



## **A social relational critique of the biomedical definition and treatment of ADHD; ethical practical and political implications**

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Attention deficit hyperactivity disorder (ADHD), its existence and treatment, is a contentious matter. The dominant view in medicine considers that ADHD is a psychiatric disorder. My position is to challenge this from a social relational orientation. I explore here a critique of the psychiatric disease model of causation and treatment, particularly the use of medication. A series of prejudices based on a political and social constructionist orientation are offered to address the ethics, politics and practice implications of the practitioner critical of the biomedical model of diagnosis and treatment especially the use of medication. This device is employed in order to invite critical reflection and further debate in a field dominated by the medical and genetic arguments in support of ADHD as a psychiatric disease. The implications of more open debate are explored, together with directions for more politically and ethically informed practice with children and their families.

*Keywords:* ADHD; systemic therapy; family therapy; ethical and political considerations.

People cannot reconsider their prejudices when they feel they are under threat. Gianfranco Cecchin (1994)

### **Introduction: owning one's prejudices**

Tolerance of another's perspective can be uncomfortable, especially if I consider their views to be fundamentally flawed. Yet, if my personal prejudices or revered preferences are fuelled by arrogance, they will ruin the possibility for creative dialogue (Cecchin *et al.*, 1994). There is also a tendency for tolerance to slide towards compliance and compliance towards capitulation.

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Attention deficit hyperactivity disorder (ADHD) is a subject in which opinion about causality and treatment brings with it ethical, political and practical implications to do with the exercise of power in therapeutic practice. Here, I wish to offer a social constructionist critique of the medical definition and treatment of ADHD. I intend this as an invitation or respectful provocation to further debate with colleagues and fellow professionals since our beliefs and prejudices about ADHD have direct effects on practice with children and families. The article makes a call for a more open dialogue to contribute to the 'constructive processes of meaning making in the face of difference' (Gergen 2001, p. 196).

Open dialogue requires a difference in viewpoints to be creative, and while not all differences can be reconciled, they can educate. In the process of writing and inviting feedback on earlier drafts from colleagues in different settings, I have found my stand becoming both more substantiated and also more enriched by the sensitivities of colleagues who take a different view from mine (see acknowledgements).

According to the late Tom Andersen (1993), 'A prejudice is composed of different kinds of knowledge that come from the culture and tradition we live in and from experiences we collect over time in our lives' (p. 303). It is my hope that prejudice couched in these terms will offer a way to explore our own assumptions and beliefs about where we stand in relation to ADHD. To start with, I briefly outline the thrust of the argument that ADHD is a psychiatric disorder.

### **The idea of ADHD as a discovery**

There are many publications outside the field of family therapy offering copious evidence in support of ADHD as an expression of brain dysfunction (Barkley, 2005, 2006a, 2006b; Barkley and Murphy, 2006; Barkley *et al.*, 2010; Fonagy *et al.*, 2002) and genetic in origin (Williams *et al.*, 2010, 2011). Everett and Everett (1999) represent a body of opinion in family therapy that unequivocally supports the idea of ADHD as a dysfunction of the brain. They offer clear practice protocols based on detailed assessment and treatment methods. Since the condition is seen as neuro-physiological in origin, its roots lie in the genetic pool of a sufferer's family. The argument follows that the condition has been around for generations but was only relatively recently discovered. According to this argument, the pervasiveness of ADHD was only fully appreciated in

recent years when professionals discovered how to look for it. Symptoms appear in clusters in a 'diversity of cultural and racial backgrounds' (1999, p. 11) and comorbid conditions will often mask underlying ADHD. While no specific neurological causation has, as yet, been clearly identified, proponents of this causal model argue that 'there is a clear genetic transmission factor in most cases' (1999, p. 20).

Family therapy, from this perspective, does not consider psychosocial factors to be directly involved in causality. Rather, the emphasis is on the repercussions caused by ADHD on family life (Carr and Nolan, 2000; Fonagy *et al.*, 2002). The 'disease' can be found in children younger than 2 years of age whose behaviour is difficult and unmanageable. Therapy is focused centrally on managing ADHD, which is seen as a condition that can be ameliorated but not cured:

the most dramatic step in expanding the clinical understanding occurred with the recognition that ADHD can occur in children and adults in which the classic symptoms of hyperactivity are either less prominent or nonexistent while the symptoms of inattentiveness continue to be present. (Everett and Everett 1999, p. 13)

This broader definition of ADHD (including sub-types), made in 1980, allowed a wider range of children's behaviour to be included. In other words, widening the road of criteria allowed a greater flow of symptomatic traffic in the direction of ADHD. The general view is that ADHD can be considered on a continuum from less to more severe symptoms.

