FOREWORD

Martha Burge's book is a useful response to the recent "epidemic" of attention deficit disorder. When we published DSM-IV in 1994, the rate in children was just a bit more than 3 percent. Now, it has almost tripled to a remarkable 10 percent. The diagnosis of ADD has also exploded in adults, with rates jumping from under 2 percent to as much as 5 percent. And this diagnostic inflation is not just a local United States phenomenon; it is happening simultaneously in all the developed countries around the world.

Ms. Burge offers a strategy she hopes may help cure the "epidemic" of ADD. She warns us to stop medicalizing what is often basically normal behavior and to stop over-treating with unnecessary and potentially harmful medication. She offers an alternative approach for dealing with the "myth" of ADD that accepts and accommodates the human variability it represents, rather than pathologizing and treating as illness all hyperactivity, impulsivity, and distractability.

Let's first explore the causes of the ADD "epidemic"—this will help us understand how best to contain it. A small part of the growth in ADD rates was a predictable result of changes we made in its DSM-IV definition. Previous definitions required hyperactivity, impulsivity, and inattentiveness. We recognized that some people with ADD (particularly females) have clinically significant inattentiveness, but without the hyperactivity or impulsivity. Our field testing

predicted that allowing for this in our DSM-IV definition would increase rates of ADD by about 15 percent.

But none of us working on DSM-IV imagined there would be a tripling of rates in so short a period of time. We weren't psychic and had no way of predicting the other two events that soon completely changed the ADD landscape. Shortly after DSM-IV was published, new and expensive on-patent ADHD drugs were approved for marketing by the Food and Drug Administration. The previous generic drugs were so cheap and unprofitable that drug companies didn't bother to push their sales. Now, with potential blockbusters in hand, they had powerful financial incentives to aggressively extend their market by promoting the diagnosis of ADD and encouraging its medication treatment.

And, almost simultaneously (for unrelated reasons), the FDA deregulated some of its control over drug company marketing. It gave Big Pharma permission to advertise its pills not only to doctors but also directly to consumers. Soon, the companies were mounting expensive and ubiquitous promotional campaigns in print media and on TV and the Internet. Total marketing budgets grew from an already hefty $791 million in 1999 to an astounding $4.8 billion in 2006. A small but significant fraction of this consisted of a highly successful marketing campaign to convince psychiatrists, pediatricians, family practitioners, parents, patients, and teachers that ADD was under-recognized and under-treated. ADD became a fashionable fad diagnosis and drug sales took off—from $304 million in 1994; to $658 million in 1999; to $2.11 billion by 2003.

Ms. Burge correctly worries that the drug companies have succeeded in their campaign to re-label as mental disorder what is often just a normal variation in behavior. As a consequence, the use of ADD drugs has doubled, so that almost 5 percent of our children are now receiving a pill for it (with an even higher percentage among boys). Loose diagnosis and careless prescription bring questionable

benefit but accrue considerable costs and risks. Although medication clearly helps in the short term, its long-term benefits are unclear. Often there are side effects (like insomnia and decreased appetite), and the long-term risks (especially for kids with their developing brains) are unknown. Inaccurate diagnosis may unleash stigma and cause a reduced sense of self-control. And then there is the serious problem of the secondary market for diverted stimulant drugs. Illegal stimulant use for recreation and performance enhancement already occurs in up to 10 percent of high schoolers and up to 35 percent of college students.

DSM-5, a new revision of the diagnostic system, is scheduled to appear in May, 2013. Unfortunately, it will markedly increase the current diagnostic inflation and open the floodgates to even greater overmedication. The DSM-5 redefinition of ADD further reduces diagnostic thresholds and makes it even easier for kids, and especially for adults, to be misdiagnosed and over-treated. I see absolutely no justification for this further expansion of an already bloated diagnosis. Unless there is a huge public outcry or government intervention, DSM-5 will blow up the ADD bubble even further.

Many people make the false assumption that the experts working on DSM-5 must be expanding the diagnosis of ADD because they are in bed with the drug companies and want to help them sell pills by expanding the market of potential customers. I strongly disagree. The DSM-5 experts have an intellectual, but not a financial, conflict of interest. They are making very bad decisions, but for pure motives. Experts tend to overvalue their pet diagnosis, worry about missed cases, underestimate the risks of over-diagnosis, and ignore that ADD is often diagnosed carelessly—especially in primary care settings by rushed practitioners who are much less expert than they. DSM-5 will be a great boon to drug company sales and profits—but that will be a side effect of DSM-5, not its intent.

Martha Burge cures the worrisome ADD "epidemic" by turning ADD instead into a "myth." She correctly points out that symptoms of hyperactivity, impulsivity, and inattention are very common in the general population—really no more than part of the Bell curve distribution of individual difference. ADD is not a clearly defined illness diagnosable with an objective, biological test. There is no bright line delineating where to draw the boundary between normality and disorder. Burge considers ADD to be a harmful myth that errs by seeing the glass half empty. She presents a contrasting half-full perspective that celebrates the emotional intensity and breadth of attention that is currently mislabeled ADD: "With a greater range of attention we are never inattentive; we are always taking in more than others."

