information that is rarely given to them by prescribers (Baldwin & Cooper, 2000).

Developing non-toxic solutions for ADHD-type behaviors

As with non-medical theories of causation, non-drug-based solutions to the problems children with ADHD-type behaviours present have been marginalized by the more politically powerful, often drug-company-supported medical and consumer bodies. However, I believe it is our (i.e., powerful professionals) responsibility to challenge this. We must encourage a wholesale shift in attitude away from the self-defeating lunacy of labeling kids with a medical disorder, in the absence of any evidence that they are suffering from a physical defect.

In my opinion, the starting point for offering a holistic, integrated, multiperspective model has to be the rejection of ADHD as label that offers anything meaningful or useful to clinical practice. Paradoxically, although the use of the ADHD diagnosis and stimulant medication may appear to offer a cheap, labour-saving way of helping these children and their families, as with stimulants effectiveness, it does the opposite. One gets quick results in the short term; in the long term one creates a group of children who are dependent (on the drugs and the doctors who prescribe them) and need to carry on seeing the doctor for years (some say the rest of their lives), without ever having dealt with the cause of the original difficulties. By seeing my basic role as that of empowering children, parents and schools to find their own solutions, dependency on doctors doesn't happen and my clients can be discharged from my clinics in a comparatively short time and with a better outcome than going down the more labour intensive (in the long term) diagnosis and medication route.

In mainstream practice the treatment most usually mentioned in addition to drugs is that of behavior therapy, where parents are given advice on how to manage their children's behavior. There is no magic to this for, hiding behind the pseudo-scientific jargon, is a modern version of the centuries old, common sense, carrot and stick based methods. Most modern Western behavior therapy based parent training methods tend to emphasise more carrot (rewards for good behavior) than stick, the main stick used being that of "time out". Behavior therapy, parent training methods used with children diagnosed with ADHD vary from this in emphasizing more immediate and stronger rewards for appropriate behavior, as well as, using more prompts, cues, and reminders (in other words giving children more attention). Use of more stick (punishments), more common in many other cultures' approaches to parenting, is considered to be counter-productive. This is nonsense; in many schools and families this professional discourse has unintentionally resulted in them developing a state of learned helplessness in the face of more actively disobedient children (usually boys) who then are felt to have a medical disorder because the children are thought to be unable to respond to normal parenting and behavior management strategies.

David Stein (2001) has described an approach that challenges some of the wisdom of conventional behavior management approaches used with ADHD-labeled, children's parents. In Stein's method, called the Caregivers Skills Program (CSP), the assumption is that children with ADHD-type behaviors can be enabled to develop more adaptive behaviors and that current behavioral strategies used with these children's parents maintain and even increase ADHD behaviors. The approach is strict and based on imposing sanctions at the slightest sign of inappropriate behavior together with the use of social re-enforcement of desired behaviors. According to Stein (1999), children's ADHD behaviors improve dramatically or disappear within 4 weeks of starting on the programme.

In a more ordinary vein, Peter Breggin (2000, 2002) appeals to what could be considered old-fashioned wisdoms by emphasizing the importance of re-establishing the moral authority of the parent in the home setting. He advocates a common sense based approach that places greater importance on the parents developing their own sense of responsibility, recovering and developing their own value system, and reawakening their faith in their ability to influence the conduct of their children.

Peter Oas (2001) also claims that therapeutic efforts with children who present with ADHD-type behavior should be directed towards working with the child's parents. Using the simple idea that parents are responsible for their children's behavior as his starting point, he narrates how through a process of guided introspection, reflection, discussion and free-association, parents can learn to understand just how they actively and passively shape their children's behavior. Parents then learn to discover their own solutions to their children's problems by understanding their own problems and their own patterns of behavior with their children.

Oas's (2001) emphasis on parents developing an understanding of the nature of their relationship with their child(ren) is similar to the theme Neven, Anderson, and Goodbar write about (2002). Criticizing the

conventional view that ADHD-type behaviors need to be managed rather than understood, they instead propose that therapeutic efforts should be directed at helping the development of relationships. By helping parents deepen their affectional bonds with their children, the authors believe that children show greater internal security and develop the capacity to act instead of react.

