

ADHD IN HISTORICAL AND COMPARATIVE PERSPECTIVE

MEDICAL, EDUCATIONAL AND PUBLIC APPROACHES TO
CHILDHOOD HYPERACTIVITY IN THE US AND THE UK,
1960–2010

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ADHD in historical and comparative perspective: medical, educational and public approaches to childhood hyperactivity in the US and the UK, 1960–2010

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Abstract

Adding a much needed historical and comparative dimension to current debates about Attention Deficit Hyperactivity Disorder (ADHD), the present thesis provides an analysis of the changing construction and treatment of childhood hyperactivity in Britain and the United States, focusing on the period from 1960 to 2010. The focal point is the historical discrepancy between the two countries in diagnostic and therapeutic practices, and the question of how and why perspectives have increasingly converged over the past 20 years. Whereas British medical and educational professionals continued to rely on environmental explanations and interventions for the vast bulk of disruptive behaviour in school children, the American concept of hyperactivity disorder from the 1960s onwards became increasingly inclusive and biomedical in orientation. This expansion was closely related to the rise of psycho-stimulants as a widely employed treatment for hyperactivity and attention problems in the US. British and other European clinicians, on the other hand, resisted drug treatments up until the mid-1990s, when rates of diagnosis and prescription grew dramatically on both sides of the Atlantic. A key aim of this study is to explore and explain the rise of ADHD and Ritalin in both the American and British contexts, looking at the interplay of political, professional, institutional and socio-cultural factors that have contributed in each case.

The study concentrates on three interconnected spheres which have underpinned and shaped approaches to hyperactivity in the two countries: medicine, education and the wider public arena, represented by parent support groups. While chapters 2, 3 and 4 focus on the medical debates and practices surrounding hyperactivity, and the points of connection and disconnection between the two medico-psychiatric communities, chapters 5 and 6 examine the role of schooling, disability activism, and educational policy, especially that relating to special educational needs. Finally, chapter 7 explores the issue of parent activism which has been an important factor in the growth and critique of ADHD in both settings.

Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institution of learning.

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Abbreviations

ACLD	– Association of Children with Learning Disabilities
ADD	– Attention Deficit Disorder
ADDA	– Attention Deficit Disorder Association
ADHD	– Attention Deficit/Hyperactivity Disorder
ADDERS	– Attention Deficit/Hyperactivity Disorder Online Information Service
ADDISS	– National Attention Deficit Disorder Information and Support Service
APA	– American Psychiatric Association
BAP	– British Association of Psychopharmacology
BMA	– British Medical Association
BMJ	– British Medical Journal
CAMHS	– Child and Adolescent Mental Health Services
CEO	– Chief Executive Officer
CHADD	– Children and Adults with Attention-Deficit/Hyperactivity Disorder
DEA	– Drug Enforcement Administration
DTC	– Direct to Consumer
DSM	– Diagnostic and Statistical Manual
EBD	– Emotional and Behavioural Difficulty
EHA	– Education for All Handicapped Children Act
ESN	– Educationally Subnormal
ESN (M)	– Educationally Subnormal (Mild)
FDA US	– Food and Drug Administration
FSA	– Food Standards Agency
GCSE	– General Certificate of Secondary Education