Burge decries the ADD "myth" as a medicalization of emotional intensity. She would prefer we accommodate human difference, rather than explain it away as an ill to be casually treated with a pill. Burge normalizes what the DSM pathologizes. She recommends that we not be preoccupied with the limitations and impairments that come with ADD. Instead, Burge focuses on the benefits inherent in an ADD lifestyle, and suggests ways to enhance them further and to limit and cope with the concomitant difficulties.

Readers will feel engaged, understood, and inspired and will find a wealth of practical tips and useful information. Ms. Burge uses her experience and wisdom to turn what may have seemed like problems into opportunities for growth and discovery. Her style is lively, accessible, vivid, and intimate. For many people diagnosed with mild or nonexistent ADD, her techniques may be an effective way to a better life and may reduce or eliminate the need for medication.

I agree with much of Burge's approach and think it is a useful deterrent to diagnostic inflation and pill pushing. But she and I do have a definite parting of the ways. Burge describes ADD as harmful "myth." I see it more as an overdone fad. We both agree that ADD

is currently being wildly overdiagnosed, but Burge would get rid of it altogether, while I endorse ADD as a useful diagnosis when cautiously and correctly applied to the small percentage of people at the far extreme of the Bell curve in their hyperactivity, impulsivity, and inattention. ADD should be diagnosed when the problems have started in early childhood; are severe, persistent, and classic in presentation; and cause unremitting and unacceptable impairment at school and at home. In these extreme cases, a diagnosis of ADD makes sense, and—when nothing else has worked—medication is often useful, and sometimes absolutely necessary.

So, I agree with Burge that a good deal of the current ADD hoopla is "myth," and I applaud her methods for dispelling it. But I think she goes too far in altogether denying the existence of ADD and in dismissing the sometimes essential role of medication. This is the perfect book for the many with mild or nonexistent ("mythic") ADD, but it may be misleading for the few with severe and classic ADD that has not been managed sufficiently without medication. Everyone should try the techniques taught by Ms. Burge, but we shouldn't expect they will always be enough by themselves to get the job done. And people shouldn't feel like failures if they don't work. Medicine should not be a casually overused first line intervention, but it is nice to have in reserve when other interventions like the ones suggested here are not enough.

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This book is intended to be an informational guide and is not meant to treat, diagnose, or prescribe. Always consult with a qualified health care professional regarding any medical condition or symptoms. Neither the author nor the publisher accepts any responsibility for your health or how you choose to use the information contained in this book.

A NOTE TO READERS

Other people may have told you there's something wrong with you. They may have said you are damaged and labeled you disordered. But what if that is not true? This book reveals the underlying condition responsible for many misdiagnoses of mental disorder, particularly ADD. It explains both the symptoms that often result in a diagnosis and the reasons for the complexity of your character. It's not too late for you.

INTRODUCTION

This is a place where you are welcomed,
where people big and small who save insects from the pool are cherished,
where your next big idea is taken seriously and supported with a whole heart,
and where the curiosity that leads you to obsess on something for hours or days on end is understood and no one will mention the stack of mail on the desk.
Welcome to a world where dancing, pacing, and chattering are to be expected,
where it's understood that the next great project is all consuming, as it should be,
where even your quickness to anger is met with understanding of the frustration behind it,
and the underlying dissatisfaction with all that is wrong in the world, which strikes your moral outrage and sometimes leaves you feeling powerless, can be set aside for a short while.
Here the strength and beauty of your spirit is valued,
deep frustrations that keep you awake at night are soothed,
and you are free to share your naturally sensitive, creative, gifted, and unique soul in a safe place.

Those that would say that you are too sensitive, too emotional, too active, or too different are banned.
Welcome to a place where you can finally relax and be yourself, where the weight of matters beyond your control is lifted, and you can play again.
You are my people, and I am honored to have you here.

There is a strangeness about certain people that fascinates me. I can recognize it very quickly now by the spark in a person's eye, a certain determined quickness in the gait, or the lovely flowing way a conversation can get carried away and lead down uncharted paths. Whenever I meet this type of person, my heart quickens. They are my people. I didn't have a name for them until my firstborn child was diagnosed with ADHD.

As I started to write about the unique qualities of these people I had come to call "intense," I found that while it sounds a lot like ADHD, it's so much richer. There is a deep sensitivity, a fullness of experience, a capacity for fantasy and creativity, and an intellectual curiosity that seems to define them so much more than the one-sided, negative descriptions found for ADHD do. At that time I had identified intellectual, emotional, and creative intensity. I read everything I could find on the subject of intensity and stumbled upon Dr. Kazimierz Dabrowski. This man had already spent a lifetime on this very same path. He used different terms both for the perceived disorder and the underlying condition, but his perspective was identical to mine. His work has allowed me to progress in my work as if he had personally held out a hand and pulled me up.

I blended his work with my own and others'. When it began to come together into a single cohesive approach, I felt that something special had emerged. As I shared it with my coaching clients, they said it was the missing piece.

The realization that the true condition of those often diagnosed with ADHD is intensity was a bittersweet epiphany. I wish I had known this when my children were young. I wish I'd had a clue about it when I was young. There were so many missed opportunities and so many times when I felt, as you may have felt, too different and in many ways not good enough. Now I'm grateful to be able to share the truth and a path out of disorder with others, and I hope that it may make as profound a difference in their lives. I've found that intensity, when nurtured, is the greatest asset a person can have if they want to achieve really big things, bring about change, or create new and exciting possibilities.