Given the psychiatric disease frame of causality, treatment options include stimulant medication, particularly methylphenidate, commonly known as Ritalin. The supporters of drug treatment use the analogy of wearing spectacles to correct eye dysfunction – the drug being the equivalent of eyeglasses to redress an inherent deficit. Although the drugs rectify much problematic functioning, this approach also advocates parent training programmes and impulse control methods for the ADHD client (Fonagy *et al.*, 2002).

### **Beyond a psychiatric formulation: from discovery to invention**

The following series of prejudices set out the ethical, political and practical implications for practitioners who are, at best, sceptical about the medicalization of the cluster of behaviour expressed by children and defined as ADHD. I use the term prejudice (Cecchin

*et al.*, 1994) to suggest that my own opinions are themselves predicated on arguments that confirm my beliefs in support of a social orientation. However, prejudices creatively employed should also leave room for doubt about the certainty of one's position. I therefore return later to the question of open dialogue, its possibilities and limitations.

*A prejudice about prejudices: it is impossible to work without them*

Few opinions are founded on rational argument alone. Preferred theories, approaches and choice of orientation are shaped by passionate beliefs and ideologies as much as, if not more than, objective argument. Our actions are wrapped in our professional identities, and to be challenged on our ways of thinking and acting can be felt as an attack. It is precisely because the diagnosis of ADHD is contentious that challenge can strike at the heart of principles for understanding the meaning of children's behaviour.

We choose a therapeutic orientation that fits ethically and politically with our personal experience (Jensen 2007). It feels right as if the approach we are attracted to has also chosen us. Colleagues with beliefs different to my own will muster arguments and research findings to support the use of diagnosis and drug prescription because their professional, and perhaps personal, experience indicates that this is a justifiable course of action. As a consequence, discussing the meaning of, and response to the idea of ADHD can become an emotive and personal matter, not a matter of objective debate at all.

On the wider stage of therapy and psychiatric treatment, views on the existence of ADHD can come to symbolize a battle between core premises about the construction of psychological problems in general: the medical model versus a contextual model (Read *et al.*, 2004; Wampold, 2001); a paternalistic-medical approach, versus an autonomy-promoting approach (Bentall, 2003, 2009); psychiatric drug treatment as means of controlling differences and 'stifling' children's creativity (Timimi, 2009). Winnicott (1986) saw troubled behaviour as hopeful communication, not signs of individual dysfunction.

I acknowledge such passions and convictions when talking of the possibility for open dialogue and set out below the following considerations as prejudices to redress the imbalance of the popular argument that behaviour called ADHD is adequately explained as a psychiatric disease.

*Prejudice one: don't restrict yourself to the microscope when you can lift your eyes to the mountains*

As a geology student many years ago I spent fascinated hours looking through a microscope analysing the fine geometric shapes and beautifully refracted colours of thin slices of rock in a science laboratory. It told me much about the origins and composition of the specimen but it needed field trips to see the rock formations and the wide landscape they had moulded over time. With ADHD geneticists have kept their heads down and assumed that the study of genomes is like the study of hard rock, instead of the ever-moving landscape of human relations. A search for genetic explanations only marginalizes a social relational field despite the interconnectedness of brain function and relational emotional environment.

R.D.'s provocative statement that 'a medical scientific perspective applied to human matters, helps us 'to see what is going on about as much as dark glasses in an already darkened room' (1969, p. 5) points to the unlikelihood that an assessment can be objective. The typical process of defining a complaint by taking a history, making an examination, defining a diagnosis and then prescribing a treatment is a well-worn sequence in the mental health professions. It fails, however, to take sufficient account that when we meet the other we join a chorus of voices and ideas that in turn affect our participation in the ongoing diagnostic process. Colleagues who, like me, support a social constructionist orientation invite multiple perspectives and try to celebrate different points of view. In support of this position, a social diagnosis can be offered (Laing, 1969) but this social orientation creates particular ethical and practical challenges for all professionals.

