Sophistry and ADHD: The Dual Myths of Organicity and Biochemical Imbalance and the Ensuing Medication Tidal Wave

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In a time of universal deceit, telling the truth is a revolutionary act
—George Orwell

When I was about eight or nine years old, I recall having a teasing *tête a tête* with my father in which he issued a somewhat mischievously conceived, but as it turned out, clever challenge to me. He told me that he could demonstrate that I was not here. Oedipal rivalry implications aside, my father said that through the simple use of logic alone, he would be able to do this. I was young, wide-eyed and curious, so I eagerly dared him to prove to me that I was not here. His demonstration was fairly simple, to the point, and short. He asked me the following questions: "Are you in Chicago?" My reply was even shorter. "No," I answered. "Are you in San Francisco?" Again, my answer was "No." He continued, "Are you in Winnipeg?" I answered, "No." He named several other locations, but each time, my answer was an unequivocal, "No." Finally, he said, "Well, if you are not in any of those places, you must be somewhere else, is that correct?" "Sure," said I. Armed with little more than a twinkle in his eyes and a mischievous grin, my father then summed up his argument by concluding, "Well, if you are somewhere else, you cannot be here!"

Taken at face value, this was merely light-hearted banter between a father and his son. Of course my father and I both knew the truth about my whereabouts (which was New York City). It goes without saying that

even though I was not in any of the places that he named, this simply meant that I was somewhere other than in those places, not somewhere other than where I actually was. In other words, being somewhere else did not negate where my real location was. Nor did our mutual understanding of the truth about my whereabouts negate our being able to suspend our spatial orientation temporarily and allow us to mutually delight in this display of verbal chicanery.

However, on a deeper level, this miniscule vignette represents a veritable demonstration of how manipulation of terminology that *seems* to be logical on the surface can produce a quasi-conclusion that *appears* to make sense, at least superficially, but which has no factual basis in reality. This is a prime example of what is meant by the term, *sophistry.* By that, I am referring to the use of reasoning and/or argumentation that is inherently false, and which is designed to subtly or otherwise, deceive.

Historically, the term, Sophistry, comes from a group of particularly eloquent individuals, called the Sophists, who touted themselves as logicians, and who ardently privileged winning over everything else. This often meant disrespect, disregard for, or distortion of the facts. Logic was utilized as a central part of their argumentation in order to achieve their desired ends.

In opposition to these tactics, Isocrates wrote a treatise entitled, *Against the Sophists*, indicating that anyone who deals in generalizations about the proper way to conduct one's life or attempts to promulgate absolutes, regarding what constitutes virtue, for example, gravely misleads the public into believing that important issues and questions can be reduced to simplistic, one-size-fits-all principles and procedures. He believed that there was no specific "science" which is capable of spelling out all of the conditions necessary for insuring a good life filled with happiness and success, and he showed contempt for the Sophists who argued that this could be taught. In his *Antidosis*, he wrote:

> If all who are engaged in the profession of education were willing to state the facts instead of making greater promises than they can possibly fulfill, they would not be in such bad repute with the lay-public (In, *Classical Rhetoric*, trans. George Norlin, 1980, p. 72).

He characterized the scruples of such individuals as indicative of a kind of "cloud morality," which he maintained was not based on lived experience, and not grounded on earth. He added the following:

> Indeed, who can fail to abhor, yes to condemn, those teachers, in the first place, who devote themselves to disputation, since they pretend to search for truth, but straightway at the beginning of their professions attempt to deceive us with lies? (p. 72).

Subsequently, Aristotle declared that sophistry was wisdom in appearance only. Centuries later, D.C. Schindler (2008) distinguished genuine philosophical inquiry from sophistry by observing that:

> Sophistry is indifferent to content, and that this indifference prevents it from integrating what it knows into a well-ordered meaningful whole…because to do so would require a genuine knowledge of the good (p. 261).

Three General Methods of *Knowing*: Autocratic, Socratic, and Scientific

This begs the following questions: what is truth, and how does one go about the business of seeking it out? At first, the central means of obtaining a semblance of 'truth" was handed down by *the powers that be*, whose main means of transmitting the canon of the day was by virtue of what I call the Method of Authority. Under this "method," information was derived from the word of the Authority, such as, the High Priest, the Church, the King, the Elder, and so on. Not infrequently, this method was autocratic.

Another method of seeking truth came from the work of Socrates. This refers to what has become known as the Method of Inquiry, in which the quest was as important, or perhaps more important than the answers or conclusions, if any, that might be obtained. However, this method left many matters unsettled and open for debate. Into the void of debate, the autocratic power—intertwined with the authoritarian

voice—made itself heard and demanded obedience. The authoritarian diktats usually generated grave risks should they not be heeded, no matter how ridiculous their conclusions and proclamations may have been. Hence, declarations that the earth was flat, or the universe revolved around the earth needed to be respected and strictly obeyed, lest one incur the wrath of the authorities. Mere philosophical inquiry, open debate, or divergent thinking did not dare refute opinions coming from on high, without the threat (and/or actuality) of dire consequences. One of the few ways available could come through the development of carefully gathered, systematic, keen observations and measurements. From this, the next approach—the Scientific Method—and the formal study of the sciences were born. Although, as it happens, even the development of science itself, was not impervious to being influenced, or obstructed by those in power, as evidenced by what happened to Galileo and other "dissenters," many of whom met with a gruesome fate.

Science, and the scientific method emanated out of the need to establish uniform standardized methods of observation for the purpose of obtaining a sense or measure of predictability, consistency, and stability designed to assist us in understanding our environment, as opposed to having it dictated to us by those in power. But it also developed as a means of departing from, and even challenging long-held (sometimes superstitious) beliefs and/or dogma.

Good science attempts to tally the tolls it carefully accumulates and measures. But what if a fake coin is somehow inserted into the computational system's collection device? What happens to the data, to the calculations and resulting conclusions to be drawn? As we know, in any syllogism, if we start with a faulty premise, or if the accumulated data are skewed, as in the above example, we arrive at a faulty conclusion. What has come to be known as, "Attention Deficit Hyperactive Disorder" (ADHD) is a prime illustration of this.

ADHD is a perfect illustration of a controversial diagnostic categorical misnomer. It has long been fraught with misinformation, misunderstanding, and mistakes, but has caught on nonetheless, and persisted, especially once it was officially engraved in the Diagnostic Statistical Manual (DSM), the Holy Bible of psychiatry. Practically from the start, even before it was

ever formally studied, ADHD was regarded as a neurobiological disorder. Even though no biological basis had been uncovered at that time or since then, once ADHD was enshrined in the sanctum sanctorum of the holy *Diagnostic Scriptural Mystifier* (the DSM), it became accepted as a real disease entity, necessitating a biological cure. Yet no genetic or biological marker, lesion, bacterium, chemical imbalance has ever been found that has withstood the test of time to support the widespread conjectures of a biological causality connection. As Justman recently wrote (2015):

> The tangled history and mutating specifications of the disorder alternately known as ADD or ADHD make it clear that the disorder (call it ADHD) is not a specific entity given in nature but a construct, and by the same token, its prevalence is highly subject to interpretation (p. 138).