You'll notice that while I use the more commonly recognized term "ADD" (attention deficit disorder) in the title, I use the correct term "ADHD" (attention deficit/hyperactivity disorder) throughout the rest of the book. It's a technicality, but I don't want it to confuse anyone. The term "ADD" was only used by the DSM (*Diagnostic and Statistical Manual of Mental Disorders*) from 1980 to 1987.

This book is organized and clearly labeled so that you can get the information you want when you want it. You have my permission (not that you need it) to read this book in any way that works for you. To that end I include summaries of the main points for the impatient at the end of each chapter. Feel free to hit the high points and move on or dally in the stories and details for a deeper understanding. The practices to develop each of the intensities are designed to culminate in an understanding of how to use your intensities to achieve whatever you want in life.

1

There Is No Such Thing as ADHD

The hardest part about gaining any new idea is sweeping out the false idea occupying that niche. As long as that niche is occupied, evidence and proof and logical demonstration get nowhere. But once the niche is emptied of the wrong idea that has been filling it—once you can honestly say, "I don't know," then it becomes possible to get at the truth.

—Robert A. Heinlein, The Cat Who Walks Through Walls

I know I have very few standing beside me in my stance that there is no such thing as ADHD. The vast majority of psychiatrists, psychologists, educators, parents, and others believe at their core that ADHD is truly a disorder. I'm not anticipating that this little book will change their minds. The ideas they have are well substantiated by years of practice and documentation. The longer these ideas exist, the more valid they appear.

I contend that while perhaps well-meaning, this description of intense people as having a disorder is a farce. Millions of people have been taken in by it, and most of them believe that their participation in the farce is in the best interest of their patients, their children, and

themselves. It is with great conviction that I tell you that labeling these people as disordered not only is an error, but also contributes to creating the dis-ease it intends to treat by withholding the understanding and development of their true intense and gifted nature.

THE DSM AND A CULTURE OF DISORDER

ADHD began as a construct in someone's mind. Psychiatrists see mental disorders or potential signs of mental disorder in every patient that presents to them. The very fact that a person goes to see a psychiatrist means that the psychiatrist must find a diagnosis in order to bill for the visit. It's a reward system. Find a diagnosis, get paid. It's that simple. The possible diagnoses are found in the DSM, which is created by consensus of a group of people who regularly get together and publish a book. This book contains descriptions of every mental disorder. By definition, if a condition is in the book, it's a disorder; if it's not in the book, it's normal. You can see how important this one book is to the way we see ourselves in this culture.

The DSM is sometimes treated like the Bible of the psychiatric profession. It states its primary purpose is to provide a guide for clinical practice in diagnosing psychiatric disorders. Because we are forever learning about disorders, the DSM goes through a continual review process, resulting in new versions being published every few years. The DSM-5 is scheduled to be released in May 2013.

As happens with manuals like this one, people who use it tend to anoint it with powers beyond its intent. It is sometimes seen to define the entirety of mental health and disorder. Common sense tells us that there is no way a single reference book can include all the information needed to identify every type of mental disorder that exists within the human population. We can also guess that with such a broad scope, there is at least a possibility that the criteria supplied

could be used to indicate disorder within what should be healthy human differences. But the glow around the book continues.

Before the first printing of the DSM, little had been done to categorize mental disorders. Each mental hospital had its own system. The federal government was interested in collecting statistics on mental disorders, but the lack of a unified system to categorize these disorders made the effort impossible. As a result, the American Psychiatric Association (APA) took on the challenge to produce a system that could be used nationwide. The first printing of the DSM was based on input from both mental hospitals and the Department of Veterans Affairs. Considering the sources, there wasn't much emphasis on childhood disorders or development.

In 1966 Dr. Samuel Clements wrote an article on minimal brain dysfunction in which he describes a number of learning or behavioral disabilities found in children with average to above-average intelligence. He identified the effect on motor activity and attention span. The label "minimal brain dysfunction" likely resulted from the fact that he believed the cause of these disabilities to be minor damage to the brain stem. This may have been the first formally accepted description of ADHD, although it has been recognized in one form or another by mental health professionals for at least a century.

By the time DSM-II was printed in 1968, the label had been adjusted to "hyperkinetic reaction of childhood or adolescence" with a one-line description: "This disorder is characterized by overactivity, restlessness, distractibility, and short attention span, especially in young children; the behavior usually diminishes in adolescence." This change reflects the APA's efforts to avoid labeling a disorder according to the cause of the disorder, mostly because they knew they were only guessing at the cause. There was no evidence of differences in brain structure or functioning. By this time, Ritalin was already in use to treat hyperactivity.

MEDICATION GOES IN SEARCH OF PATIENTS

Once there was a description of ADHD as a mental disorder and a pharmaceutical treatment option available, the disorder seemed to go in search of patients. This practice is very different than the treatment of any other type of mental disorder. In the case of paranoia or schizophrenia, the patients bring themselves to the doctor for treatment. ADHD goes in search of patients, much like many newly discovered and much-advertised physical ailments such as restless legs syndrome. "Ask your doctor!" It should be no surprise that the pharmaceutical companies are paying for those ads. But are they also funding ADHD awareness?