*Prejudice two: to diagnose social relational problems in medical terms is to dodge important ethical matters*

This section is concerned mainly with the ethical implications of a social constructionist critique of ADHD but, first, I mention major ethical concerns for all practitioners.

*A cursory or wrong diagnosis.* Ethical considerations fall into two categories depending on the core assumptions of the practitioner. For all practitioners, including those who subscribe to the neurological dysfunction theory, ethical considerations address injustice about a superficial or cursory diagnosis, inattention to the side effects of drug

treatment and inappropriate or short-term support and short-sighted practice restricted to managing symptoms. Ethical concerns may include situations where consultations are overly brief and with or without the child being present, where discussions are restricted to talk of repeat drug prescription and where there is an absence of concern about environmental and relational features. In short, the practitioner cuts corners in the guidelines for the assessment and treatment of ADHD.

If we reject the assumptions of the neurological model we are required to challenge both its supposed truth and certainty and the resulting practices that are built on its shaky foundations. Seen from within this frame, ADHD is a medical construction of a condition that has no neurological origin warranting medication. It categorizes a range of behaviour to fit a contrived definition of neurological dysfunction. As the case for the brain dysfunction hypothesis remains unproven, ethical dilemmas arise about the duty to 'do no harm'. To contradict the medical view challenges the supremacy of the medical model when a patient presents with behaviour that fit the DSM-IV (American Psychiatric Association, 2000) criteria. In this critical view, the diagnosis presents an illusion of certainty and as a consequence the prescription of drug treatment is a wrongful use of medication.

*Living with contradictions.* Practitioners may choose to comply with a regime of treatment whose validity they may privately doubt but feel compelled to support for other reasons, such as facing desperate parents, long waiting lists and staff shortages, or trying to convince themselves that, for pragmatic reasons, the diagnosis may bring financial benefits to the family, relieve stress and open the door to other resources like extra educational provision.

The temptation may be to silence one's disagreement with colleagues in positions of power and with a perceived expertise greater than one's own. Some colleagues, who remain sceptical about the medical basis for ADHD compromise by seeing drug treatment as a strategic concession to gain access to further treatment and practical resources for their clients.

*The problem with not challenging the dominant medical discourse.* A monopoly only serves to impoverish the creativity of an organization such as a child and adolescent mental health service. One way of assessing the health of such organizations is to look at their capacity to represent the different perspectives of colleagues in order to enrich professional

dialogue for the benefit of children and families. What is the cost to professional relationships if dominant views about ADHD close down alternatives? If disagreement is not safe to express, should the dissenting professional remain silent and stand aside even if convinced that the course of medical treatment suggested offends their moral judgement? What if such a practitioner becomes aware that colleagues are trying to convince parents of the merits of diagnosis and the benefits of medical treatment? What if she sees colleagues lose focus on other more pressing family matters because the medical talk of ADHD stifles other topics of concern?

We each take a stand even if the stand is not to take a stand. Since my basic position is to value the importance of co-operation between my colleagues and myself, this position organizes my starting point for facing such ethical considerations, especially where I hold strong opinions about the need for a social diagnosis. In collegial relationships there may be overlapping social or personal intimacies, rivalries, alliances and informal peer support, all of which shape what is said, how and to whom. The community of my colleagues will have an influence on my behaviour, including my ways of challenging the views of others. My position within a formal hierarchy, my perceived power to influence others, my expertise and experience will all play their part in contributing to how I talk with others and how they may respond to me. I may disagree with a colleague in one forum but not disagree about the same issue with my client, at least, not in the same way. Useful dialogue is made possible by attending to the limits and opportunities apparent in different contexts of conversation, including embedded beliefs about the meaning of disagreement in professional matters such as ADHD. All is context-dependent and since professional relationships are infused with passionate beliefs and prejudices, it is not easy to separate the argument from the person making it, despite a desire to do so.

The heart of the argument is not intrinsically against medicine, psychiatrists and psychiatry as a profession. It is about upholding professional ethics and influencing how informed decisions are reached. Disagreement about medicating children for ADHD is not intended as an assault on psychiatry but an appeal to a deep and shared disquiet about the growing trend towards medicating children unnecessarily.

