

'Smartening up or dumbing down?': A Look Behind the Symptoms, Overprescribing and Reconceptualizing ADHD

A Public Seminar presented by:

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Summary

To take a look behind the symptoms of Attention Deficit Hyperactivity Disorder (ADHD) allows us to explore a number of issues: first, 'overprescribing' of medication; second, the notion of 'manufactured epidemic'; third, the process of 'dumbing down' and 'smartening up' the assessment of children's mental health; fourth, discuss the unifying concept of the 'developmental perspective'; fifth, use case studies to introduce new concepts of 'attachment deficit' and 'hyperreactivity'; and sixth, debunk the myth of 'childhood resilience'. Finally I suggest 'smartening up' our understanding of ADHD needs inclusion of current advances in attachment theory favouring the new conceptualisation of ADHD as 'Attachment Deficit Hyperreactivity Disorder'.

Introduction

Overprescribing

The themes for today's Seminar were born out of major social concerns, namely the factors driving the dramatically rising number of prescriptions of psychoactive drugs for children in the last decade.

When this phenomenon is due to non-rational prescribing, I use the term 'Overprescribing'. This is a major risk in the big business of health highlighted in '*Too Much Medicine?*' by Ray Moynihan (1).

Concern with 'overprescribing' is not just centred on factors that lead doctors to diagnostic biases (2) and non-rational prescribing behaviour, but also the context for non-rational prescribing, that is to look at the 'big picture' of the 'flawed mental health care system' (3) Green & Bloch.

Best care mental health care is a carefully considered blend of art and science. Increasingly, it is practiced in what Green and Bloch call a 'not good enough' environment: how is this defined? what drives overprescribing? how can 'centres of excellence', those tertiary teaching settings and university affiliated hospitals that produce tomorrow's professional leaders, fail the test of adequacy of modern medicine in the face of human suffering? (4)

I explore these questions with you today. In our quest for authentic answers to these questions we will confront the impact of the health care revolution of the 90's that has ushered in a New World of Health Care. (5)

Underpinning the current failure of our system of medicine is the step-by-step erosion, both at organisational and individual levels, of the fundamentals of medical practice: failure to accept ethics as a legitimate concern; failure to keep learning; failure to develop and revise processes; failure to be realistic; failure to think broadly; failure to consider context; and failure to accept frustration (6). The end result of these processes has resulted in the '**dumbing down of medicine**' and the '**numbing down of our patients**'. Our task is to find solutions, to '**smarten up**'.

We must be prepared to engage in a passionate debate, to participate in the intellectual, moral and philosophical tradition embodied in the first aphorism of Hippocrates:

*Life is short, and the art long; the occasion fleeting;
experience fallacious; and judgement difficult.*

*The physician must not only be prepared to do what
is right himself, but also to make the patient, the
attendants, and the external co-operate.*

The first aphorism of Hippocrates. (7)

My motive for speaking here today, aside from responding to Helen's kind invitation, is to put on the public record the increasing concern of many people in the community about the changing prescribing habits of medical practitioners. This affects young people in increasing numbers at younger ages, now even preschoolers, as I will show later.

First I declare some of my beliefs and assumptions:

1 Parenting deeply affects and shapes children's growth, development and maturation both in health and illness.

2 Children are not as much 'resilient' as 'malleable' (8) in the face of trauma.

3 There is growing evidence that childhood reactions to traumatic experiences can lead to many symptoms. Furthermore, these symptoms directly or indirectly may result in: '**behavioural problems**' of attention deficit hyperactivity disorder (ADHD) conduct disorder, oppositional behaviour; '**emotional disorders**' especially anxiety, panic attacks, and depression; finally '**mental illnesses**', including borderline personality disorders and hysteria.

4 There are genes and genetic contributions to illness including mental illness.

5 The US National Institute of Health's ADHD consensus statement (9) was correct when it concluded: the 'unproven' status of the disorder (ADHD) 'should give pause to both researchers and clinicians who may have reified ADHD as a 'thing' or 'true entity' (rather than a *working hypothesis* that serves scientific, communication, and clinical decision-making purposes). They do provide a caveat not to confuse *unproven* with *disproved* (p195).