Medication for ADHD is a multibillion-dollar industry. It's clear that the pharmaceutical companies have a lot to gain from an increase in diagnosis. It's also becoming clear that they have the resources to influence the outcome.

In 1987 CHADD (Children and Adults with ADHD) was founded to support people with ADHD. According to a transcript from *PBS NewsHour*'s Merrow Report, CHADD was funded by Ciba-Geigy, secretly receiving almost $800,000 between 1991 and 1994.[1] I've been involved with CHADD for years. I still am, and this hit me like a ton of bricks. The CHADD website states:

> CHADD was founded in 1987 by a small group of parents of children with AD/HD and two treating psychologists in Plantation, Florida (near Miami). These parents came together because they felt frustrated and isolated, and there were few places to turn for support and information about AD/HD.[2]

However, they also state that pharmaceutical donations received by CHADD as of June 30, 2009, included support from Eli Lilly, McNeil, Novartis, and Shire US. This constitutes 39.5 percent of CHADD's total revenue, or about $1.5 million, in 2009. This fact

by itself is not as troublesome as the fact that these arrangements were kept secret for so long.

The use of stimulant medication to treat ADHD in children in the United States has grown from 2.4 percent in 1996 to 3.5 percent in 2008. That's a half million more children on drugs.[3] The drug is introduced to parents as a safe treatment plan. Indeed it's not very hard to find supporting articles and studies showing that taking stimulants under a doctor's supervision for treatment of ADHD is safe. But the very same people will also tell you that stimulants are deadly. The list of potential serious side effects of stimulant use contains paranoia, anxiety, depression, tachycardia (increased heart rate), dizziness, high blood pressure, increased sweating, decrease in appetite, sleeplessness, and more. One side effect usually attributed to consistent abuse or a serious overdose is amphetamine psychosis. This is similar to the symptoms of schizophrenia. Vivid auditory hallucinations and paranoid delusions are caused by the brain's fear center being overstimulated. This couldn't happen when the drug is prescribed by a doctor and administered as directed, right? Wrong! My son was only ten years old when he began to experience auditory hallucinations while taking a prescribed stimulant for treatment of ADHD. There are other stories about children taking medication for ADHD as prescribed and under a doctor's care that have had even more serious side effects, including death.[4]

I'm not one of those antidrug advocates. I believe in better living through chemistry; it's just that this should be done with a solid understanding of the risks. Drugs should be used only when there are no other options. To prescribe such strong psychotropic drugs to children for an illness that cannot be proven seems irresponsible, particularly if the intent of the prescription is only to improve performance in school.

There's no question that the pharmaceutical companies that manufacture the medications used to treat ADHD stand to ben-

efit from an increase in prevalence. The only remaining question is how much misinformation has been distributed and what part drug manufacturers are playing in today's increase in ADHD diagnosis.

WHY SCHOOLS AND PARENTS SEEK DIAGNOSIS

The symptoms in the diagnostic criteria for ADHD fall into three categories of behavior: inattention, hyperactivity, and impulsivity. The chart below shows the symptoms matched with what the implied "normal" behavior should be.

INATTENTION

	Symptom	*Normal*
(a)	Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities	Pays close attention to details and rarely makes careless mistakes
(b)	Often has difficulty sustaining attention in tasks or play activities	Sustains attention in tasks
(c)	Often does not seem to listen when spoken to directly	Listens when spoken to directly
(d)	Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)	Follows through on instructions and finishes schoolwork, chores, etc. without reminders
(e)	Often has difficulty organizing tasks and activities	Has no difficulty organizing tasks and activities

	Symptom	*Normal*
(f)	Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)	Enjoys engaging in tasks that require sustained mental effort
(g)	Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)	Rarely loses things
(h)	Is often easily distracted by extraneous stimuli	Is not distracted by extraneous stimuli (maintains focus on an activity not of their own choosing regardless of extraneous stimuli unless directed to change focus by someone in a position of authority)
(i)	Is often forgetful in daily activities	Is not forgetful

HYPERACTIVITY

	Symptom	*Normal*
(a)	Often fidgets with hands or feet or squirms in seat	Sits still for extended time
(b)	Often leaves seat in classroom or in other situations in which remaining seated is expected	Remains seated in classroom as expected

(continues)

(continued)

	Symptom	*Normal*
(c)	Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)	Sits still
(d)	Often has difficulty playing or engaging in leisure activities quietly	Engages in leisure activities quietly
(e)	Is often "on the go" or often acts as if "driven by a motor"	Normal activity level is low to medium
(f)	Often talks excessively	Talks when appropriate

IMPULSIVITY

	Symptom	*Normal*
(g)	Often blurts out answers before questions have been completed	Waits for questions to be completed before answering
(h)	Often has difficulty awaiting turn	Waits his or her turn
(i)	Often interrupts or intrudes on others (e.g., butts into conversations or games)	Waits to be invited into conversations and games

Based on the expectations of "normal," what does this sound like to you? It may just be me, but this sounds like a schoolteacher's dream student. This "normal" child sits still for extended periods of time, speaks when spoken to, is patient, and doesn't lose or forget things. The "normal" child is even quiet when engaging in leisure activities. The best part of this for the teacher is that this "normal" child maintains focus on anything they are directed to do until they are directed to do something else.