HACSG	– Hyperactive Children’s Support Group
HAS	– Health Advisory Service
HKD	– Hyperkinetic Disorder
ICD	– International Classification of Diseases
IDEA	– Individuals with Disabilities Education Act
IEP	– Individualised Educational Plan/Programme
INCB	– International Narcotics Control Board
LD	– Learning Disability
LDA	– Learning Disabilities Association of America
LEA	– Local Education Authority
MBD	– Minimal Brain Damage/Dysfunction
MRC	– Medical Research Council
MRI	– Magnetic Resonance Imaging
MTA	– Multimodal Treatment of Attention Deficit Hyperactivity Disorder Study
NAACP	– National Association for the Advancement of Colored People
NAMI	– National Alliance for the Mentally Ill
NCLB	– No Child Left Behind
NCMH	– National Committee for Mental Hygiene
NDEA	– National Defense Education Act
NHS	– National Health Service
NICE	– National Institute for Health and Clinical Excellence
NIH	– National Institutes of Health
NIMH	– National Institute of Mental Health
OCD	– Obsessive Compulsive Disorder
PRU	– Pupil Referral Unit
RCT	– Randomised Controlled Trial
SAT	– Scholastic Aptitude Test (graduate school entrance examination in the US)
SATs	– Standard Assessment Tests (National Curriculum assessments in the UK)
SEN	– Special Educational Needs
SENCO	– Special Educational Needs Coordinator
SSRI	– Selective Serotonin Reuptake Inhibitor

TSA – Tourette Syndrome Association
WHO – World Health Organisation

CHAPTER 1

Introduction and literature review

1.1 Prologue

Since the early 1990s, a growing stream of government and media reports on rising levels of antisocial behaviour, motivation problems, and psychiatric disorder among young people has fuelled fears that British youth is undergoing a serious crisis. In 2008, the mounting sense of emergency was thrown into sharp relief by a cover feature in the international edition of *Time*. Showing a Union Jack and a hooded teenager on the front page, the popular American news magazine told the story of “an epidemic of violence, crime, and drunkenness” among British children, who, compared to their Continental European counterparts, are “unhappy” and “out of control”, addicted to junk food and junk television, under pressure at school, and controlled by a consumer-oriented culture ([Mayer 2008](#)). Public panics concerning maladjusted youth are of course not unique to present-day Britain. However, the article described the current outbreak of troubled and troublesome behaviour as qualitatively different, being more encompassing and affecting children of a younger age than previously.

As one might expect, the somewhat melodramatic *Time* editorial provoked considerable debate, with some commentators noting the peculiar absence of reflections on the relatively poor living conditions and opportunities of many

children in the United States, and the American influences which increasingly affect the lives of young people in the UK today. Indeed, one obvious symbol of the perceived crisis in children's mental and behavioural health is the recent international rise of Attention Deficit Hyperactivity Disorder (ADHD) – a diagnostic category originating in the third edition of the American diagnostic manual, the DSM, and associated with stimulant drug treatment. In Britain, hyperactivity and the use of stimulants and other psychotropic medications in children was for many years seen as a peculiar product of an American pill-popping tradition – a circumscribed cultural phenomenon which one could only frown upon. Much like in the rest of Europe, hyperactivity and attention problems were considered to be general features of child psychopathology, or simply behavioural signs of inadequate parenting, rather than symptoms of a singular and specific organic disorder, except in a few severe cases, which were given the ICD diagnosis, Hyperkinetic Disorder. However, from the late 1980s, considerable areas of cross-Atlantic overlap began to emerge in medical perceptions of hyperactive child behaviour, and by the mid-1990s, the American diagnosis, together with stimulants like Ritalin, was fast spreading to the rest of the Western world, particularly Australia and Northern Europe.

Britain was the first European country to approach the US in this matter, but others soon followed, prompting leading American ADHD expert Russell Barkley (2006) to announce that national cultures of child psychiatry no longer existed.¹ To a great extent, the implication here was that everyone was finally catching up with the US, where hyperactivity had been established in the 1970s as a relatively common condition requiring early intervention in the form of drug treatment and behavioural therapy. A similar view was expressed by several British child psychiatrists who pointed out that the UK was simply behind, in this case by as much as 25 years. However, implying that there was more to the story than a simple delay in uptake, most seemed assured that the more restrained British

¹ Australia started the trend in the late 1980s, about five years earlier than the UK, and quickly became the country with the highest frequency of ADHD diagnosis outside the North America.

attitudes to diagnosis and medication would “guard against the worst excesses” (P. Hill *int.* 2005).