Thomas Armstrong (1995), another ADHD skeptic, believes that ADHD research is fundamentally flawed by lack of attention to context and by seeing the child labeled with ADHD in terms of his or her deficits, not strengths. Armstrong offers a long list of ways to improve children's behavior without the need for labels or pills. Most have to do with lifestyle changes and include: a balanced diet, limiting television and video games, encouraging a child's interests, plenty of exercise, removing allergens from diet, providing positive role models, plenty of hands-on activities, spending positive time with the child, valuing achievement through personal effort, teaching problem-solving skills, offering the child real-life tasks to do, giving the child choices, letting the child teach a younger child and holding family meetings.

A view from the UK:

In my book *Pathological Child Psychiatry and the Medicalization of Childhood*, I described the setting up and running of an ADHD clinic in East London and the guiding principles we used to help develop a multiple perspective approach to helping these children and their families (Timimi, 2002, chapter 7). Since that time I have changed jobs and now practice in the county of Lincolnshire in the UK where I have continued to develop this approach. As a consultant in the UK National Health Service, I do not have a choice about the clients I see, as I serve as a consultant child and adolescent psychiatrist to a geographical area and therefore accept all appropriate referrals that come mainly from the client's general practitioner. At the same time referrals for children with behavioural problems also go to the local community paediatrician. In over 3 years in Lincolnshire I have been the child and adolescent psychiatry consultant to two community patches, each with its own particular dynamic.

In my first 2 years I was working in a community patch that was part rural and part inner city urban. I inherited 26 children who, at the time of my starting in this patch, were taking stimulants. Many of the clients I inherited had been seen by a consultant child and adolescent psychiatrist (who still had a local community patch that overlapped mine) who was a strong believer in the ADHD diagnosis and the use of psychopharmacology (often multiple prescriptions and in high doses) for children. The local community paediatrician was also a firm believer in the diagnosis and use of stimulants in children. Consequently, the local community already had been "cultured" into believing in ADHD and the merits of drugging children to control their behavior. Amongst the 26 children on stimulants I inherited at the time I took over, the average age was 12.7 years, the average daily dose was 41mg of Ritalin or Ritalin equivalent- the maximum licensed dose for Ritalin is 60mg per day, and the maximum dose for a child I inherited was 100mg a day; the average number of years the children had been taking a stimulant was 3.5 years. By the time I moved after 2 years, only 6 of the 26 I inherited remained on a stimulant, 16 children had come off the stimulant through a co-operative effort with the child's parents, 2 children had their prescription discontinued through persistent non-attendance (in the UK Ritalin prescription requires that the child is followed up by a specialist) and 2 children were lost to follow up by me after I raised child protection concerns. Of the 6 who remained on stimulant medication at the time of my departure, the average daily dose was about half the dose they were taking when I inherited them. During the time that I was working in this community patch I commenced 5 children on a low dose of stimulants, 2 of whom were discontinued by the time I left. Many families expressed dissatisfaction at previous interventions feeling that the medication centred approach was too narrow and did not take into account their history and particular situation. I continue to discover that many families have a far more sophisticated understanding of the psychosocial causes of behavioural problems than most psychiatrists and paediatricians I meet these days.

I then moved to a smaller community patch that is predominantly rural and have been working there for just over a year now. Prior to my starting, this area had not had a permanent consultant child and adolescent psychiatrist for the 2 years before I arrived. Instead a succession of locum consultants had been covering the vacancy including several stints from a consultant whose main practice was in Canada. Despite my new patch having a much smaller population than my previous one (this being only part of my current responsibilities, the other being the Lincolnshire in-patient adolescent unit), I inherited 28 children on stimulants. At the time I started seeing these children the average age of the children on stimulants I inherited was 10.2 years, the average daily dose of Ritalin (or Ritalin equivalent) was 18.9mg and the average number of years the children had been taking a stimulant was 1.7 years. In just over a year only 4 children remain on stimulants, 2 children (siblings) are seeing another doctor (after I raised child protection concerns), I have not needed to start a single child on a stimulant and am hopeful that the remaining 4 will be able to come off their medication within a year. The local community paediatric service providers are much more cautious prescribers than in my previous patch, and having met with them am aware that they are prescribing stimulants to no more than 8 other children in my area.