It's no wonder that ADHD is usually diagnosed at age seven and a half. By this time the child has entered second grade, and the expectations are set. Teachers typically have thirty or more students in a classroom and a lot of material to cover. That would be possible if every student fit the description above of "normal." So the kids that are the furthest from this idealized description of the perfect student are singled out as being the problem. It seems that there is no attempt to question the system that expects young children to sit still and study attentively all day, every day.

The teacher, wanting to help the child who is not in step with the good students in the class, indicates to an administrator or a parent that this child may have a disorder. This is usually done in a formalized meeting around a table full of teachers, school counselors, and administrators. It can be pretty intimidating. The parent or parents are bombarded with tales of the child's problem behaviors, missing assignments, and other proof that there is indeed a problem. A suggestion is made that perhaps it isn't bad parenting. Perhaps there is a medical explanation. The parents usually agree that the child should see a doctor as soon as possible. They are then assured that once the child has a diagnosis, the school will be much more able to help the child.

Many of us can see something of ourselves in the list of symptoms used to diagnose ADHD. However, the criteria are more stringent than that. A diagnosis of ADHD must be based on more than just a

list of behaviors. The condition must also cause impairment in two or more settings such as home and school. Since the DSM doesn't offer a definition of "impairment," we'll fall back on this definition found online at *www.thefreedictionary.com* as a point of reference:

> Impairment: The condition of being unable to perform as a consequence of physical or mental unfitness; "reading disability"; "hearing impairment"

Based on the requirement of impairment in two or more settings, it's easy to see why ADHD has traditionally been considered a childhood disorder. The impairments are usually related to expectations of behavior and performance in school. Since schools are dealing with so many children in a single classroom, they simply work better when all the children are on the same program and no one child requires greater-than-average attention. When school activities come home in the form of homework, the impairment comes home, too. Once we're no longer students, the "disorder" seems to go away. But did the underlying condition really go away? Was a side benefit of graduation a cure from ADHD?

Let's say, for example, that a man with ADHD is impaired at home and at work. At home the impairment is related to paying bills on time. The task is boring and so he puts it off and the bills stack up. Then one day he discovers online bill pay. Since he enjoys his computer, the task is quick and easy, and he now pays his bills on time. Since the impairment no longer exists at home, is he cured?

Another criterion required for a diagnosis is "clinically significant impairment" in social, academic, or occupational functioning. The DSM doesn't provide a definition of clinically significant impairment, but it is safe to assume that "clinically significant" is being used in comparison to "statistically significant." For example, a 5-point difference in IQ may be statistically significant in a study, but it wouldn't be considered clinically significant since we wouldn't

expect a 5-point difference in IQ to have a profound effect on functioning. Clinical significance requires subjective judgment on which "impairments" are important and which are not. While one person may consider an impairment clinically significant, another with the same level of functioning may disagree on the level of impairment.

It seems unlikely that a true disorder would be cured or eliminated by online bill pay or graduation from school. It is also troublesome to have a disorder defined by a subjective measure of impairment, particularly if the impairment is related to a situation that is temporary. I propose that the underlying condition is still there, but the negative aspects of some of the traits only surface under certain conditions.

NOT ALL DISTRESS OR DIFFERENCE IS MENTAL DISORDER

These people, my people, are different. They do experience some distress and they are impaired in some situations. That does not equal mental disorder. Stephanie Tolan has a beautiful story called "Is It a Cheetah?" which can be found on her website *www.stephanietolan.com*. In the story she uses the cheetah as a metaphor for children with different abilities. She explains acts of lashing out or empty-eyed staring as expressions of frustration, comparing them to a cheetah in captivity throwing itself at the bars of its cage or giving up. She compares the cheetah cage at a zoo to the classroom. This environment doesn't give them the opportunity to show what they are really capable of, so they are not recognized as special, gifted students, and they may be misunderstood as not really trying or even disabled. If this sounds a lot like ADHD, you are beginning to see the light.

There are statistically significant differences that aren't considered disorders such as giftedness. On the scale of intelligence, the bottom 2 percent are considered mentally retarded and therefore

subject to a diagnosis of mental disorder. However, the top 2 percent are considered mentally gifted and not subject to a diagnosis of mental disorder. The difference between the two is the expected outcome. Mental retardation is expected to produce less-than-desirable outcomes while giftedness is expected to produce better-than-average outcomes.

It's understandable that intense people would be under consideration as disordered when viewed by people looking for mental disorder. They are different. But, as we see in the example of mentally gifted persons, different doesn't necessarily mean disordered.

Neurodiversity

A new concept of neurodiversity proposes that differences in neurological development in humans is just as important to the health of the human race as biodiversity is to the health of an ecosystem. Neurodiversity takes into account differences in the way different people process information including sound, textures, light, images, and even movement. Although the concept of neurodiversity is associated with a particular view of autism, it applies as well to intensity.

Differences in the way the senses take in information and the way that information is processed in the brain and nervous system make certain types of people better able to adapt to certain environments. The typical school environment is well suited for nonintense people. A preference for convergent or linear thinking (thinking in a straight line with only one possible right answer) makes schools an uncomfortable place for the divergent or nonlinear-thinking brain (spontaneous, free-flowing, and capable of holding many possible solutions) so common in intense people. In this way the values of the society, which control the values in the environment, end up being the determining factor in whether an intense type of neurology is considered a disorder or a gift. Most of our society is congruent with

the value system found in the schools; however, there are some pretty important areas where a more intense neurology is a huge advantage. Those who are successful in those areas, such as entrepreneurs, CEOs, inventors, and artists, are likely to be intense.