Certainly, the concept of ADHD had a very cool reception among British professionals and social commentators, and although things have changed in the past 15 years, the reluctance to medicate children partly remains. Indeed, looking at the related subject of childhood depression, this was nicely illustrated by the different reactions of the UK and US regulators to the controversy in 2003/2004 concerning the paediatric use of SSRI-antidepressants. After examining a series of 13 clinical trials including more than 2,300 children and adolescents, drug regulators in Britain strongly urged doctors not to prescribe the antidepressants for children because the risk of self-harm and suicidal thoughts was judged to be too great. In the US, however, many experts expressed their frustration, emphasising that the British regulators had overreacted and generated unnecessary anxiety and concern among parents already struggling to choose the best way to help their child (Goode 2003; Satel 2004). Relying on the same clinical data, officials at the Food and Drug Administration (FDA) could not make up their minds on the safety issue, and in the end decided simply to issue a “black box warning” on SSRIs, advising on the risk of suicidal ideation.

Although it would be misleading to identify one specific approach with each country, these divergent responses can partly be explained as products of patterned cultural styles involving different health care systems, professional identities, and treatment strategies, which in turn reveal varying levels of commercialisation, competitive specialisation, reliance on medical technology, and impatience with disease and impairment. Medicalisation – that is, the process by which medical assumption, practices, and vocabulary penetrate areas previously dominated by lay common-sense understanding – is of course prevalent throughout the Western world, but the US has since the late 19th century provided an especially hospitable environment for medical approaches to a wide range of phenomena. There are many cultural and organisational features of American society that have contributed to this nurturing context. More so than Europe, the US has a long tradition of experimentation and utopianism, and a history of being

open to new ideas and innovative interventions. It is a society that celebrates the heroic and displays an extraordinary faith in science, both as a way of making sense of experience, and as a source of problem-solving technology and personal self-improvement. Furthermore, the dominance of the principle of individualism means that typical treatment strategies are those which involve intervention not in the social and cultural environment, but rather in individuals' lives or organisms (Conrad & Schneider 1992).

Building on a long public health tradition, the British state-run National Health Service (NHS) conversely promotes a more socially-oriented, multi-faceted approach, which exhibits a higher threshold for disease, a tendency towards parsimony, and recognises the profound impact of social and economic conditions on health (Payer 1988, pp. 101-104, 137-140). Thus, in the UK there has been more focus on the prevention and environmental causes (both psychological and physiological) of health problems, as well as a high degree of solidarity in the organisation of health care, which translates into a guaranteed basic package of benefits, controls on the cost of services, and restricted choice of doctors and access to certain specialist services. In the US, by contrast, universal health care has been opposed by a large part of the population and by the interests of insurers and the powerful medical profession. However, rather than simply relying on the private sphere, American medicine has long combined private and public; while the government regulates and pays for basic research and training, the health care system is largely market-driven, displaying a unique mix of health maintenance mainly financed by commercial insurance companies; means-tested programmes; and a proclivity for consumerism and litigation. Further, it is important to note that the current US managed care system, in attempting to cut costs, encourages quick and immediately effective drug-based solutions.

Medicalisation has also been more prominent in the American education system. Since the 1970s, both the US and the UK systems have adhered to the principle of inclusion, but whereas US policy and practice in special education came to revolve around a medical model of disability in which children's disabilities are recognised and accommodated primarily through individual

diagnosis and action strategies, in the UK emphasis has been placed either on a “moral” disciplinary approach or on a social model invoking the environment in its broadest sense as the dominant source of misbehaviour and learning difficulties in school. Compared to their American counterparts, British educators have tended to be mistrustful of the benefits of labelling and drug intervention as a method of behavioural control and a means of addressing academic underperformance. These attitudes are supported by British educational legislation which, contrary to American law, does not recognise specific categories of disability and does not give access to special services on the basis of these categories.