6 The best explanation to account for the large increase in the number of prescriptions for drugs like Ritalin and dexamphetamine (see Table 1) used to treat ADHD is the final common path or outcome of the combined pressures on the medical profession giving rise to misdiagnosis, over prescribing and non-rational prescribing habits. This can be heard in the complaints of doctors "I have no time to listen, or do anything but prescribe.' The old maxim 'Don't just do something, sit and listen' seems impossible.

Behind the symptoms

The current American culture of child psychiatry, and increasingly in the UK and Australia, is dominated by the 'new genetic paradigm'. In this culture, my claims may sound contentious, provocative or by some even perhaps idiosyncratic.

An example that highlights the sociocultural controversy is the condition of Attention Deficit Hyperactivity Disorder (ADHD), affecting roughly between 2-6% children and is characterised by overactivity, restlessness and attention problems in various combinations. Some leading experts in the field emphasise the biological causes and treatments for ADHD (10a) even when all agree that the cause for ADHD is not known (10b).

(It is beyond the scope of this paper to discuss the history of ADHD and its relationship to the older concept of 'minimal brain dysfunction'; the clinically useful distinctions between 'organic' and 'reactive' ADHD (personal communication, A Firestone); the differences between the DSM IV and the ICD 10 narrowly defined 'hyperkinetic disorder'; and the central issues of validity, reliability, and syndrome status of the condition.)

Yet, at our peril we overlook the major developments in the neurobiology of attachment. This development lends support to Bowlby's tradition and draws on earlier works by ethologists Lorenz and Harlow; psychoanalysts Klein, Balint and Winnicott; child developmentalists, Ainsworth, Main, Fonagy, as well as Homes, P Hobson, Mears; and current infant researchers and writers in emotional development, Allan Schore, B Perry et al, C Zeanah, M Rutter, D Siegal to name a few. The '**renaissance of interest in the early years**' (11) of childhood development is thankfully with us.

This renaissance encompasses the evidence regarding the critical relevance of infant-mother attachments and interactions for the child's ongoing development of health and well-being. A crucial element of this emerging science is discussed by Dr Isla Lonie, Past President of the Australian Association of Infant Mental Health, and I commend her chapter (p106-117) in our book "*She STILL Won't be Right, Mate!*" (12) written as an emergency measure because she also wished to ensure that the 'dumbing down' process in mental health was signalled to the Australian community.

'She STILL Won't be Right, Mate!', alerts readers to the impact of managerialism shaping our New World of Medicine and Health Care. That managerial philosophy, originating in the US, has created what Green and Bloch (13) call a 'flawed mental health care system' in both our countries. That system is defined as one which is regarded as 'not 'good enough'... (to) adequately meet the needs of patients and patients' families' resulting in a number of ethical quandaries.

Today I will show how the 'flawed systems' that we all live and work in as educators, health professionals and parents alter our experiences with ADHD and lead to overprescribing. This worrying phenomenon increasingly confronts parents, teachers, mental health workers, doctors and is triggering heated debate in legislative, educational, scientific, legal, social and ethical arenas.

Green and Bloch emphasize that when a flawed system compromises the 'principle of fidelity' to the patient, our professional integrity is also threatened.

ADHD and 'manufactured epidemic'

Elsewhere I called the ADHD phenomenon of the 90's a 'manufactured epidemic' (14). Since then community concern has increased. The use of medication in young people is the focus of two state parliamentary inquiries: South Australian Parliament's Social Development Committee's focus is the Attention Deficit Hyperactivity Disorder (ADHD) Inquiry, while the New South Wales' Parliamentary Inquiry is into the broader issue of Prescription and use of Drugs and Medication in Children and Young People.

In Australia our reason for concern is indicated by the figures in Table 2.

State	NSW	Vic	Qld	SA	WA	Tas	ACT	NT
1992-93	6253	1590	2555	2250	3450	191	190	80
1999-00	69312	35761	32290	22446	71510	8226	2891	960

Table 2. Dexamphetamine PBS prescriptions, state by state. Methylphenidate is not on PBS

The figures show a nearly tenfold (in SA) to over twenty fold (Vic, WA) increase. Yet Victoria, with a much larger population has half the rate of WA from 1992/3-1999/2000.