Nevertheless, as a result of being given the premature imprimatur of disease status, millions of children, and subsequently adults who were given this questionable and unsubstantiated diagnosis were prescribed powerful stimulant drugs. Currently, some of the original proponents of ADHD, who were instrumental in it being accepted as a real diagnostic condition cannot run fast or far enough away from their association with it. They too, although quite belatedly, have come to recognize its questionable status which includes, but is not limited to its complete lack of empirical, verifiable validity.

Up to now, a reductionistic biological approach has been taken regarding ADHD. And, based on the extant belief that ADHD had a neurobiochemical origin, an increasing number of children, especially boys, who had been diagnosed with ADHD, have been treated with stimulant medications. However, many are now beginning to question whether ADHD can justifiably be classified and thus treated as a disease (Baughman, 2006; 1993; Furman, 2005, 2002; Rosemond & Ravenel, 2008; Seitler, 2011; Seitler, 2008; Seitler, 2006a; Seitler, 2006b; Kaye, 1994).

A methodical review of the literature shows that the symptoms of ADHD listed in the DSM IV, of inattentiveness, forgetfulness, hyperactivity and impulsivity, are not unique to ADHD. In fact, most of us have

exhibited one or more of the previous symptoms in our lives. According to Hallowell and Ratey (1994), Mozart might have been diagnosed today as ADHD, based on the following behaviors that he exhibited. He was said to have been:

> impatient, impulsive, distractible, energetic, emotionally needy, creative, innovative, irreverent, and a maverick (p. 43).

Therefore, the terminology and description add nothing definitive that distinguishes ADHD from other behaviors. Moreover, no neuropsychological test results or physiological pathology have uniformly been found for ADHD (Rosemond & Ravenel, 2008; Furman, 2005). Also, no structural or functional neuroimaging studies have ever consistently identified a unique etiology for ADHD (Jackson, 2006; Furman, 2002; Weinberg, & Brumback, 1992;). Rather than relinquish the ADHD category, it was now said to be "co-morbid" with other diagnostic entities, such as conduct, oppositional, and mood disorders, and even learning disabilities (Kaye, 1994; Weinberg & Brumback, 1992). Earlier, Henker and Whalen (1989) commented on the broadly written generalities subsumed in the criteria for these "disorders,"saying:

> …the criteria for these disorders are written in such a way that a child with ADHD could and often does receive one of the other two diagnoses at the time. In fact, the overlap between ADHD and the other externalizing disorders is so high—over 50%—that many have questioned the utility of making distinctions among them (p. 216).

Joseph Glenmullen, a psychiatrist at Harvard Medical School, went even further in asserting, "We do not yet have proof either of the cause or the physiology for any psychiatric diagnosis. In every instance where such an imbalance was thought to have been found, it was later proven false" (2002).

In this regard, Flaherty, et al. (2005), on behalf of the American Psychiatric Association, boldly asserted that the current state of

neuroimaging does not warrant using such technology for diagnosing psychiatric disorders. Keith Connors (1998) said as much in a paper he presented to the National Institute of Health (NIH) Consensus Development Conference: Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder. In reviewing neuroimaging studies, he stated,

> The embarrassment of riches from neuroimaging studies reflects a poor understanding of any specificity for the neural basis of ADHD. The high levels of comorbidity of ADHD with oppositional, conduct, and mood disorders also call into question the specificity of the definition of the disease and whether current criteria are sufficient to allow further understanding of the neurobiology of the syndrome (p. 23).

Commenting on data from the Centers for Disease Control, which showed that diagnoses for ADHD were given to 15 percent of high school-age youths and that the incidence of children receiving stimulant medication for ADHD had dramatically risen from 600,000 in 1990, to over 3.5 million, Connors, in a New York Times interview on 12/14/13, referred to this as "a national disaster of dangerous proportion." He added, "The numbers make it look like an epidemic. Well, it's not. It's preposterous." In a subsequent interview, Connors uttered an even more powerful disclaimer stating, "This is a concoction to justify the giving out of medication at unprecedented and unjustifiable levels."

According to Craig Newnes (2009), in Great Britain, less than 5000 children were diagnosed as ADHD prior to the 1990s. In 2003, more than 200,000 children were now labeled with this condition (p. 161). To put this in perspective, the sales of stimulant medication for this so-called ADHD entity have quintupled just from 2002 to 2012. So widespread has the connection between stimulants and their presumed attention-enhancing attributes become that the use of stimulants by university students (believing that their test scores would be dramatically enhanced) has skyrocketed. Watson, Arcona, and Antonuccio (2015) assert, "There is no evidence that stimulant medications used for ADHD increase intellectual functioning or scholarly contributions" and point out that:

> compelling new evidence indicates that ADHD drug treatment is associated with deterioration in academic and social-emotional functioning (p. 10).

And yet, no genetic markers for ADHD have been identified. Even the definition of ADHD has been fuzzy, thus making studying "it" an empirically murky endeavor, chock full of difficulty. To date, most empirical studies have heavily relied on the Conners Rating Scales, which themselves have questionable validity. Although supporters of the Connors Scales claim that it has high inter-rater reliability, research only notes "high face validity" (Connors, 1998; Goldman, et al., 1998), which is essentially how a test *looks* but not how well it answers two essential questions which constitute the essence of validity: (1) *Does it test what it claims it tests?* And thus, (2) *Does it measure what it claims to measure*? Ultimately, when all is said and done, having "face validity" is really no better than having no validity at all.

Even results of the Conners Revised Rating Scale, as well as teacher or parent "ratings" of school children have been highly discrepant. Additionally, studies have shown that Scales like the Connors, the ADHD Rating scale; the Brown and the Wender Utah are "Significantly easy to fake" (Jachimowicz and Geiselman, 2004). What this means is that an objective basis for the diagnosis of ADHD has been severely undermined by the use of subjective informant data derived from the above scales or from interview material.

On top of that, the use of stimulant medication has been a disaster in its ability to make any differential behavioral distinctions that distinguished children diagnosed as "ADHD" from other children that were not so diagnosed.

In a brilliant presentation at the Australian Association for Research in Education, Graham (2005) invoked the reasoning of Foucault and asserted that when children are called ADHD it is for exclusionary reasons in which such children "are placed in a field of exteriority" (Foucault, 1972, p. 139). She indicated that attaching the label ADHD to students simultaneously accomplishes several self-serving aims:

(1) it is a means of legitimizing the existence of "behavior- disordered" students as a separate class of infra-humans,

(2) it is a means of legitimizing the diagnostic nomenclature of ADHD, and

(3) it is a means of legitimizing the ensuing exertion of control over "them."