Of course, in the present age of the internet and evidence-based medicine, the differences between American and European perspectives have become much less noticeable. Ideas about ADHD are now widely circulating within global networks of psychiatric, scientific, and public exchange, and clinical practices are increasingly regulated through the use standardised rating scales and guidelines which reflect the growing impact of risk discourses and approaches in the governance of troublesome individuals. The increasing use of ADHD diagnosis and stimulant treatment can thus be used a powerful lens through which to view the processes by which the two countries have recently converged in terms of medical, educational, and wider cultural practices and values. However, as we shall see in the following, the factors sketched above continue to shape and differentiate approaches to ADHD/hyperactivity in the US and the UK respectively. Seen from this perspective, hyperactivity represents a useful framework for analysing recent transformations of local Western psychiatric and educational cultures in an increasingly globalised world, and addressing persisting tensions between local and global constructions of disability and psychiatric disorder.

1.2 A divisive disorder

ADHD is both the most studied and arguably also the most divisive disorder in the history of child psychiatry. Its history is first and foremost marked by deep

controversy, both in the public and in the professional domain. The same can be said about the stimulant methylphenidate (Ritalin), which up until recently was the most commonly prescribed drug for the disorder.² Really, ADHD and Ritalin cannot be separated in public debates, where they both enjoy almost iconic status as focal points of modern anxieties about children, parenting, families, schools, city life, and Western civilisation in general. Since the early 1970s, when stimulants first started to be used in disruptive children in the US, environmental and cultural views on hyperactivity have been positioned on one side of a polarised and heavily politicised debate about the legitimacy of the diagnosis, the other pole being occupied by the biomedical perspective which currently posits dopamine processing dysfunction as the key to understanding the condition and recommends drug therapy as the most effective treatment. Psychiatric research has increasingly emphasised the interplay of nature and nurture; gene-environment interaction is clearly the respectable contemporary framework for discussing and researching genetic inheritance. But in practice the environmental perspective has been seriously weakened in the face of sophisticated medical research asserting organic aetiology, and powerful patient advocacy movements. However, there is still considerable resistance to the diagnosis, certainly in Europe, but also inside the US where disparate groups of cultural commentators, academics and dissident paediatricians and psychiatrists continue to voice a deep concern about the global ADHD epidemic.

Fundamentally, ADHD diagnosis and stimulant treatment is seen as controversial because children are usually diagnosed and medicated as the result of decisions made *for* them by parents and clinicians. Moreover, ADHD diagnosis is based on the existence of behaviours that are widely distributed in the whole population. One of the most enduring objections from commentators representing varying degrees of opposition is that ADHD cannot be distinguished accurately

²Up until the late 1990s, the stimulant drug Ritalin was by far the most prescribed, but its position as the most prescribed has now been taken over by extended release drugs such as Adderall and Concerta. Whereas Ritalin had to be taken two or three times a day, posing practical problems in school, the effect of the new drugs lasts longer.

from neither “normal” child behaviour nor from other child disorders in terms of its cause, prognosis and treatment. The American taxonomy in particular has provoked widespread disagreement, with critics questioning the wisdom, clinical utility and motivation of making a wide variety of children’s behaviours classifiable as separate mental disorders, not least because the reliability among diagnosticians has been shown to be low ([Kirk & Kutchins 1994](#)). The identification of ADHD children through scores on behaviour rating scales is problematical as there are no objective cut-off points and because raters’ standards and tolerance for disruptive behaviour may differ significantly. Similarly, diagnostic criteria themselves just refer to “abnormal” levels of childhood behaviour. Even psychiatrists sympathetic to the classification system have acknowledged the above mentioned problems. As [Achenbach \(1980\)](#) noted, attempts to define valid psychiatric syndromes in children “represent provisional, state-of-the-art compromises with ignorance rather than definitive achievement” (p. 396).