What do the figures tell us? A number of interpretations lead to different arguments in the current ADHD debate. In a nutshell, some argue that the welcomed increase in prescriptions finally reflect the medical profession 'waking up' to the problem, especially in Western Australia.

'Smartened up' or 'dumbed down'?

Based on the figures, Dr Trevor Parry, director of the State Child Development Centre, Perth, was reported to be unconcerned about the overall rise in stimulant use, nor about WA's well-documented position as the country's highest prescriber of stimulants. (15) He was quoted as saying:

"Yes, we are higher than the other states, but we are not as high as we would be expected to be if we were identifying and treating all the kids that should be expected to be identified. It really means that the other states that are lower have got some catch up to do.

If we look at the figures and the graphs, particularly Victoria which have been the lowest, that has been because they have not strongly believed in the existence of ADHD nor have they trained their paediatricians accordingly until quite recently."

Dr Parry was also reported to say that WA has an advanced training program for registrars in developmental paediatrics for more than two decades which has helped their graduates identify and treat ADHD.

In summary, Parry suggests the dramatic increase in prescription rates in Western Australia reflects the 'smartening up' of assessment, diagnosis and treatment, in short, the therapeutic practice in that state. According to that view, the Victorian prescribing culture may be characterised as 'dumbed down'. I disagree.

Dumbing Down the Developmental Assessment: 'Manufactured Epidemics'

A preamble on the 'biopsychosocial paradigm (16, 17) and its history to Moses Maimonides (18)

During the last decade, as a child psychiatrist I have witnessed child mental health undergo a radical change in the assessment, diagnosis and treatment particularly of ADHD. I have witnessed the prevailing 'bio-psycho-social' paradigm gradually eroded so that in many cases of children with behavioural disturbances, the current approach seems to me to be 'dumbed down' (19).

By 'dumbed down' I mean the gradual erosion of the art and science of assessment of symptoms. This is in part due to the training of new doctors. In part also due to the reduced time available to doctors to undertake the necessary comprehensive developmental assessments including a full attachment history.

Instead, we witness the emerging medical model as one where professional time is reduced to a (DSM IV) symptom check-list, or a glance at a 'practice guideline' (20) followed by a 'rapid' diagnosis. The end result is usually a prescription for a 'quick-fix' medication, by the end of the first consultation. There is a parallel deskilling of professional practice where doctors lose their capacity to think about and interpret the meaning of the behaviours. This results in more and more 'simple' explanations to account for complex behaviour problems.

Are we to believe that 50-60 minutes is really adequate time to assess how a child's symptoms of overactivity, inattention and the like developed? Are we to believe that a professional need *not* consider the impact of early attachments? I will illustrate the need, a scientific need, to assess such symptoms in light of current research. Are we to believe the current 'new genetic paradigm' offers adequate explanation to account for the symptoms and justify medication in ADHD?

We are fast following the US experience, where Schaefer (21) observed that according to current guidelines, with the need for clinicians to justify requests for authorisation for developmental assessment from managed care companies, it is much easier to meet the criteria approving the authorisation for medication than developmental assessments. Children who have been exposed to risk factors such as a 'history of parental loss, exposure to a traumatic event, placement in foster care, lead exposure, or abuse or neglect *do not in and of themselves warrant comprehensive developmental assessment.* (my italics).

It is precisely in such a clinical context, where developmental assessment is unauthorised by virtue of time limitations, that the doctor under pressure to 'do something' is likely to prescribe drugs as a first rather than a last measure for children with behavioural disturbance such as ADHD. In the extreme, some advocate assessment to be reduced to a single session (22, 23). I know that sometimes that includes prescription as well.

The Developmental Perspective

A developmental approach to childhood development views a child's current behaviour in the context of his or her past family and social relationships. Eisenberg (24) argues the unifying concept of development is essential in both child and adult psychiatry. Rutter's classic volume, *Scientific foundations of developmental psychiatry* (25) applies the developmental perspective to a range of 'bio-psycho-social' developmental tasks.