Specifically, she maintains:

> …the constitutive effects of psychopathologizing the pedagogical discourse imbued with the positivity of psychological power works to speak into existence the "behaviorally disordered" child as a recognizable object of scrutiny (p. 12).

Adding to this, Justman (2015) makes an interesting connection between the employment of stereotypes and the invocation of the ADHD diagnosis. He maintains:

> …like a stereotype, the diagnosis is highly connotative, distorts interpretation, replicates itself, and marks its objects. A diagnosis that a symptom of *fidgeting* or *tapping* [his italics] comes perilously close to a caricature that plays up physical variations, and a diagnosis expansive enough to acquire millions of new cases from DSM-III to DSM-5 contains more than a seed of exaggeration. Moreover, the very process of adding one symptom to another until they add up to a diagnosis plays to a kind of logic of association (p. 137).

On top of that, proponents of the neurobiological model for the etiology of ADHD have been unsuccessful in their attempts to explain the huge differences in incidence of ADHD between girls and boys (Arnold, 1996; Gaub & Carlson, 1997).

My own work (2011, 2008a, 2008b, 2007, 2006a, 2006b) suggests that the gender differences that we see in the incidence of ADHD in boys as opposed to girls may be cultural manifestations having to do with the manner in which boys and girls are differentially permitted or able to express certain kinds of feelings, particularly sadness or depression. In our culture, it is quite acceptable for girls to cry. However, for boys we

seem to have a completely different standard. Boys who cry or show tender feelings of one sort or another are often ridiculed, dismissed, or even bullied.

In short, the chant that has reverberated over a span of more than four decades, namely, that *ADHD* (or any of the multiplicity of terms that have preceded it) *is a neurobiochemical disease*, is simply not supported by a close analysis of the evidence. This is worthy of consideration because a serious consequence of holding to a strictly neurobiochemical substrate for ADHD is that it almost inescapably results in an organic solution to this purported, but not supported, "disease," one that almost invariably results in the use of stimulant medications like Ritalin, Adderall, Straterra, and so on.

While these medications might be able to *subdue* a child's excessive activity level in the short term, when viewed over a substantial period of time they no longer are effective (Rosemond & Ravenel, 2008). Sadly, what is more, children, and their parents typically do not recognize that feelings are what underlie overt behavior; nor do they know what to do when their feelings are consciously experienced. As a result, learning how to regulate or modulate affect may not occur, or may be severely compromised (Schore, 1991). This frequently results in a lifetime of dependence on drug regimens or *chemical cocktails*, rather than on their children's own learning capacities and inner resources. As if that is not bad enough, medications have been shown to have serious after-effects (Baughman, 2006, 1993; Jackson, 2009, 2005; Breggin & Breggin, 1995; Barkley, et al., 1990).

After-Effects—are not merely Side-Effects

I use the term *after-effects* instead of *side-effects* because *side-effects* imply that the effects of the prescribed drugs are either rare or minimal. Research is now telling us a different, much more somber story about the after-effects of stimulants (Jackson, 2009, 2005; Lambert, 2005; Lambert, 1998; Lambert & Hartsough, 1998; Raine, et al. 2010; Raine, 2009). The Raine study longitudinally followed Australian children who were receiving stimulant medication for 8 years. Among their findings, a few significant and alarming results stand out:

- The existence of long-term cardiovascular damage; significantly increased diastolic blood pressure, as compared to matched children who did not receive medication.
- School failure was seen. Despite the long-held, and as it turns out, *mis*belief that children concentrate and achieve better when on a stimulant, they have a 10.5 times greater chance of being identified by a teacher as performing below grade level.
- What is more, the study shows that inattention and hyperactivity slightly *worsened* over the long-term, contrary to what the public, as well as professionals in the field, have been told up until now. Drug advocates have made an argument that the above results occurred because the medicated children had more severe forms of ADHD. However, when the children were first being included in the Raine study, the medicated group and non-medicated group were compared with each other on developmental, behavioral, and health measures, producing **no** significant differences between the two groups at the outset. This spikes the "severity of the disorder" argument.
- Other longitudinal research (Lambert, 2005; Lambert & Hartsough, 1998) has noted that children, who are on stimulants over the course of time, have a significantly greater chance of becoming addicted to other stimulants, ranging from cigarettes to cocaine.

Combination of psychotherapy and medication for ADHD?

There was a time, not all that long ago, when the idea of using medications *and* psychotherapy for working with patients who had been characterized by the term Attention Deficit Hyperactive Disorder (ADHD) was considered to be the *moderate* position. After all, it was reasoned, that if psychotherapy was effective and not harmful—and if medications had efficacy and did not do any damage, it would make sense to utilize both options together. Moreover, in doing so, the whole messy debate regarding

whether or not ADHD had a "neurobiochemical" origin could be straddled by clinicians whose main aim was to focus on, and help those under their care and not have to be concerned with the on-going theoretical quarrel over ADHDs etiology. In fact, one of the initial "casualties" emerging out of the emphasis on the almost exclusive treatment of ADHD with medications was talk therapy, particularly uncovering treatments, like psychoanalysis or psychodynamic psychotherapy. This may explain, to a very large degree why there has been a relative dearth of published psychoanalytic or psychodynamic research or case studies in this area. However, in the last ten years, an ever-increasing body of researchers and clinicians have come to understand that medications were neither as benign as had previously been declared, nor as efficacious in treating this "ADHD condition" as had previously been claimed.

Anthony Roth and Peter Fonagy (2006) carried out one such piece of psychoanalytic research on ADHD. This study was conducted to determine the efficacy of the psychoanalysis of 35 children diagnosed as ADHD. After one year, 67 % of the children remaining in psychoanalysis no longer could be diagnosed as exhibiting signs of ADHD.

My own work with children spans over 40 years and includes many youngsters who were described as hyperkinetic, hyperactive, or what we now refer to as ADHD. During that period of time, I began to question the neurobiochemical ideas that were beginning to take hold. My experiences with children who were diagnosed as exhibiting ADHD lead me to different conclusions. Elsewhere, I have described those experiences in greater detail (Seitler, 2011, 2008a, 2008b, 2007, 2006a, 2006b).

The Case of Raymond S.

The following is a case study of a young boy, who I have called "Raymond," who was diagnosed by the family pediatrician as "hyperactive," and who subsequently received psychotherapy treatment with me. I offer it here as a representative case illustrating that psychotherapy, in this instance, psychoanalytically oriented psychotherapy, can provide both a parsimonious, yet not reductionistic, explanation for what has been called "Attention Deficit Hyperactivity Disorder" (in addition to a

long list of other preceding names), as well as a safe, effective, long lasting treatment of children on whom we have conferred the term, ADHD.