A relationally responsible position (Mason 2005) leads the sceptical practitioner to challenge the medical definition of ADHD without resorting to defensiveness or aggression. A more open and

challenging dialogue between professionals depends on how successfully practitioners establish and maintain a context of sufficient intimacy and mutually respectful professional relationships. I need to maintain a fine line between hearing the other's opinion and not relinquishing my own. During this process the following questions may emerge: what if my attempt to appreciate the other's point of view leads me to silence my own argument for fear of offending the dignity of the other? What if I appear to speak, not just a different professional dialect but a different language that is incompatible with the language of those who believe ADHD is a psychiatric disease? What if the brain dysfunction theory is proposed as the only truth by my colleagues? If these contingencies prove true we are back in the land where a social diagnosis has been unilaterally deposed by medical certainty.

How can I remain true to my practice principles of questioning ADHD brain dysfunction discourse while also embracing multiple perspectives? How may I not break my own rules and perform my values in practice?

These are the questions I have to ask myself before proposing a counter argument. One possibility is to entertain ideas from transdisciplinary practice.<sup>1</sup> Soren Hertz, Danish psychiatrist (in press) refers to research on transdisciplinarity (Montuori, 2005) that 'focuses on the creativity that emerges out of the interaction of multiple perspectives, that is, moving beyond the contradiction of biology and psychosocial issues' (pers. com., 2010). The brain develops in response to the socio-relational environment and is especially responsive during the first year of life (Balbernie, 2011; Siegel 1999). Here the false dichotomy of biology versus environment dissolves and we are once again in the realm of both/and (Bateson, 1978). Hertz proposes moving beyond compromise and instead towards differing positions in a third way described as

[l]eaving the dichotomy towards a new way of meeting these children by seeing the problem behaviour as ... the way they have understood their lives ... and an invitation to adults among them to create a pattern where faith and confidence in mutual understanding and mutual interaction can grow. (Hertz, pers. com. 2010)

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<sup>1</sup> Transdisciplinarity is an elusive concept that is used to counter both the fragmentation of the (academic) disciplines into more or less isolated disciplines and the professionalization of disciplines in order to preserve and maintain disciplinary standards or purity. For a fuller definition and exploration see Montuori (2005).



In support of this position, Gergen (2009) promotes the idea of enriching dialogue between different disciplines in attempts to explore means of dissolving conflict, where mutuality can be encouraged and the 'promise of shared meaning' evoked (2009, p.193). But who can and should take the initiative to facilitate such democratic forms of dialogue? And who will create the spaces within organizations and practice frameworks for the provocative and potentially creative conversations to occur?

Here we return to the exercise of influence within structured power relations. Campbell and Groenbaek (2006) acknowledge that their model of semantic polarities in the reciprocity of taking positions in an organization must take account of the exercise of power:

Certain decisions are made over others. Power is the ability to maintain a position and for that position to be influential in the way other positions are taken and maintained. (Campbell and Groenbaek, 2006, p. 44)

The risk is that, within a close collegial context, to take the position that 'ADHD is a construction and drugs are bad' tends to invite others to either sign up or oppose. Dialogue, at this local level, is stifled. Creating a setting where multiple perspectives are invited requires the presence of a therapist or consultant who is well enough placed in the organization to be allowed to question certainties, listen to and observe openings in the not too unusual differences between participants and help establish a safe enough context for creative dialogue to flower. This can be a delicate endeavour and is not always possible. When it seems that all roads are blocked for creative dialogue the sceptical practitioner has to change the context in order to influence debate. The argument against ADHD as a medical condition requiring medication then needs to be taken to a broader political arena.

### *Prejudice three: therapy needs to be located in a wider political context*

The commodification of healthcare raises further ethical concerns about the propaganda promoted by drug companies in support of the neurological dysfunction theory. If the diagnosis is an invention, the promotion of drug treatment becomes a cynical profit-making enterprise aimed at manufacturing a demand and increasing the company's profit. Prolific publications in cognitive-based approaches, mentalization approaches (Verheugt-Pleiter *et al.*, 2008) and certain specialist authors, particularly Barkley (2006a, 2006b) promote the notion that ADHD is a neurological condition in books, newsletters,

website advertising, DVDs and training programmes. The growth of ADHD as a psychiatric commodity has solid financial support from the pharmacology industry (Newnes and Radcliff, 2005) and is not sufficiently challenged by National Institute for Health and Clinical Excellence guidelines (2008). While these advise against the use of drug treatment for children aged younger than 5-years old and for its use only as a last resort for older children, practitioners say there are many exceptions to this advice. As guidelines do not carry the weight of a statutory requirement their effect can be limited.