This perspective extends from the prenatal through to natal and early postnatal periods of infancy (Table 3). Just as genetic factors are known to be transmitted from generation to generation, a growing body of literature focuses on mechanism in the 'family ecology' to explain the phenomenon of 'transmission of attachments' (26) and 'transmission of trauma' (27). Questions explored include the way parental traumatic experiences alter

parenting capacities and styles. It is to these factors, as part of the general Family Environment (Table 1 column 2 no.3) I now turn.

Vignette to illustrate the relationship between attachment, traumatic bonds, in developmental assessment (See Figure 1 Ladnier & Massanari 2000, ADHD as 'Attachment (not attention) Deficit'HD)

Mr and Mrs Smith (not their real names) presented with 11 year old son 'Kevin'. He was diagnosed with 'classic ADHD' and started on Ritalin at the age of 5 years. His behaviour improved with medication. Understandably his parents were satisfied. Current concerns centred on a renewal of past behaviour problems when he became frustrated with his younger siblings. He was never a good student, but concentrating was becoming a problem at school. Parents thought he was not motivated and maybe lazy. It was time for a second opinion. Kevin was taking Ritalin for over five years.

A developmental history revealed that Mrs Smith suffered from post-partum depression and was hospitalised for a number of weeks after Kevin's birth. A brief review of Kevin's early childhood revealed his intense stress reactions to separation; delayed language development; and difficulty settling at kindergarten with behaviour problems 'from the beginning'.

The idea that Kevin was either depressed or showing signs and symptoms a reactive attachment disturbance (28) in infancy was not considered. All his parents were told was he had 'classic ADHD. In fact Mr and Mrs Smith could not recall being asked about Kevin's early mother-infant relationship. With a detailed review of his early childhood milestones, it was possible to offer parents and Kevin alternative treatment approaches to his clinical and developmental problems. This included parents learning new communication skills. (29).

This brief vignette illustrates some of the steps that potentially 'smarten up' both the assessment and diagnosis as well as treatment for childhood behaviour disorders. It also sets the stage to introduce the first conceptual review of the traditional view of ADHD as 'attention' deficit.

Attachment Deficit Hyperactivity Disorder (the first new concept)

The developmental model for the origin of ADHD, as 'attachment' deficit, offers a powerful model to explain the emotional and behavioural symptoms of ADHD. In this model, the symptoms of ADHD are seen as the 'final' expression of a developmental process with attachment antecedents grounded in the 'cycle of conflict between parent and child and the 'traumatic bonding' (see Figure 2).

The developmental approach details the child's earliest experiences, including what Shore has integrated as the 'effects of early relational trauma on the right brain, affect regulation and infant mental health' (30). Why you may ask is it necessary to return to the earliest infant experiences?

To explain, I need to digress slightly to describe the subtle details that are the object of study in traumatic relationships (31) in the emerging field interfacing attachment theory and psychoanalysis (32, 33) I will quote a previous article (34):

Traumatic relating and hyperreactivity

'Trauma'. In contrast to the usual attitude of health professionals who regard 'trauma' in terms of the medical connotation of wound or injury,(35) the psychoanalyst DW Winnicott defined trauma for the infant by linking it with the idea of impingement.

'Impingement' occurs in the form of a parent intruding when the infant needed to be left alone, or when the parent was absent when needed. "They may take the form of repeated changes in techniques of care, loud unexpected noises, missattunements to the infant's natural rhythms, insufficient physical support, or abandonment for a time period beyond which the infant can cope. Erratic or 'tantalizing' care constituted a particularly **toxic form of impingement** because it undermined the infant's fundamental need for stability and reliability – to make the 'unpredictable predictable.'(p154).(36). This unpredictability sensitises and thus exaggerates the infant's fear response to which I'll return later as the basis of hyperreactivity."

To make the point explicit, Winnicott observed that children can deal with 'mood swings in their parents by carefully observing them, but it is the unpredictability of some parents that can be traumatic. Once children have come through the earliest stages of maximal dependence, it seems to me that that they can come to terms with almost any adverse factor that remains constant or that can be predicted.'(37)

From a psychoanalytic perspective, Winnicott's connotation of trauma as impingement offers a way to understand the mother-infant relationship in its complexity: to combine feelings of love and affection with violent, aggressive, sexual and envious states. These dimensions are integral to a fuller understanding of the transmission of trauma between survivors of trauma and their infants.