Raymond was brought in to see me by his parents, Mr. and Mrs. S., when he was 6 years old. Prior to their visit with me, Raymond's parents had to take him out of pre-school due to a series of ongoing misbehaviors, such as— pushing children out of his way, impulsively shouting out in class, repeatedly interrupting classroom activities (often, but not always, by calling for his mother), and not obeying the instructions of his teacher or other adults who were in charge. When Raymond's parents enrolled him in Kindergarten, his behavior was similarly marked by agitation, unrest, and his inability to contain his impulses. So pervasive was his misconduct that it had a negative influence on caretakers and other important figures in his life and on the ways in which they interacted with him.

When I saw Mr. and Mrs. S., they said that they did not know what to do. They indicated that Raymond, their only child, was out of control and that they felt helpless and frustrated. They were also embarrassed, and believed that others looked down on them in the upwardly mobile neighborhood that they worked so hard and were finally able to afford to move into. What appeared to be their great awareness and hyperconcern about "what the neighbors would say" unquestionably compounded their initial apprehensions.

Despite their description of Raymond being highly impatient, with a very limited frustration tolerance and an exceedingly high activity level, they were totally opposed to his being on any kind of medication. They were very emphatic about their antipathy toward the use of any kind of psychoactive medications, particularly stimulants, and asked if I would work with Raymond without drugs. I agreed to work with Raymond and indicated that I thought that it would be helpful if they also received ancillary counseling as part of the process.

Mr. and Mrs. S. were observed to be a bright, articulate, and hard-working couple in their late thirties, who moved from New York City to a fairly well to do suburban area. They were socially conscious and indicated that were attempting to "fit in" to their new, upscale neighbor-

hood by taking an active interest in, and working hard for their community.

Mr. S. was an electrical engineer. His wife was part owner of a small neighborhood restaurant, which demanded a great deal of her time, energy, and focus. At the end of the day, she was often physically spent and emotionally wrung out. And, although she loved her husband and Raymond, her attention was sometimes diverted by the exigencies of work. She was high strung and given to emotional expressiveness, while Mr. S. often tended to retreat to the safe confines of his inner ideation. At first glance, she seemed to be "dramatic," and he appeared to be excessively reserved and perhaps, even a bit "inhibited." Mrs. S. was lively and filled with verve. She broke away from her traditional, strict, Mediterranean family roots to marry Mr. S., whose heritage was Eastern European, with its emphasis on obedience, conformity, and achievement. He seemed to be low-keyed, mild-mannered and thoughtful, but not necessarily in touch with his feelings, while she seemed to be much more aware of and responsive to her inner feelings, but less able to contain them.

However, their work schedules and the heavy demands that they imposed on themselves by moving into a more expensive neighborhood than they had been in before placed considerable stress on both of them. Thus, when Raymond arrived, their family system was now threatened with becoming overtaxed and was susceptible to and in danger of being toppled. As long as they were able to operate together as a unit, they seemed to compliment each other quite nicely and were able to weather most storms. Mr. S. was able to remain calm, cool, and collected in times of stress, while Mrs. S. was able to be assertive, to take charge, and be decisive when action was needed.

Although Mr. S. often deferred to his wife when it came to decision-making, he had a number of respect-worthy ideas of his own. Unfortunately, he rarely voiced them. Nevertheless, they both recognized the centrality of their son's problems, along with their own issues, and were very cooperative, dedicated, and committed to therapy, so much so that both sought out and got involved in treatment for themselves, as time and their schedules permitted. Mr. and Mrs. S. came together once per

month, as an adjunct to Raymond's therapy. In addition, Mr. S. came for group psychotherapy once a week, and Mrs. S. sought out individual therapy for herself on a once a week basis.

A developmental history was gathered over several sessions. For the most part, Raymond 's developmental milestones did not seem to be out of the ordinary. If anything, he achieved most of his physical and cognitive landmarks considerably earlier than expected. However, he occasionally experienced nightmares and would shriek in the middle of the night, awakening his already overburdened and on-edge mother. Usually, at such moments, she was unable to soothe Raymond and, probably because her own exhausted state left her with limited emotional resources, she became frustrated with his screaming and often screamed back, in what appears to have been an impotent rage on her part. In the latter respect, Sylvia Brody (2009) sensitively observed:

> …excessive or unprovoked punishment wounds the nascent ego of the child. Such blows may be felt only vaguely, yet they can affect the quality of the child's self-regard. Excessive or hasty punishment is likely to arouse confusion in the child as to whether he or she has done something wrong or is an unworthy person (p. 207).

In some of our monthly sessions, we discussed this and found effective ways in which Mrs. S. could learn to calm herself down and in turn, soothe Raymond. She was assiduous in implementing any suggestions that came out of our meetings, and when she put those suggestions into practice, a very curious thing happened. She discovered that more than once in a while they actually worked. Raymond was now able to return to sleep, and so was she. Of course after that happened, it should come as no surprise that Mrs. S. would then become an ardent devotee of psychotherapy.

Preparing the Child for Psychotherapy

I have always felt that it is usually a good idea for a child to be prepped for coming to see "this strange doctor." So, before seeing Raymond, his

parents and I discussed what they would tell him in order to help him get ready to come to see me. I have said elsewhere (2011) that there is a significant downside of not doing so:

> When a child is not told why he is being taken somewhere, the potential for all kinds of fantasies to occur (some of which are not necessarily calming) may increase.

Admittedly, fantasies are an integral, and an indisputably fundamental facet of growing up. However, in some cases where the thoughts lend themselves to a misperception of reality, it might be prudent to further the cause of "reality" by simply explaining to the youngster the reason for the visit. The reason ought to be predicated upon, and consistent with the reasons the parents sought treatment for the child in the first place. That is, when the parents let their child know that they are concerned that he gets into "trouble" (I recommend spelling out exactly what is meant in simple language in a concerned, kind, and compassionate tone of voice), the stage is set for the beginning of his/her learning cause and effect in a compassionate context. Simultaneous with this, structure and constancy is subtly introduced in terms of setting up an appointment, with the same person, in the same place, each time.

When I see the child for the first time, I routinely follow up with the child and ask if s/he knows the reason for coming to see me, if s/he knows who I am, and what it is that I do (all of the things that I previously had discussed with the parents). Even a child as young as Raymond was when he first came to see me (6 years-old), can understand a global description given by his parents like, "we're taking you to Dr. Seitler who likes to help children who sometimes have problems in school." So long as the child is aware of the difficulties s/he is having in school (or elsewhere) it is much easier for the child to apprehend the rationale behind the parents' concern and his visit to the doctor. It gives him a chance to orient him/herself or build a "handle" onto which he can hold. In the latter regard, if it is at all possible, it is important that the child be helped to recognize that his being brought in to see "the doctor" is not a punishment, but an attempt to help him deal more effectively with what is bothering him.