The availability of other approaches may be sadly lacking, so that medication as a last resort may be all that is available. It appears that the number of children on drug treatment in the UK soared between 1998 and 2004, prescriptions almost doubling (Newnes and Radcliffe, 2005). The diagnosis of ADHD is growing and is having serious deleterious effects on children and families, particularly as the long-term effects of drug treatment are as yet not fully understood (Whitaker 2010).

A shift towards a more politically informed arena for debate ensures that the sceptical practitioner will have a wider forum for expression and influence. For example, the Association for Family Therapy has taken initiatives to address mental health matters in political, public and professional contexts. Family therapy education also plays a part in influencing the attitudes and beliefs of the wider community of professional towards more contextual perspectives. The Taos Institute and pressure groups such as the International Society for the Psychological Treatments of the Schizophrenias and other Psychoses, and the recently formed Open Network for Dialogical Practices and Mind, argue the case for mental health matters to be much more grounded in contextual models. These organizations stimulate a widely informed debate and aim to influence social and political policies that affect the culture of mental health practices.

Redressing the balance by arguing forcefully for a social orientation to ADHD is not the type of neutrality that argues 'on the one hand and on the other'. It is aimed at countering an already strong imbalance in the ways mental illnesses are being defined and spread in Western societies (Read *et al.*, 2004). The less this imbalance is corrected the more the mental health ship will list and sink in the sea of psychiatric certainty.

The broader theme, of which the ADHD discussion is a part, is the trend towards the pathologizing of daily distress and the individuation of this distress that excludes the relevance of communal

and relational resources and contributory features in families and social networks (Seikkula 2007, Watters, 2010). The practicality of creating communities of engaged participants requires an attitude of exploration and initiative in the political arena of mental health organizations, not just in therapeutic consultations with clients or debates locally between colleagues in the same team (Gergen, 2001).

Shorter, (as cited in Watters, 2010) proposes that cultures possess a symptom repertoire for the physical expression of conflicts deemed to be psychological. In this light the growth in diagnosing ADHD may not just spread a treatment modality; it is also part of a self-fulfilling cultural language. Professional and practitioner beliefs shape the possibilities of practice.

Now I point to some practice principles in family therapy that are informed by the ethical and political considerations sketched above. These can help maintain practitioners' curiosity and the possibility of working with patients who have bought into the idea that ADHD is a psychiatric illness.

*Prejudice four: ethical practice involves the craft of doing what is possible*

How do ethical considerations affect practice when meeting family members with different views on the diagnosis of ADHD? What options are possible for therapists, like me, faced with clients who hold strong views in support of the brain dysfunction theory?

*Example one: the certain soldier.* One father said to me in an initial consultation, 'ADHD is 95 per cent genetic!' He responded with interest when I asked for his views about the 5 per cent that was not. My question provided him with an opportunity to consider a slightly different emphasis in our conversation. While it stimulated his curiosity, the question also challenged the safe certainty of his conviction (Mason, 1993). What created this response in our work together?

There are many possible explanations as to why this particular man allowed himself to entertain the possibility I suggested as a focus. He was a firm believer in authoritarian parenting methods and had many worries about his child's disobedience towards him. He had been in the army and expected his children to obey his instructions. When they did not he felt angry, disempowered and ignored. When he spoke of being ignored it seemed to carry a heavy weight of regret and sadness in addition to anger. I asked him, 'Is it more that you are furious at your instructions not being followed, or that you feel

ignored by your daughter?’ Without hesitation he said it was not being listened to. I then asked, ‘Was there another time in your life when you felt you were not listened to?’ ‘Yes ‘said the ex- soldier, ‘when my father committed suicide when I was 12. I have not felt listened to since’.

This stopped me in my tracks and led to the father and me, together with my male co-therapist, suggesting a fathers’ group of the three of us to discuss how hard it can be to bring up children, especially when the role of fathers is changing and we do not have role models any more.