Asynchronous Development

Hidden behind the concept of impairment is a concept of normal development. Someone who doesn't display the same level of development as their peers in a particular area may be considered impaired, but this view doesn't take asynchronous development into consideration. Asynchronous development is uneven development of intellectual, physical, and/or emotional abilities. The measure of normal development is based on what the average child is capable of at a certain age. A normal five-year-old has a certain range of intellectual, emotional, and physical abilities. An intellectually gifted five-year-old is more likely to perform above grade level intellectually. Gifted children are also more likely to be out of sync in emotional and physical development. A gifted five-year-old may be performing at the intellectual level of a seven-year-old, the physical level of a five-year-old, and the emotional level of a three-year-old. The traditional definition of "gifted" focuses on intelligence and measures of IQ. While the traditional definition of gifted doesn't cover all types of giftedness we now recognize, such as creative genius, the characteristic of asynchronous development still seems to apply.

I look at it like the developmental timelines I see in different species. A puppy takes a week or two to begin walking and can be weaned onto solid food at six to eight weeks. A human takes about a year to begin walking and starts solid food within a few months. That's a drastic difference and perhaps not the best example, but I think you get the idea. A human, who is more complex than a puppy, takes longer to develop. The same seems to be true of humans

of different complexities. A less complex person may develop fully by age fifteen. A more complex person may continue to develop for an additional fifteen or thirty years, or perhaps they may never stop developing. So while the intellect is developing, the emotional and physical development may lag behind. In another person the emotional development may be first while the intellectual and physical development catches up later.

The concepts of asynchronous development and neurodiversity caution us to be careful not to label normal human differences as disorders or impairments.

THE DSM IS FALLIBLE

We can see that the DSM changes over time but few people are aware of the extent to which it changes. It is created and maintained by committee and is influenced by changing societal norms, which seems like the best way to keep the manual current. However, a look back at previous diagnosable disorders may provide a more accurate look at the dangers of this type of system to identify disorders.

Runaway Reaction of Childhood

In 1968 the DSM-II identified an interesting disorder called the "runaway reaction of childhood." Individuals with this disorder "characteristically escape from threatening situations by running away from home for a day or more without permission. Typically they are immature and timid, and feel rejected at home, inadequate, and friendless. They often steal furtively."

Marital Maladjustment

Here's a really good one. According to current marital statistics, 50 percent of all couples would eventually fall into this disorder: marital maladjustment. The DSM-II describes those with marital maladjustment disorder as "individuals who are psychiatrically normal but who have significant conflicts or maladjustments in marriage."

Homosexuality

Homosexuality was considered a mental disorder in the DSM until the sixth printing of the DSM-II in 1973. After the gay rights movement began, there were organized protests at APA conferences, which eventually forced the APA to reconsider homosexuality as a psychiatric disorder. This excerpt from the APA's position statement for the proposed removal of homosexuality clarifies the basis for the argument:

> For a mental or psychiatric condition to be considered a psychiatric disorder, it must either regularly cause subjective distress, or regularly be associated with some generalized impairment in social effectiveness or functioning. With the exception of homosexuality (and perhaps some of the other sexual deviations when in mild form, such as voyeurism), all of the other mental disorders in DSM-II fulfill either of these two criteria. While one may argue that the personality disorders are an exception, on reflection it is clear that it is inappropriate to make a diagnosis of a personality disorder merely because of the presence of certain typical personality traits which cause no subjective distress or impairment in social functioning. Clearly homosexuality, per se, does not meet the requirements for a psychiatric disorder since, as noted above, many homosexuals are quite sat-

isfied with their sexual orientation and demonstrate no generalized impairment in social effectiveness or functioning.

The only way that homosexuality could therefore be considered a psychiatric disorder would be the criteria of failure to function heterosexually, which is considered optimal in our society and by many members of our profession. However, if failure to function optimally in some important area of life as judged by either society or the profession is sufficient to indicate the presence of a psychiatric disorder, then we will have to add to our nomenclature the following conditions: celibacy (failure to function optimally sexually), revolutionary behavior (irrational defiance of social norms), religious fanaticism (dogmatic and rigid adherence to religious doctrine), racism (irrational hatred of certain groups), vegetarianism (unnatural avoidance of carnivorous behavior), and male chauvinism (irrational belief in the inferiority of women).

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As these examples demonstrate, the DSM has flaws. For the ADHD diagnosis, the criteria rely entirely on observable symptoms and subjective interpretations of the distress caused by them. We could use a similar argument to the one made for removing the homosexuality diagnosis to consider the removal of ADHD as a disorder. Many intense people are quite satisfied with their lives, including the differences in the way their brains work. The majority of the "distress" reported in children with an ADHD diagnosis is the distress of the teacher. That just doesn't count. However, I recognize that humans experience distress sometimes. I will argue that distress is a perfectly normal human condition that intense people feel more commonly. While consulting a mental health professional can help reduce distress, the presence of distress by itself doesn't constitute a mental dis-

order. Even the argument to remove homosexuality from the DSM as a disorder allowed that some people who consider themselves homosexual may experience distress. If that distress is severe, they can and should seek treatment, but the problem is the distress, not necessarily the homosexuality.