Hope: A weapon, which works wonders when wielded wisely

Mr. and Mrs. S. took their "job" very seriously and were quite conscientious about properly carrying out their task of prepping Raymond for his first visit with me. They sat down with Raymond and explained to him that they were worried about him— because they could see from the way he behaved that something was upsetting him. They followed this by telling him that they had found someone with whom he could talk that would try to help him with whatever was upsetting him. Almost immediately after their conversation with Raymond, they called me to let me know that they had spoken with him and that everything was in place for me to meet and begin therapy with him. They added, that since their conversation, "he (Raymond) has been behaving like an angel." Sometimes the mere hope that things will get better helps improve things at least for a while, allowing for the real work to begin.

Initial Meeting with Raymond

Raymond came into my office accompanied by his mother, who introduced him to me. She assured Raymond that she would be in the waiting room until Raymond 's first meeting with me was over. Hesitantly, she then ushered him into my office. Raymond was a handsome-looking six-year old, who sported a full, thick head of shiny, auburn hair and a broad toothy grin. He appeared to be enthusiastic and at the same time wary about this novel situation into which he was entering. When Raymond came into my office, he looked up and down and back and forth, apparently in an effort to orient himself to this new circumstance, place, and person. He immediately told me that he wanted to make sure that his mother had remained and asked if he could leave the door open just a crack. Even before I could answer, he rapidly opened the door, stuck his head out, and checked to see if his mother was still in the waiting room. Even though Raymond saw that she was in the waiting room as promised, he still seemed to be somewhat restless throughout the session.

For much of our beginning relationship, Raymond needed to keep the door between my office and the waiting room slightly ajar, apparently to be certain that his mother would not disappear on him. While *his* separation anxieties were obvious, it became clear that they were also shared by his *mother*, who often insinuated herself into many of our sessions. On those occasions—which occurred mainly in the beginning phase of Raymond's overall treatment—I accommodated their mutual attachment needs and in fact, incorporated them into the therapy by making Mrs. S. into an instrumental part of the treatment interaction. During the times when she was present, I paid very close attention to what Raymond was like in relation to his mother, to me, and to both his mother and me. What he was doing, or saying, his facial appearance, what his posture was, or any clues that might help me understand what was going on inside of Raymond, all became grist for the mill. It invariably seemed as if Raymond's "connection," as it were, to his mother was somewhat ambivalent. On one hand, he clearly feared losing her, while on the other, it seemed as if he made every attempt he could to "break from her." While it is understandable why his basic needs for love, nurturing, food, shelter, clothing and protection required him to depend on his mother, it remained to be seen, as we proceeded, why he had what seemed like an equally intense need to disentangle himself from her.

Mrs. S. had positive attitudes about psychotherapy, which she seemed to convey to her son non-verbally. Ultimately, her trust for me transferred to Raymond and acted as a transitional object. As she grew more and more secure that her son would be safe being with me without her physical presence in the consulting room, she seemed to relax sufficiently and to feel comfortable enough to be able to separate from Raymond in our sessions. With my encouragement and assistance, she slowly weaned herself from attending the sessions. Correspondingly, over time, and as we began to understand what was underneath Raymond's overt behavior, the manifestations of Raymond's separation anxiety lessened. After approximately three months, Mrs. S. was generally able to entrust her son's safety to me and to remain in the waiting room. However, there still were occasions when she felt an urgent need

to enter the session. Usually, this was when something untoward occurred that she wanted me to know about. At such moments, it was not sufficient for Mrs. S. to merely call me on the phone; she needed to speak with me in person.

As an interesting aside, it is worth noting that as much as Mrs. S. had rebelled against and seemingly broken away from her traditional upbringing, in many ways, she was still a captive of a childhood that emphasized close family ties, and particularly intensive involvement with one's children. Given those cultural circumstances—combined with whatever intrapsychic events that were operating in Mrs. S.—it was not surprising, nor unusual for her to have made herself part of the treatment process. But it was not so much her wish to be helpful that was noteworthy; her motivation was a desirable quality, as much as the intensity of her insistence along with the existence and degree of her incursions that were problematic.

This illuminates Raymond and his mother's interactional and dynamic symbiotic enmeshment and behavioral reactivity to and with each other. Quite possibly, this was a remake of his mother's own family constellation, in which someone was perceived as the good object. In this case, it seemed to be me, or, at least Mrs. S.'s idealized version of me. I was the one who was given the role of a "favored Uncle" and who was granted the privileged and idealized position of reverence, respect, and authority. And, if it was so that I was the Uncle (or some other good object), then I became the one who wore the mantle of *the adult*. Accordingly, she may have unconsciously experienced herself as a child in relation to me, and so, if Raymond had been perceived by his mother as a transferential object associated with an important authority figure from her childhood, then she—via the process of transferential regression—unconsciously becomes the child in relation to her son as well, or, more properly, the object that he represented to her. Under those circumstances, where would that leave Raymond? To briefly reiterate, Raymond thus becomes the embodiment of a negative transferential figure of Mrs. S. when she was but a child.

More about Raymond

Although Raymond was constantly in motion, he was never intentionally malicious. Rather, he was often cheerful, gregarious, exuberant, and, of course, a very animated youngster. Just as Raymond was unable to sit still in class for stretches at a time, he also was motorically active and unable to remain in one place in our early sessions (i.e., moving from the chair, to the sofa, to the armchair, and then back again). Even when seated, his legs were constantly flailing about. His difficulty staying in one place was even seen when using some of the games in my office that he selected to play with me. Instead, he would get up, walk around the room, and either change where he sat, or return to his original spot. I quietly took note of this, but, reasoning that many people have probably called this "restless" behavior to his attention on innumerable previous occasions (probably in unkind or critical ways), I decided not to comment on this at first. I could always return to it if it recurred on a regular basis, but at a later time, when rapport was fully established and the therapeutic alliance was solidly in place.

Right at the outset, Raymond was given the time-honored three options that I typically offer to children. I told him that (1) we could talk, (2) we could play games, or (3) we could talk and play games. Much like many children with whom I have worked, he elected to talk and play games. "Talk therapy" is helpful for children, as well as adults, but children sometimes struggle with identifying and then naming what it is they are feeling. For them, playing is a powerful, but non-threatening means of dealing with—and safely expressing—their inner and outer emotional worlds.

Nemiroff and Annunziata (1990) understood this quite well when they stated, "sometimes kids play their feelings better than talk about them" (p. 29). Winnicott (1971) built conceptual bridges between the infant's early objects (the mother and the breast) and transitional phenomena (i.e., those things that are somehow related to and/or stand in place of the primary objects). Included in this are the infant's internal responses to these objects and subsequent behavior, which involves playing with objects. In that sense, the very act of playing, all by itself, becomes a transitional activity.