A shift in conversation can lead to more creative options for practice. Noticing the special weight given to words like ‘feeling ignored’ suggest a new and more useful avenue to explore. The therapist responds to the emotion in the client’s words of complaint. Anger born of frustration, feelings of sadness and a longing to know what to do as a father all seemed present in this man’s statement about being ignored.

While I disagreed with the father’s assertion, I needed to find a way to keep the conversation open. Showing one’s doubt directly may be worthy but not useful if it results in the patient’s withdrawal from dialogue. Instead, it is better to bide one’s time. Only when I try to grasp the systemic logic in the other’s position can I appreciate how best to challenge and provoke new possibilities. Fortunately, it is rare for all family members to have the same watertight certainty that ADHD is a brain dysfunction.

*Example two: where possible, talk about the ‘marriage’ to a diagnostic label. Some therapists feel uncomfortable when their clients are convinced that the genetic, biomedical diagnosis of ADHD is true. Options for challenging certainties can emerge if one follows the idea that being ‘married’ to a diagnosis can feel very important and getting a ‘divorce’ can be extremely painful. Marriage to the ADHD diagnosis can close initiatives for change, leaving the family dwelling in a state of fixed certainty: ‘This is how it is, and always will be’.*

Talking about a diagnosis can also be the beginning of a useful conversation. As with the authoritarian soldier father, this requires the therapist to broaden the focus from talk about ADHD, which often seems tired and repetitive, and instead inject talk of family life in all its resourcefulness, possibilities and tensions. This appreciative orientation towards family life enriches talk and can inspire therapist and family to look at life beyond ADHD. Introducing the metaphor that

ADHD is a wave, sometimes strong as white horses, at others quiet and still offers an image of a more dynamic view where time, place and circumstance all influence the ADHD behaviour.

One family talked of their son George's behaviour becoming increasingly problematic after his younger brother was hospitalized. The parents explained that George had thought he had caused his brother's serious illness, at which point the ADHD got worse. Through a careful exploration of the child's feelings of guilt and with reassurance from his parents, George's ADHD seemed to diminish. Looking for alternatives, emphasizing family and individual resources drew the conversation away from seeing ADHD as a fixed state towards seeing it as a process that is relationally situated. Too much emphasis on repeat prescriptions, parent training and behavioural management may stop other more creative discussions and options from being explored. The key is to move towards a sense of agency over the alleged symptoms of ADHD (Timimi 2007, 2009, Timimi and Leo, 2009).

*Example three: search for the resources within a social orientation.* Ash is 12-years old and folds his body over a chair like a part open penknife. I talk with his mother and stepfather. I am trying to create a safe enough context to begin our talks but the atmosphere is aggressively loud and chaotic. Ash interrupts his sister and brother, unfolds from his penknife posture and sharply challenges his stepfather when he tries to talk. I become a therapist referee trying to manage the session and hear everyone's point of view. However, out of the corner of my eye I notice a glimmer of interest from Ash. He looks up at me when he thinks I cannot see him. He responds to my attempts to tease him into conversation and I have the feeling he wants me to keep trying to make a connection with him. It is as if he is playing with his role as the unmanageable person who would like somebody to take charge and begin to see beyond his 'ADHD' behaviour; the designation offered in the referral.

So began a year of meeting this child, the members of his family and related professionals. Instead of pursuing a medical diagnosis, a social way of working emerged. The themes discussed and the problems solved were to do with their life as a step family, the relevant past experiences of his parents, the threat of the ex-husband's stalking of Ash's mother and past violence from the mother's ex-partner. The most urgent topics; the current troubles and conflicts between Ash and his siblings and their struggles to find better ways of living

together, shaped the way we worked. This was a family with multiple stresses in a community with many social problems. There were occasions when desperation stoked the desire to fix him. At these times his mother thought drugs would help him (and her). At one level this boy showed all the hallmarks of a case of ADHD, yet the therapy created between the participants and the shape it took followed no ADHD protocol or medical treatment. We worked in the realm of possibility and what worked for them. The therapy was a creative improvisation by all participants. We developed a way of meeting that suited the clients' expectations and my abilities to join with them. The rest was dependent on maintaining that central connection of commitment in our joint expertise: the therapist's dedication to exploration and expanding the conversation, which often results in a gradual shift in the client's internalized beliefs about ADHD as a brain dysfunction. Methods that promote a contextual model all lend a hand in deconstructing ADHD as a fixed internal state. For example, foster carers living with children diagnosed with ADHD regularly report on the beneficial changes in children's behaviour by living an ordinary life in a different and helpful substitute family. ADHD disappears.