Consider the experience of the infant who attempts to engage her mother's gaze during the moments of breastfeeding. The mother had experienced major traumas in the past. During this intimate, intonational relationship of mother and infant, empathy and all the modalities of sensation are 'switched-on': touch, smell, taste, sight and sound.

Imagine that during the feeding, as the mother is fully engaged with her infant, she experiences a flashback. She recalls her moments of near-starvation. The flashback triggers old thoughts: 'every-crumb-is-precious'. At that moment, her infant becomes anxious, refuses her breast, and regurgitates the precious milk-food-crumb. The infant wastes the mother's precious food. For the moment, the mother's mind is lost to her infant's needs. In that moment, the mother's consciousness has been altered by an inaudible, but not invisible, thought. The thought has interfered with her containing gaze. Her infant is 'abandoned'.

At the same time, imagine her infant, contained by her mother's engaging gaze, reciprocally 'in love'. Suddenly the infant is abandoned, disconnected. At that moment, the mother's empathy, her 'emotional knowing' of her infant is inhibited, temporarily. The

infant, with no time sense experiences the abandonment as lasting to infinity. Should that abandoned state persist, the infant uncontained, experiences catastrophe. In the infant's moment of need for the empathic mother, the mother's mind is preoccupied with her own traumatic flashback. Mother remains absent, she is numbed entirely to her infant's needs.

At critical moments during the feed, her infant is 'seeking' to reconnect, to make eye contact, again and again. Instead of experiencing a moment of 'mirroring', a reflection of containment, the infant experiences mother's 'absence'. For the infant, this moment of mini-loss of contact is critical. The infant may experience a catastrophic reaction, observable from the outside as total body convulsions.

With no anchorage, the infant-caregiver relationship adrift²⁵, the infant's mind experiences more fleeting 'mini-loss reactions'. Of course chances to repair the loss appear, if the mother is able to re-establish empathic contact. But what if the mother remains 'absent', 'gone' for a time longer than her infant can yet tolerate? How does her infant cope?

Unless reparative moments arrive in time, the infant's increasing level of frustration results in overwhelming distress, impingement after impingement. These are moments of trauma. The trauma can be said to be 'transmitted' in the mother-infant relationship as the infant experiences her mother's absence as 'out of sight, out of mind'. Taken concretely, the infant is really 'out of mind', her mother's and her own.

As such moments accumulate, the infant's bonds gradually detach from the 'feeding' mother. Observed from the outside, the infant gradually becomes 'unrelated' to her mother.

"Get over it": the myth of childhood resilience

Let me return from the digression to place the experience of infant trauma into the 'renaissance of early childhood' context and the exciting work of neurodevelopmental correlates of attachment and trauma.

Perry et al (38) emphasized the importance of understanding the 'impact of experience on the developing child. They debunk the 'children are resilient' myth, 'they'll get over it, they did not even know what was happening', noting that of course, 'children "get over it" – they have no choice.' Their conclusion: 'Children are not resilient, they are malleable.'

Contrasting with the erroneous attitude of childhood resilience, fashionable in the 80's (39) Perry et al observe that 'in the process of getting over it, elements of their (children's) true emotional, behavioural, cognitive and social potential are diminished – some percentage of capacity is lost, a piece of the child is lost forever.'

Hyperreactivity (the second new concept)

Profound implications arise from the intricate brain processes whereby the traumatised child's survival responses are concerned when it comes to conceptualising ADHD. Two well known responses are both served by the autonomic nervous system. The first, the

'sensitised' hyperarousal continuum and the defensive fight-flight responses; the second, the 'sensitised' dissociative continuum: the freeze or surrender responses.

These latter states include daydreaming, fantasy, depersonalisation, derealisation, and fugue states and in the extreme, of torture, loss of consciousness. In contrast, the child deploying the former responses exhibits **motor hyperactivity**, anxiety, behavioural impulsivity, (readily observed in ADHD) as well as sleep problems, tachycardia, hypertension and a variety of neuroendocrine abnormalities. Most importantly, these children are now also sensitised to fear responses. Thus any stressor can trigger an 'exaggerated' reactivity – **hyperreactive**. **I emphasize that in considering ADHD this hyperreactivity** should be distinguished from hyperactive, although hyperactivity may be rooted in the hyperREactivity.