For Winnicott, play is not a trivial matter, but an essential process by

which the very action of the child learning to play enables mental life to proceed. Shakespeare also highlighted the importance of play. In, *As You Like It*, he affirmed how we are all players engaged in some form of play, plays, or playing, famously remarking:

> All the world's a stage. And all the men and women merely players; They have their exits and entrances. And one man in his time plays many parts (Act II, Scene VII).

To Play or Not to Play

Raymond was uncertain what to play with, and wound up going from item to item, quickly scanning each one before moving on to the next. Finally, he decided to play the "Candy Land™" game. We played this for a short while. When it no longer held his attention, he moved on to a different game. At first, he stayed with most games for only a short while, moving from one to the next with alacrity.

Although I typically provide children with a great deal of latitude, there is one thing that I uniformly insist on, albeit in a low-keyed manner. The way I work with each child is for both of us to play one game at a time. It is perfectly acceptable for the child to decide to discontinue a game at any time and for any reason. Nonetheless, before we move on to another game, my rule is that we close down and put away whatever we were working on. So, at those moments when Raymond started on another game, I would ask him if he was done with the one that was before us. If he said he was done, I would ask him to help put away that game, toy, and so on. Almost without exception, practically every child with whom I have ever worked has followed this regimen.

This is not simply an arbitrarily imposed condition for playing with the materials in the office; it is a subtle, yet integral part of the treatment. It helps the child develop and internalize a sense of structure; one built on uniform, unambiguous instructions, expectations, sameness, consistency, constancy, and boundary limits. As such, it helps children who either see or internally feel the world as chaotic develop a beginning sense of organization, efficacy, and security.

After the child assists in putting the games etc… away, I am openly grateful and consistently express my appreciation for their helpfulness in the clean up process. For those children who are so extremely chaotic that they are completely overwhelmed by the very prospect of *putting things back in order*, a different tactic must be employed. Fortunately, this was not the case with Raymond.

"Next Time"

Once in a while, a child will be so caught up in the game that s/he does not want the "inconvenience" of stopping when the session ends. When that occurs, I commiserate with the child by expressing the desire aloud, as follows: "This is so much fun, I wish we could do this forever." Then I add, "It's a good thing that we will be able to do this again next time." The idea of a "next time" organically builds in a means by which the child can develop the ability to delay gratification, as well the capacity for hope. As we have learned from the developmental psychological work of Sylvia Brody and Sidney Axelrad (1978), excessive indulgence—much like over-protectiveness, is frequently related to parental compensation for self-reproach—and often results in the failure to nourish the child's capacity to postpone and tolerate frustration, which may be very much akin to the parent's own inability to delay gratification.

Eventually, Raymond became more engrossed in some of the games for longer periods of time. Even so, he could be easily distracted by noises from the street or just random sounds. Whenever he heard even a minute, ambient hum, his reaction was almost catastrophic. "What was that!" he would declare. Fortunately, when I gave him an answer that made sense to him, such as, "that sounded like a train to me; there's one that comes to this town at this time every day," he was able to calm down. In fact, at subsequent sessions, when the "train sound" recurred, he was able to announce, "That's the train, right?" He thus asked for, received, was able to internalize reassurance, and ultimately, was able to settle himself down. By virtue of "knowing" more about his environment, he was able to feel safe.

A Revealing Riddle

Raymond had no problem however, finding ways to amuse himself. He was a very eager youngster, filled with verve and what seemed like very strong needs for interpersonal connection. So, when he lost interest in playing games, he merely talked, or became silly. Sometimes, he made up jokes. For example, he delighted himself with the following witty (and quite telling) riddle that he made up himself and which he returned to often over the course of therapy: "*What did the lonely boy eat*? Answer: *soul (sole) food*." This is but one example of how bright and exceptionally creative Raymond was; yet so very isolated and lonely. All Raymond wanted to do was join in social activities and play with other children. However, perhaps because he was too rough with them in his exuberance, after awhile, they tended to avoid him. Time and again, whenever he experienced rejection, his feelings were hurt, he felt sad, became frustrated, and then aggressive. This began a cycle of what I call his *intense sociability sequence*, whereby after practically forcing his way into group situations he was repeatedly greeted with reproach. Understandably, this did not always go over very well, leaving him feeling rejected yet again. In an obvious bid for recognition, he then acted the "class clown;" made goofy faces, and so on. This was usually met with further rebuke, which in turn, led to more impulsive activity on his part. On and on went the sequence. Each time, resulting in rebuff and his feeling dejected.

Compounding this, Raymond's ensuing impulsive behavior was then seen as disruptive by his classmates and teacher alike, often prompting his teacher (or other authority figures) to remind him to "control himself," or failing that, to punish him by removing him from interactions with other kids. It seemed as if everyone told him what *not* to do, but not what he *could do* with his feelings. Merely curbing his inner feelings was as inadequate a solution as it was an impossible task. Simply put, it neither addressed nor resolved the underlying problem. As Brody (2009) insightfully reminded us:

> A child's early discontents that are unrelieved may propel the young child to erect close-to-consciousness defenses such as

> avoiding, externalization, restriction, and some degrees of denial (p. 15).

She later added:

> Naturally, when the poor tolerance of frustration and related behaviors and affects are relieved in good time, development can proceed to an advancing of the child's capacity to develop an observing ego. Then he or she can see the need to settle partially internalized conflicts with mother and father, and to reduce fears of losing parental love (p. 24).

When Dreyfus Roared

Raymond had been in treatment for slightly over a year when he came into the session more agitated than I had seen him in a long time. He seemed to be overwrought with fear. Despite this, he tried to let me know as best as he could in words, what had happened to create such inner turmoil. His words came at me almost as rapidly as a hockey puck heading straight for the goalie. I tried hard to field what he was saying, but what he said came so fast that it did not make sense at first. But, as I allowed myself to listen with even hovering attention without trying to apprehend anything, it all started to come together. As opposed to translating what Raymond was telling me by using my cognitive faculties, I allowed my thoughts and feelings to wander wherever they might in order to get an experience-near intuitive "sense" of what Raymond was experiencing and trying to communicate. Instead of the words getting in the way, I saw them as the mere conveyance by which I could form inner images which then might help me on a gut level more than my intellect ever could hope to achieve, to fully appreciate and subsequently understand Raymond's inner experience.

He said, "I had a dream, a very very very bad dream. It was so bad that it scared me and I woke up and was afraid to go back to sleep. I said, it sounds like a nightmare. Nightmare's can be very scary." I asked, "Would you like to tell me about it, perhaps I can help? "It it it was very

scary. I'm afraid," he stammered. "I know something about scary dreams, especially nightmares. Would it scare you if you talk about it with me here?"