*Example four: when stuck, go wide.* The emergence of a creative community of colleagues can take time but it pays dividends in efficiency. While working with one 8-year-old boy who had been expelled from school and had attacked a paediatrician and other women, I learned that he and the two taxi drivers taking him to his new school had established a good rapport. He was now happy to travel to school so long as the taxi drivers met him in the morning. At the next consultation of family and professionals the taxi drivers were invited. Thus a wider definition of a 'significant system' was facilitated that made our communal endeavours somehow more solid and connected. These colleagues participated in a joint exploration that created an atmosphere of co-operation where professionals were encouraged to talk more openly about their own learning from each other and family members. This form of reflexive consultation stopped tendencies to objectify the child and family, or create them as passive recipients of the professionals' services. The family members' experience of the joint endeavour led to a renewed trust in service providers who, according to the child's mother, 'promised the world but didn't deliver'.

When, as in this example, family members stop talking specifically about ADHD they may still continue with the view that their child is

different or special but ADHD in capitals is gradually replaced by *adhd* and may even disappear as a label altogether.

When internal attributions are no longer considered to be the cause of one's behaviour there is no reason to treat children exhibiting the behaviour of ADHD in different ways from others in therapy. However, given the growing beliefs in the existence of ADHD, exploring family members' idea of the diagnosis is important. This raises both practical and ethical question about who has the right to define what is the matter and how to try to bring the young person's views onto the stage.

*Example five: seek the young person's perspective on diagnosis.* Some young people subscribe wholeheartedly to medication and programmes about impulse control. These are considered useful and necessary conditions of ongoing treatment. Some welcome medication to assist them in living their lives with ADHD; they are concerned to maintain treatment to help support them in their future life. They have internalized ADHD as a part of them, rather than apart from them.

For others, it is not so clear. Where a diagnosis has been made but not explained to the child his protest is neither possible nor invited. If the therapist's aim is to embrace the complex vicissitudes of the child's life then this includes the child's attitudes to professional helpers and their views on what is the matter. Here the ethical concern is to avoid oversimplification, closing down engagement by airbrushing out the gritty texture in the picture of the child's life.

In contemporary practice few enquire about children's own understanding of ADHD. As Brady, (2005, p. 49) states, 'An overwhelming emphasis on biomedical individualized explanations may negatively influence the developing self-identity of children'. Children may internalize this definition, decreasing their sense of their own influence over their behaviour. Brady asserts that some children may also feel slightly unreal while on medication, sensing that the 'real me' is the 'me' who is not on medication. Children with what is called ADHD need therapists who are willing to look for creative connections that allow the child or young person to feel that they are being attended to as a human being and not an expression of a genetic brain dysfunction. This is a political stance as much as a practical one (Wilson 2008). Here, the invitation is to melt the apparent ice-cold certainty that ADHD is a problem of the brain. Unsurprisingly, children designated with ADHD are often reluctant to see a therapist. These examples do not exclude any other form of practice negotiated with clients to help

with their child's 'busy-ness'. It is quite simply a matter of finding creative and resourceful means to find therapeutic connections with children and their families (Wilson 1998, 2005, 2007); ways that do not require a psychiatric diagnosis or drugs to help.

### **Owning my prejudices revisited**

In the process of composing this article I sent earlier drafts to colleagues in psychiatry, psychology, family therapy and social work. Their critical and thought-provoking responses made me aware of my rhetorical style, my prejudices towards a social model and the effect of my passionate views in provoking or revealing oppositions and criticisms that could have closed down the debate. But my colleagues did not back off and their persistence and creative disagreement fired the writing all the more. This is generative dialogue in action. I revisited my prejudices with an ear to critical thinking that has allowed more room for the appreciation of radical differences of opinion and the tolerance of some. This dialogue had the effect, not of changing my mind, but of opening my mind up so I appreciate the logic of others' views. The possibilities that flow from this include:

1. An awareness of the sensitivity felt by some colleagues when my criticism failed to take account of their compassion and the logic that supported their diagnosis and the medication they prescribed. Sometimes medication can help in the short term to make unmanageable children better able to be worked with. This sentiment is expressed by colleagues in the teaching profession, based on their ideas and experience of how to help some previously unreachable and uncontrollable children. Within the constraints of current educational policy this argument is understandable. At the same time one has to pose the question whether drugs are inadvertently being used to control a child instead of seeking a richer and responsive educational environment.
2. An appreciation that the use of diagnosis can sometimes be the beginning of a therapeutic process, not necessarily the deadening of therapeutic possibilities. 'The way a diagnosis is incorporated into personal and family narratives [is useful to explore]. It is important, therefore, to track a diagnosis, as it were investigating its orienting powers' (Bryce, 2004, pers. com.) This argument also speaks to the relief that parents feel when someone recognizes that their child is different and special.



Yet the problem remains when this specialness is awarded with a psychiatric condition and where medication confers a medical meaning on matters that may either not require such a diagnosis or risk creating a fixed identity of pathology. The cautious (strategic) use of a diagnosis may prove effective in engaging the child and family in therapy, while privately acknowledging that the consequences of using a diagnosis can adversely affect a child's identity. However, I remain deeply concerned about this strategic use of diagnosis to engage a family in therapy as

[w]hen words are spoken in the open they become extremely powerful. A fantasy or a fiction may start to exist as a fact in time if it is talked about long enough.

(Andersen, 1998, p. 76)

3. A shift towards an appreciation of how transdisciplinary approaches go some way to offset the either/or nature of disagreement I have been outlining. But this also raises questions about who makes decisions about a child's presentation in a psychiatric or paediatric assessment and this, as I have argued, raises questions, not only of disciplinarity, but of the power and the politics of relationships within the culture of mental health services more generally.

## **Conclusion**

Given the current state of debate about ADHD or *adhd* I wonder if we will look back in 10 or 15 years and be appalled by our ignorance or our complicity in failing to dispel the mirage of certainty about the purely neurological and individual basis of ADHD and its treatment as a medical condition? Will we see that the belief that ADHD is a dysfunction of the individual's brain has the same condemnatory effect as did labelling homosexuals as mentally ill, fifty years ago? The brain dysfunction hypothesis is problematic when seen only as a genetic, fixed state nurtured by professionals cocooning ADHD in a quasi-scientific explanation (Bentall, 2003).

Talking about ADHD raises questions about ethical practice, political awareness and action. It is necessary to try to co-operate with the views of others to appreciate and understand the logic of the other's argument. However, there are limits to co-operation and an appreciation of the logic of argument. Kindness, self-criticism and an appreciation of the other's opinion also need to be allied to the careful exercise of power in order to create the conditions for useful change

(Phillips and Taylor, 2009). To try to explain the complexity of a child's experience by describing him only in behavioural categories that fit a diagnosis of ADHD is to risk taking out the colour from the picture of the child's life. In practice those who do have the power to describe and define marginalise other views. An alternative approach, favoured by this author, is to refuse to name the other as an object with a prescribed diagnostic identity. This is a social orientation informed by the politics of practice. A circular argument – he behaves this way because he has ADHD and ADHD makes him behave this way – is unacceptable because it is illogical when social realities and family troubles are staring us in the face. Yet, if debate is to continue, the many different voices of clients and colleagues, from advocate to opponent, deserve to be heard. Staying silent about ethical concerns can only risk collusion and continuing contradictions between our beliefs and our actions. Since the debate already exists within and between professionals there is merit in contributing further to ways of putting ethics into practice. This is especially so with ADHD, where children are powerless in the decision-making process about what is the matter with them and where their views demand expression. If mental health professionals settle for the supremacy of a medical definition of ADHD, the psychosocial context is relegated to a secondary form of treatment. To comply with a biomedical approach that one disagrees with creates a form of dissonance between one's practice and one's beliefs about more useful and ethically appropriate ways of working therapeutically with children and their families.

As for those children considered different or special, the ADHD label points them towards a medical treatment that, in effect, drugs their specialness into submission instead of finding ways to accommodate, support and humanize practice with them. All of us have a duty to consider the ethical cost of failing to challenge features of practice detrimental to the psychological well-being of children. To mistreat by missing possibilities of exploring a child's context will leave everyone involved impoverished. If therapy is indeed a process of humanization then the challenge is to ensure this ethical position is not eroded through a lack of debate about ADHD and the children behind the diagnosis.

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