If we discard the condition of distress, we are left with the condition of impairment. In this case, as in the case with homosexuality, the impairment is based on a societal norm that is more a matter of personality and environment than it is a matter of disorder. While some environments such as school make it seem as though intense people are impaired, other environments make it seem as though they are uniquely gifted. If there isn't impairment and there isn't distress, there isn't disorder.

In the DSM-5 there are changes to both the symptoms and the age of onset of ADHD. Symptoms must only have been present before age twelve. In prior versions it was age seven. Also the list of symptoms was modified to include an adult version of each so that it will be easier to diagnose adults.

The changes planned by the APA in the DSM-5 that make it easier to diagnose ADHD are suspect to say the least. These changes are taking place in spite of a plea from a previous chairman of the taskforce that created the DSM-IV. Dr. Allen Frances pleads for an end to this practice in an article titled "It's Not Too Late to Save 'Normal.'" He identifies ADHD as one of the areas where the taskforce made the biggest errors:

> Our panel tried hard to be conservative and careful but inadvertently contributed to three false "epidemics"—attention deficit disorder, autism and childhood bipolar disorder. Clearly, our net was cast too wide and captured many "patients" who might have been far better off never entering the mental health system.

Frances continues with a concern that the proposed DSM-5 "is filled with suggestions that would multiply our mistakes and extend the reach of psychiatry dramatically deeper into the ever-shrinking domain of the normal."

Dr. Frances attributes the move toward an increase in diagnosing normal people as disordered to inadvertent mistakes made by the panel trying hard to be "conservative and careful." But we have to wonder what kind of influence the pharmaceutical companies continue to have over the decision-making process, particularly when we see the proposed changes in the DSM-5.

TOO COMMON TO BE A DISORDER

The DSM-IV states the prevalence of ADHD as 3 to 5 percent. Based on more recent studies, this prevalence rate is not accurate today. According to the CDC (Centers for Disease Control and Prevention), the prevalence of parent-reported ADHD averaged 9.5 percent in 2007. In a 2007 study of the prevalence of ADHD in children age four to seventeen by state, the results varied from a low of 5.6 percent in Nevada to a high of 15.6 percent in North Carolina. These results were compared with a study completed in 2003. The prevalence has grown by 22 percent in four years.

The National Institute of Mental Health (NIMH) lists the prevalence rate of other disorders at a lower rate. Schizophrenia and autism spectrum disorder are each found in less than 1 percent of the population. Obsessive-compulsive disorder is also in the 1 percent range. This is compared to a reported prevalence of ADHD in 9 percent of children and 4.1 percent of adults.

Going back to the DSM-III, ADHD is described as a common childhood disorder with a nearly 3 percent prevalence rate. If 3 percent is common, what is 9 percent? With the changes in the DSM-5, the prevalence is expected to increase. At what point do we look at a

pattern of behaviors as within the normal range? If it isn't 9 percent, is it 15 percent, or perhaps 30 percent?

There is no need to explain or label behavior that is within the norm, only that which lies outside the norm. And it should be pretty far outside the norm to qualify as a mental disorder. Statistically speaking, it should be at least two standard deviations from the norm. In English, that means that it should be either in the bottom 2 to 2.5 percent or in the top 2 to 2.5 percent, leaving about 95 to 96 percent of the population to fall within statistic normality.

A report published in 2003 on the concerns of overdiagnosis of ADHD in school-age children indicates that statistical rarity is the only method by which to measure developmental deviance:

> In fact, definitions of some disorders—including ADHD—are reliant on the concept of *statistical rarity*, or what is sometimes referred to as *developmental deviance*. Consider the case of mental retardation vis-à-vis intelligence. Mental retardation (the condition) is defined by intelligence (the construct) that is measured to be at least two standard deviations below the population mean. While some individuals may have low intelligence, only those whose intelligence is significantly developmentally deviant (i.e., statistically rare) are considered disordered. The diagnosis of ADHD is conceptually akin to that of mental retardation in that the definition of both disorders relies on the concept of developmental deviance. As with intelligence, the hallmark symptoms of ADHD (impulsivity, hyperactivity, and inattention) exist in all children to some degree, but ADHD is said to exist only when the behaviors are expressed to an extreme or statistically rare degree.
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> Given that the definition of ADHD is based on statistical rarity, only a limited number of children can qualify as having the disorder. As in the case of mental retardation, the ADHD

> prevalence estimate was set at 3 percent to 5 percent, which restricts the disorder to those children whose ADHD-related behavioral characteristics are approximately two standard deviations away from the mean. The 3 percent to 5 percent estimate may constitute a liberal estimate because, as with mental retardation, statistical rarity is only one of several criteria for the diagnosis.

If the statistical rarity criterion holds, prevalence rates of greater than 3 to 5 percent cannot occur. Actually a statistical rarity would have to be two standard deviations from the mean. Using this kind of measure, roughly 95 percent of people should fall within the two standard deviations. The remaining 5 percent would fall equally to either side. So if we are trying to determine what an abnormal level of attention is according to this measure, about 2.5 percent would fall in the lowest end of the spectrum, which may be considered developmentally deviant.