Although he was quite shaken, Raymond agreed to tell me his dream. He spoke of a lion, named Dreyfus, "All of a sudden," said Raymond, "this great big lion appeared out of nowhere. He was roaring so loud that I thought the whole house was going to break apart and fall down. Then, I saw something else. I'm not sure what to call it. It looked like a big animal, kinda like a deer with horns, but much much bigger, and dark. The two were face-to-face. Then Dreyfus roared real loud and the other animal just put its head down. I thought the two of them were gonna fight and that it would be terrible, but the other animal put its head down and slowly toddled away" (did he mean toddled or trotted, or both, I wondered to myself?). "Then only Dreyfus was left and I felt like—what will save me—if Dreyfus sees me all by myself? I was so scared, but I could not cry out because Dreyfus would hear me. Then I woke up."

When I asked him to tell me more about what he was going through, he said, "I feel scared and sad." As with the clever "riddle" that Raymond had devised, once again the mythic theme reappears, of being alone with his feelings; this time laden with the prospect of imminent danger emanating out of the potential for aggression. In his dream, Raymond depicts himself as all alone and left to his own resources. He was frozen with terror and depressed.

In this dream, we see an imagistic representation of the nucleus of Raymond's symptom constellation, which stands as a coherent explanation of his so-called ADHD. Without interpreting the whole dream, which would go beyond the space available for this chapter, let me provide a brief overview. In the dream, Raymond is frozen and unable to take flight, whereas in real life taking flight is precisely what he does in the face of things that upset him. In short, the dream architecture builds on a combination of his feelings of agitation and depression, which emerges behaviorally in waking life as excessive motoric discharge of Raymond's impulses.

Rather than specifically working to curb his impulses, they needed to be understood and respected as necessary coping devices for his survival

(flawed as they may have been). The object was not to take away Raymond's voice (i.e., his ability to cry out for help) or his ability to run away from perceived (or misperceived) danger. On the contrary, by encouraging Raymond to tell me his dream—in the safety of the consultation room—his feelings of inner agitation and sadness could be expressed, heard, worked through, and ultimately relieved. As part of the working through process, the aim was to help Raymond develop an observing ego, by which he could notice what he felt, and how he usually acted in reaction to those feelings, so that he could develop insight into, and subsequently modify his behavioral reactivity.

As time went on, Raymond's inner feelings slowly began to emerge and make themselves known verbally instead of motorically. Raymond increasingly improved his ability to move from action to conversation. As he became more and more aware of his inner turmoil, he became much more comfortable with, and adept at talking about his feelings, eventually learning to transform his reactions from action into observations, reflections, and conversation.

I Refuse to Cry

Flashing forward to one of our later sessions, Raymond revealed to me that he recalled crying a great deal as a young child, which is consistent with his mother and fathers' reports. He said, "I used to cry a lot, but now I never cry!" What struck me about this disclosure was the manner in which Raymond related this to me. Instead of figuratively "puffing up his chest" and proudly boasting of his achievement, his tone of voice seemed almost like a defiant refusal. When I asked him about never crying anymore, he vigorously insisted, "I will never cry again!" I asked him "how come?" What he said in reply greatly surprised me. "If I cried, and nobody cared I just wouldn't know what to do. I would feel all by myself like nobody loved me and I would be scared to death." "Just like in that dream you once told me, about Dreyfus?" Raymond looked up at me, almost quizzically, as if taken aback by the fact that someone had paid serious attention to him, to his words, and had regarded them as valuable and remembered them, and what is more, actually understood

what he was saying, what he probably had been unable to say ever before. He teared up momentarily, but quickly wiped the moisture away from his eyes… "I guess you're not used to being listened to, except when you're angry or screaming, huh? His answer said it all. He replied, "nobody *ever* heard me if I wasn't mad! Then they heard me a lot, but I would be in big trouble. Great." "How *great* was it?" "Not very," came his reply. "First I would get scolded. Then punished. Then I would have to listen to a really long lecture about how I was upsetting the family and how much they sacrificed for me, and blah blah blah, you know." "I'm guessing that didn't make you feel all that terrific about yourself either." "I felt crummy." "I bet." "I mean, they would be fighting constantly, and that's okay, but if *I* make a commotion, it's the end of the world!" "Just doesn't seem fair does it," I said. "No, I hate it!" At the end of the session, I asked Raymond how he was feeling now? He said, "I feel much better now, thank you." "No thanks necessary. Your feelings are very important. I'm glad we have this chance to talk with each other, and that talking helps."

Doc, Are You There?

Once, a session I normally have just before Raymond's ran about 10 minutes overtime. Raymond told me that when his session was supposed to start, I was nowhere in sight, he pressed his ear to my door. However, (because my office is sound-proofed), he heard only silence. He concluded that I was not there and that I had abandoned him. When I *finally* stepped out and brought Raymond into my office, he was not relieved. On the contrary, he was both sad and furious with me. "Why did you leave me, he loudly bellowed?" I knew that when Raymond felt furious, it was because he was filled with fear. In response to him, I neither retaliated nor recoiled. Rather, I sat with him until his emotional storm subsided. And when he had calmed down, I asked him if he wanted to talk about it? If he said "no," I was prepared to accept that he was not up to it just yet, and I would have reassured him that "it's sometimes difficult to talk about painful things and that we will talk when he was able to."

Fortuitously, he had accumulated enough ego strength (or desperation) to discuss his feelings. He did not seem to hold anything back. He verbally pummeled me with his anger about having been deserted by me, and how I was the one person who he always counted on, and now I too had let him down! Possibly for the first time in his life he was able to express his feelings openly, particularly his anger, without the fear (and actuality) of retaliation. Instead, his anger was validated and listened to respectfully, without defensiveness or turning the blame back on him, as had so often been the case in his life. I said, "how scary it must have been for you when you didn't hear any sound coming out of my office. No wonder you thought I was not there. Anyone would have come to that conclusion. I can see why you were so upset and disappointed. It was very important for you to see me. After finally learning to trust me, I was nowhere to be found. How could I leave you like that? What's wrong with me?"

At our next session, Raymond seemed a bit fearful for some reason. I asked him about it, but he was hesitant about responding. I wondered aloud if his unease was at all related to our previous session. He paused for a second, apparently unsure if he should reveal what he was feeling and thinking. I followed up by asking if he was worried? "He said, "yes," but did not continue. I reviewed the last session and said, "You were very angry with me. Is it possible that you are worried that I might get back at you?" "He said, a little bit." As we talked more and more about this, he disclosed that most people get mad at him very easily to begin with, and if he ever dared to *speak the truth to power*, so to speak, then he would dearly have to pay for it—either in the form of reproach, rebuke, or rejection. This was a terribly high price for any human being to pay, particularly a sensitive, vulnerable youngster. "How do you feel now that you told me this?" I asked. "I feel much better. I guess I should have known you wouldn't yell at me. You never have." I answered, I'm glad you told me. When two people are able to talk with each other about feelings, and listen to each other the way we do, there's usually a much better chance to work things out."