In both of the above jobs, my experience has been that the other professionals in my team (nurse therapists, social workers, psychologists, and psychotherapists) are sympathetic to my views and approach- it is the other child psychiatrists who are most at odds with my clinical practice. The guiding principles I use to help children who could be diagnosed with ADHD and their families have been set out in more detail elsewhere (Timimi, 2002, chapter 7). Below is a summary of these principles, which I have called a mutliperspective approach and which continues to evolve:

Slow down the assessment process and engage the system. Ideally a three-stage assessment is helpful. The first appointment is a clinic-based appointment and is a first opportunity to meet with the family and the child. The second stage is to do a school visit as for many children referred, school is the main concern of the parents. The third stage of the assessment is to do a home visit where I have the opportunity to meet with the family on their territory. Finally an appointment back at the clinic completes the assessment. Since moving to Lincolnshire pressures of time and geography have meant that I am unable to routinely offer a school and home visit as part of every assessment. Instead I have developed a standard letter to send to schools that asks about a number of areas including behavior, academic level, peer relationships, relationship with teachers, extra help given, strategies used by the school, changes noticed over time, and, in particular, strengths and positive qualities of the child. I do not use any rating scales. I carry out school visits and more occasionally home visits only if, in my judgment, this is necessary. From the first appointment I show an interest in the family's and their children's own ideas about what the problem is. Frequently opportunities for what might be considered treatment arises during the assessment; thus I also view the assessment period as the first opportunity to begin interventions. By trying to slow down the process I am, from the start, covertly introducing the idea that my job is not to simply focus on a "yes he has it" or "no he doesn't" medical test kind of approach.

Put a lot of effort into trying to engage children and their families. Some families who come to see me have had previous referrals to child and adolescent mental health services and other agencies (for example social services and educational psychology). Many of these families feel ambivalent about helping agencies, possibly experiencing them as blaming or perhaps even fearing that these agencies are about taking their children away. A patient, sympathetic, long-term approach is needed. Steering clear of any suggestions on how to parent may be important in the initial stages of engagement. Instead picking up on any examples of good parenting or examples of how dedicated the parents appear to be towards their children that I hear or see in a session, can be experienced as positive and trust building. Obviously, there are important precautions to be taken as one doesn't want to condone abusive situations. I try to talk to the referred child first in the company of the parent(s) and I like to focus questions and comments on the more functional, coping, and

thoughtful aspects of the child. If a child is completely hostile, then a more playful approach can be rewarding, for example, give them easy challenges and tell them that you bet they can't do it and express surprise when they do.

Take a multi factorial approach. Try to move families from single explanation approaches to including all other explanations available. These may come up through my own opinions during the assessment, but often are explanations that families, schools and others have put forward, but whose significance have been pushed down in status as being less meaningful than ADHD as an explanation. Thus I am continually trying to rehabilitate complexity. It's very easy to miss these everyday explanations that many parents and children have about why they are the way they are and it's very easy to give these explanations no significance at all. Once you look out for these simple, everyday explanations, in every case that I have come across so far, one or more of them exists (such as the child insecure or unhappy at school) but needs to be actively searched for as they are relegated to a lower status than the assumed possibility of ADHD as an explanation, particularly if they are meeting a doctor!

Take a process-orientated approach to deconstructing the meaning behind a diagnosis of ADHD. I try to be open with clients about the controversies relating to ADHD. For example, I might explain quite early on that there is no such thing as a test for ADHD and, in that sense, it's different to diagnoses, such as pneumonia or diabetes where one can take a blood sample or an X-ray- in other words where one can do actual tests to help substantiate the diagnosis. I explain that the diagnosis is not based on any "rocket science" but on clinical judgment and explain about the types of behaviors we look for in making the diagnoses. I also explain that there is substantial disagreement between professionals, not only on how to arrive at the diagnosis, but also on whether such a condition exists in the first place. The aim of taking this approach is to get the idea across that the ADHD label does not provide an explanation; it does not answer the "why" question.

Look for positives and for solutions the family has already generated. When families come to the clinic, they are there because of problems they or someone else (e.g. the school) is having with the child. Thus the session(s) will be dominated by problem talk usually in front of the child concerned. Of course, it's important to listen carefully and try to understand the nature of the difficulties the child, family, and others are experiencing. However, I often make an active attempt right from the first session to look for the positives and/or descriptions of the child that don't fit with the dominant story being given. I have yet to come across a family (where there were not any child protection concerns) who when given a bit of space, time, and a touch of persistence on my part, hasn't come up with something positive. Keeping hold of the big picture is also important. For example, 6 months or a year after you first started seeing a child and their family you, may be bogged down in a rather hopeless feeling session, yet overall you know the child has made significant progress and reminding everyone of this can be helpful. Keeping the good news alive is important in all cases, but particularly where there seems to be a history of major attachment type issues (in other words, where there is a lot of built up hostility and negative feeling between a parent and child). Noticing solutions and amplifying them can also be of great benefit. By paying attention to a time, however small or seemingly insignificant, when the child wasn't all over the place and out of control, and by getting everyone to think about what might have been different about this time (what was the child doing, what were the parents doing, what else was going on etc.), you can begin to help parents and children rediscover their own competence and expertise.