If our current rates of diagnosis are four times the highest rate that could be possible given the criteria, what is causing the epidemic? If there is no epidemic, it must be something else.

THERE IS *NO* PROOF OF DISORDER

Even though we have ample proof that ADHD is at least overdiagnosed, we still haven't proven that it doesn't exist. On the other hand, I question if anyone can prove that it does exist. There are no objective tests that prove the existence of ADHD or any other psychiatric disorder. The diagnoses are all based on subjective measures. That fact alone doesn't prove that they don't exist, but it should be cause to use greater scrutiny.

Dr. Sami Timimi, who has authored several books on child psychiatry, contends that there is no proof of ADHD. While there have been attempts to identify objective tests and measures of ADHD as a

disorder, none exist to date. Even in seemingly objective neuroimaging studies, he warns that

> researchers have yet to compare un-medicated children diagnosed with ADHD with an age-matched control group. Sample sizes in these studies have been small and have produced a variety of inconsistent results. In no study were the brains considered clinically abnormal, nor is it possible to work out whether any differences seen are caused by (rather than being the causes of) different styles of thinking, or are the result of the medication the children had taken.

He also identifies an interesting fact: that prevalence rates of ADHD vary considerably, from less than half of a percent to 26 percent in studies because of the uncertainty of description.

I'll be the first to agree that there is something different about the people typically diagnosed with ADHD. However, if the symptoms can be better explained by something else, and if that different explanation makes better outcomes possible, we should be certain to explore that as a possibility. Doctors, by virtue of the Hippocratic oath, should be bound to consider an alternate explanation.

IF NOT DISORDER, THEN WHAT?

There were once six blind men who were asked to describe an elephant. The one who touched the ear said it was like a fan. The one who touched the trunk said it was like a large pipe. The others who felt only the belly or the tail or the leg or the tusk had different explanations. When they were told that they were each right and that they had each described a portion of the elephant, they still couldn't fathom the entire beast.

Like the story of the blind men and the elephant, the descriptions of the underlying condition responsible for ADHD fall short

when offered from a limited view. The underlying condition is one of intensity. The description in the DSM of ADHD is limited by its purpose of identifying the disorder by the negative aspects of intensity. This lack of understanding of the underlying condition of intensity contributes to both misdiagnosis and a lack of education about and healthy development of intensity.

Every natural human trait can be viewed by either its negative or positive side. In truth a trait is the combination of all its aspects, negative and positive. If you can think of a trait that seems to belong to only one side, you're not thinking of a trait but of an aspect of a larger thing. For example, inattention is not a trait, but an aspect of the larger category of attention. On the one end of the spectrum of attention is inattention, and on the other is hyperfocus.

Instead of experiencing just the middle range of these traits, people who are often diagnosed with ADHD experience more of the range. They go from inattention to those things that are not interesting to hyperfocus on those things that are interesting to them. It's natural for any human to pay closer attention to something that's interesting and less attention to something that is not as interesting. However, when a subgroup of people have a greater range, we then make the low end of the range and the high end of the range symptoms of a disorder. If we consider the trait of activity, on one end we have lethargy and on the other we have both impulsivity and hyperactivity. It's interesting to me that we accept lethargy as within the range of normal, while the other end of the spectrum is considered abnormal.

If we concentrate only on the perceived negatives of having a greater range, we're missing half the picture. With a greater range of attention, we are never inattentive; we are always taking in more than others. We have the ability to take in information that is going on around us that others screen out. This has been described as missing the "space bubble" that others use to screen out unimportant

stimuli. But when the thing we are attending to is of great importance to us, we have a super space bubble. Nothing else matters. We can stay on a single subject or activity for a very long time without noticing anything else going on around us. This is then called hyperfocus and considered a symptom. Instead of looking at the positive side of this greater-than-average ability to attend to a single thing, we say that this is evidence of being "stuck."

By concentrating on the negative interpretation of each of the traits, we are ultimately convinced that we have a problem. The worst part of this is that we are never encouraged to develop the positive side. It becomes a self-fulfilling prophecy. We see only the negative, we concentrate on the negative, we have it pointed out to us on a regular basis, and we become only the negative.

If the description of intensity on the following pages better fits your experience of the world, and if it helps you to understand yourself and your potential better, then use that description in place of "ADHD."

For ADHD professionals, know that intense people are becoming self-aware. A psychiatrist, psychologist, school counselor, coach, or pediatrician who has a solid understanding of intensity will always be valued. This doesn't mean the end of your involvement with these people. It's only the beginning of what should be a much more satisfying journey together, one where you can actually offer some help in development of their inherent gifts and a better understanding of their distress.

Important Points for the Impatient

- There is no proof of ADHD as a disorder. There exists no objective method of diagnosis for ADHD. Even the neuroimaging studies have failed to produce adequate tests with comparisons to "normal" brains in subjects of the same age.
- If there is no proof of disorder, there is no cure offered, and the treatment used to manage the condition can be deadly, we have to look for another explanation. If there is an alternate explanation that offers a better outcome, in good conscience doctors should be required to consider it. Adherence to the Hippocratic oath should require them to consider it. We should consider it for ourselves.