Ultimately, it came down to having patience and being able to work collaboratively with each other. Raymond and I had many conversations

about the feelings he might have had on a number of occasions that were associated with waiting, having to postpone gratification, tolerate frustration, or endure suspense. My intent was to create an atmosphere for Raymond to feel safe and comfortable enough to be able to freely express his feelings or thoughts. He continued to learn how to speak up for himself in a manner that did not escalate the level of anger or precipitate a subsequent retaliation.

What was an interesting aftermath of this conversation is that at no point did Raymond act "wild," "out of control," "hyperactive" or even a little bit "agitated," all the descriptions that had been assigned to him prior to therapy. Instead, he was able to focus, think clearly, and formulate and describe what he was feeling inside, all in a reasonable, and even touching manner.

Before he was able to learn the *fine art of mutual, back and forth communication*, he had made himself known in a very loud, passionate, and unreserved manner. Now Raymond was starting to substitute speaking for acting, and in particular, speaking about his feelings. Instead of suppressing his inner urges, the emphasis on my part was to help him sublimate his energy into activities that would be meaningful, as well as enjoyable for Raymond. I felt that the more inter-relational dialogue we had, the better it would be for Raymond to be able to transform his action-orientation into a medium involving verbal exchange.

Over Time

The good news is that when a child is able to receive and remain in psychotherapy, we are blessed with having an opportunity to effect positive growth. Over time, and with hard work, the possibility increases decidedly for us to be able to form a relational connection, which then will enable us to collaboratively work at discerning whatever patterns might emerge and allow us to figure them out together. It is when this occurs, that significant changes often take place.

We invested considerable time and energy in our work together. And, it was over time that Raymond eventually discovered that my office was not the only place where he could get a fair hearing and that I

was not the only person in the world who would be interested in or care about him. Where before, his social and emotional worlds had become severely constricted, now they were noticeably expanding. As Raymond learned to delay gratification, tolerate frustration, and modulate his impulses, he became less "needy" and less desperate about making—and keeping—friends and less intense in his relating to his friends. Raymond's gregarious, but not overdone, newly developed "nature" was now becoming a valuable asset to him, where before, the intensity and extent of his enthusiasm substantially contributed to his undoing.

ADHD's Neurobiochemical Etiology: "*It Ain't Necessarily So*"

Before the term "Attention Deficit Hyperactive Disorder" (ADHD) was invented, a number of names preceded it, such as "minimal brain damage," "minimal brain dysfunction," "minimal cerebral dysfunction," "minimal cerebral insult," "hyperkinesis," until the present time and current nomenclature of ADHD became in vogue (Seitler, 2008b, 2006a). All these different designations beg the question: if the creators of the DSMs and ICDs got it right the first time, why was there such a need for so many revisions?

As Gershwin wrote, in Porgy and Bess (1935):

> It ain't necessarily so
> It ain't necessarily so
> The t'ings dat yo' li'ble
> To read in de Bible,
> It ain't necessarily so.

In this case, the holy bibles are the multiple versions of the DSMs and ICDs, and the words of their prophets, who have repeatedly preached that ADHD has a neurobiochemical etiological origin. This raises a dilemma, one that is somewhat reminiscent of sophistry, both in terms of the illogical manner in which their claims are proffered as well as the veracity of their assertions.

For those who contend that ADHD has a neurological basis, the reasoning goes as follows: Although we see no hard neurological signs, ADHD *must be* neurological in origin because the behavior that it produces is behavior that is associated with neurological impairment, and thus, it could not be otherwise. Moreover, the behavior that we see in ADHD children had to have its origin in a child's faulty neurological makeup; otherwise it would not take place. This verbal slight of hand is an example of the logical fallacy of *circular reasoning*. If my father had said it, there would have been a twinkle in his eyes and it would have been a tongue-in-cheek statement.

Those in the biochemical camp claim that ADHD is the result of a biochemical imbalance. They rest their speculations on the fact that children labeled as ADHD "respond" to stimulant drugs. What they fail to explain, much less acknowledge, is the fact that non-ADHD children and adults respond similarly to stimulant drugs.

Unlike my father, the proponents of the neurological and the biochemical propositions are dead serious and absolutistic about their physical emphasis and reductionistic stance, even though there is no consistent evidence—that has withstood the test of time or replication—to support their conjectures. And, it is mainly because their position stresses the physical that they are married to a physiological solution, namely, the prescribing and administration of drugs.

The case of Raymond is not the only child that I have treated over several decades that has been labeled as ADHD (or any of the preceding labels that were once used). Like the others, he was treated successfully by means of psychodynamic psychotherapy, all without the use of medication.

As the case of Raymond readily reveals, a neurobiochemical substrate for ADHD is not a necessary explanation and thus is less relevant than we have been told. Moreover, what is significant is that medication was not essential in this case or any of the other cases that I have treated, that psychoanalytically informed psychotherapy can be successful in effecting change with youngsters labeled as ADHD, and, ultimately, it is the relationship that seems to be paramount in producing the conditions for nurturing transformative growth. Something that I wrote before, best summarizes my findings:

> Practically all of the ADHD kids with whom I have worked have harbored a hidden inner sadness, which came out as hyperactivity. It is my view that the hyperactivity stemmed from sad feelings that were "bottled up" inside and which inexorably were expressed by the "court of last resort," the body—in the form of agitation and excessive motoric activity. (2011, p. 128).

And it is neither an accident nor is it a coincidence that soon after the sadness was gently revealed and carefully and patiently worked through, symptoms of Raymond's so-called ADHD faded away.

As an act of faith and courage (perhaps borne of desperation) on Raymond's part, I was granted the right of entry to Raymond's inner feelings of terror and depression. Along with such a privilege, comes the responsibility to handle such feelings delicately and with respect. Raymond needed (as all children do) to be treated as an individual rather than a diagnostic "entity." In addition, treating the feelings of a human being must be custom-fitted to each child's unique specifications. Therefore, formulaic manualized treatment approaches or medications will not effectively or safely be able to do more than suppress symptoms over time—if that. One (treatment) size cannot fit each individual's unique makeup and needs.

Concluding Statement

Summing up, it is important to ask what was instrumental in making Raymond's treatment successful? Again, I maintain that it was our relationship that made it work, our hard-earned trust and faith in each other (and in the process) that it would all turn out all right, along with painstaking, patient forbearance and working through Raymond's feelings of abandonment, sadness, and fear.

Ultimately, successful psychoanalytically oriented psychotherapy with Raymond renders the dual myths of organicity and biochemical imbalance causalities to be interesting, but irrelevant explanations and raises serious questions about whether stimulants are effective or even a safe modality for treating those children whose behavior is troublesome for adults.

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