Hyperreactivity in ADHD

Such a formulation also explains the clinical phenomenon of why more males than females exhibit sensitised hyperreactivity (as in ADHD) and more females than males exhibit evidence of the sensitised dissociative systems. The answer can be seen in the adaptive response patterns seen in the face of trauma for children and adults.

Seen as a survival mechanism, males are better placed in the activated hyperarousal system, while females and children are better served by dissociative responses. They are seen as the oppositional defiant FREEZE.

In very young children however, the use a combination of adaptive styles, predifferentiation.

Understanding the brain processes involved in childhood trauma explains the clinically observed states of childhood post traumatic states numbing, compliance, avoidance, restricted affect, consistent with primary dissociative patterns. As clinicians, teachers or parents, we note the 'numb, robotic, non-reactive, daydreaming child with the glazed look staring off into space.

In males, the so called externalising disorders ADHD, conduct and oppositional defiant disorders (3:1) compared with girls and the internalising disorders of depression, anxiety and dissociative.

'States' and 'traits'

So how do 'states' transform to 'traits'? Internalisation of fear responses a 'state' memory - if repeated, can be built into the mature brain (e.g. combat related PTSD) where the neural architecture is changed. In the developing brain, these states ORGANIZE the neural system resulting in traits.

Thus Experiences, including traumatic (? and reparative) will, during development, determine the 'functional capacity of the human brain' and thus dispel the 'persistence of the destructive myth that 'children are resilient'.

Conclusion

To conclude, I suggest that if we adopt the double conceptual leap: first, 'transformation' of the 'attention' to the 'attachment'; second, the transformation of 'hyperactive' to 'hyperreactive' results in a new way of understanding the symptoms of ADHD.

Those symptoms of impulsivity, hyperactivity and inattentiveness are now understood, from a developmental perspective, to arise from attachment deficit hyperreactivity disorder. The developmental perspective offers a formulation which is grounded in evidence based on research findings derived from the interface between psychoanalysis, attachment research and neurobiology of infant development.

What looks like ADHD (Attention D Hyperactivity D) may come about as a result of particular attachment patterns especially those characterised by 'traumatic bonds'. Such bonds are conceptualised as occurring where the mother is not able to parent in an appropriately attuned manner to respond to the infant's requirements.

Current mother infant research and neurodevelopmental studies appear to confirm that disorganized attachments may contribute to 'traumatic bonds' resulting in alteration in the developing child's brain architecture and functioning. After several years, these early attachment deficits may produce symptoms that include those of the current ADHD diagnosis. Furthermore, the 'hyperactivity' seen in many children is more accurately explained in terms of hyperreactivity, consequent on traumatic early relationships.

This reformulation suggests that where symptoms of ADHD result from *attachment deficit hyperreactivity disorder*, early intervention in the form of psychological support for parent and child is warranted if the developmental assessment indicates that it would be helpful. This may occur in conjunction with medication. In this connection it serves us well to recall Michael Balint's concept of the 'doctor as drug' detailed in his classic *The Doctor, his Patient & the Illness*.

To introduce these ideas into our current flawed mental health system requires that we understand the barriers posed by, and the deleterious impact of, managerialism on mental health reform in Australia. I quote Dr Gil Anaf, President of the National Association of Practising Psychiatrists, offering his diagnosis of the seriousness of the condition; "*Managerialism is being promulgated so uncritically and unthinkingly that it borders on being actually 'mad', the sign of a society seemingly out of control with no time for reflection or principles*" (SSWBRM). *Horror vacui*, the fear of nothingness, takes many forms.

We now come full circle.

We realise life is short. I hope that I have offered a view of 'art long'. The occasion we spent was fleeting. We will in time judge if the experience was fallacious. No doubt the judgement will be difficult. But then "The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and the external co-operate.

Life is short, and the art long; the occasion fleeting;
experience fallacious; and judgement difficult.
The physician must not only be prepared to do what

is right himself, but also to make the patient, the attendants, and the external co-operate.

The first aphorism of Hippocrates. Adams 1939.

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