Be open and informative and allow the parents to make the decision about Medication. I see my main duty where the use of medication is being considered as that of providing adequate information to allow the parent(s) to make an informed decision. Providing information means telling the clients about how the drug works, the evidence for its effectiveness, the side effect profile and the types of controversies there are. I am

open about my opinions with regard use of stimulants for behavioral control. Most parents seem to understand my approach and are happy to be treated as the expert best placed to make decisions about their child. In my experience, nearly all parents want to avoid their child having to take a stimulant and if their child is on medication would like to see them come off it as soon as is practical.

Be prepared to be in there for the long haul. Be patient - time often brings unexpected coincidences and new things to explore in a natural unforced manner. I now feel less inclined to jump into theorising and trying to find out too much information about a family (particularly things like the parents' own histories) until opportunities naturally present themselves and when there is a reasonable sense of trust established between myself and the family. Then I can start being more openly challenging and curious if necessary. Opportunities for looking at new explanations and new solutions frequently happen by chance. By being involved with cases over long periods (sometimes years) I am no longer concerned if solutions and improvements do not happen in the short term. Events such as changes of teacher or school, re-involving an uninvolved father, changes in lifestyle (such as attending a martial arts class) are continually occurring and can have dramatic effects on a child's behavior and well-being.

Be prepared to consider alternative approaches. Diet is frequently an issue that is brought up by parents. Where parents are interested, I give them any information I have on this topic. For some parents this has meant trying their children on the supplements, most commonly a multi-vitamin and mineral preparation such as Forceval Junior and an essential fatty acid preparation, such as Efalex. Others, depending on the child and family history, wish to try exclusion diets such as an additive free diet, a lactose-free diet or a gluten-free diet. I frequently refer such children to a dietician for more detailed advice on particular exclusion diets. Many other lifestyle issues are explored in sessions including exercise, sleep routines, limiting television and computer game times, social activities and peer contact, encouraging children to attend clubs, such as scouts, army cadets and other activity-based groups.

Challenge and deconstruct the hierarchy. I give greater importance to the client's own knowledge and less importance to my own. Local knowledge is searched for and explored wherever possible. Common sense, grandparent, old-school type advice is important to pick up on and follow through. Ideals like children requiring nurturing, firm discipline, plenty of exercise, plenty of time to play, plenty of fresh air, good diet, routines and good sleep, have been known about for hundreds of generations. This common sense everyday knowledge will always be relevant. As far as professional knowledge is concerned this is provided in an open non-prescriptive and non top-down sort of manner. I ask children and their parents for their ideas and tell them what the books say and perhaps something from my own experience both as a parent and as someone who has worked with other families who've had similar problems with their children. Another important aspect of deconstructing the hierarchy is that of deconstructing my professional identity. These days I feel I am a similar person at home and at work. I engage in a lot of chitchat and small talk with clients. If anyone (client or other professional) wants me to call them by their first name, then I insist they call me by my first name. Given that I spend so much time prying into other people's personal business, if someone asks me a personal question, I will answer it honestly.

Transparency. I try not to keep ideas secret. I share my thoughts and feelings as they occur to me however difficult the issues raised might be. Sometimes I feel hopeless to know what to do to help someone and I share that. Sometimes I feel angry; this I find is a difficult emotion to just talk about, so often I just end up being angry and try to explain why. Transparency is also part of deconstructing hierarchy. The more we hold secret knowledge as professionals, the more power we have over clients, and I think the more vulnerable clients feel in our company.

Conclusion

In recent years a new category of childhood has emerged in Western society in epidemic proportions- that of the ADHD child. This reflects cultural and political dynamics that have led many social aspects of childhood to become medicalized. Children are paying a terrible price for this. Not only are healthy children being drugged with highly toxic and addictive medicines, we as a culture (including my profession) are abdicating our collective responsibility to provide a secure and nurturing environment for children to grow up in. There are many viable, economical and morally more acceptable approaches to helping children in this new category of childhood. Drug Company promoted methods must be challenged in the hope that these less toxic methods can be brought out of their marginal status and into the mainstream.

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