As regards the possible causes of ADHD or hyperactivity, opponents have often argued that there is insufficient evidence to show that the group of children identified by the label suffer from a neurological disorder, despite decades of theorising to the point ([Breggin 2002](#); [Carey 2002](#); [Leo & Cohen 2003](#); [Timimi et al. 2004](#)). They emphasise that no definite cognitive, metabolic, neurological or genetic markers have yet been found for ADHD, notwithstanding considerable recent efforts to establish a biological aetiology through pharmacological, genetic and neuroimaging research. Further, critics point to the constantly changing psychiatric definitions of hyperactivity; to the situational character of hyperactive behaviour; and to the widely varying epidemiological and diagnostic prevalence rates quoted both nationally and internationally during this period.

Firstly, the gender and race distribution of ADHD differs considerably between countries. Whereas in the UK it appears to be an overwhelmingly white male disorder, it is not distinctively white in the US, although treatment rates among racial minorities and specifically African Americans still lag somewhat behind those of white children ([Bussing et al. 1998](#); [Olfson et al. 2003](#)). Further, since the introduction of pure inattentiveness as a diagnostic subtype in the DSM-III ([1980](#)),

the disorder has become less distinctively male in the US, shifting the nation even further away from the European norm. In 2004, the estimated overall prevalence was 7%, with 2.5 boys afflicted for every one girl. In Britain on the other hand, only 1.6% of children met the criteria for the corresponding ICD diagnosis Hyperkinetic Disorder in a respective gender ratio of 6 to 1 ([Hart & Benassaya 2009](#)).

Secondly, regional and local differences can be vast, as a function of geography, race-ethnicity, religion, and socio-economical factors. Data from the Drug Enforcement Agency (DEA) has shown that stimulant use and consequently ADHD diagnosis vary greatly within the US, from state to state, community to community and even from school to school ([Woodworth 2000](#); [Singh 2006](#)).³ In the UK, similar tendencies have been demonstrated, with figures supporting the impression that income and social class has a greater effect on diagnostic rates than in the US. Whereas ADHD is considered to be a middle class phenomenon in the US, linked to anxious parents' fears about their children's academic achievement and a health care system dominated by private medical insurance and consumer choice, in the UK the diagnosis seems to be most prevalent in lower socio-economic groups ([Donald 2007](#); [Prior int. 2006](#); [Timimi int. 2006](#)).

In response to the above arguments, supporters have drawn on what [Malacrida \(2003\)](#) refers to as discourses of interprofessional consensus and depictions of the "typical"/ideal interdisciplinary assessment and treatment process. Thus, in a recent consensus statement, a consortium of leading international ADHD researchers retort that recent findings from brain scanning and genetic studies have established the organic basis of ADHD beyond reasonable doubt, showing that the disorder is highly heritable and involves structural as well as functional abnormalities in those regions of the brain that are implicated in executive control ([Barkley et al. 2004](#), p. 65). They furthermore argue that the controversy over ADHD's validity is sensationalist, "existing only in certain

³The best documented "hot spot" of Ritalin use is a three-city cluster in the south-east corner of Virginia, where one in five white primary school boys was found to take the drug ([LeFever et al. 1999](#)). Other states with high use rates included New Hampshire, Vermont and Michigan ([Woodworth 2000](#)).

segments of the popular media, not in the scientific community”, and that the absence of objective diagnostic tests and local clinical misdiagnosis or mismanagement does not evidence against the validity and existence of the disorder. Indeed, it is noted that the application of the standards set by critics for “genuine disorders” (including the availability of clear biological markers, stable prevalence rates across time and place, and low comorbidity) would render invalid all known psychiatric disorders and even a substantial number of medical ones.

From a broader public perspective, the most controversial aspect of ADHD – both in the US and the UK – has been its widespread and escalating treatment with psycho-stimulants. In the US, Ritalin has in fact not been out of the media since 1970, when an article in the popular press claimed that up to 10% of children in Omaha, Nebraska, were being medicated ([Maynard 1970](#)); the ensuing furore even resulted in a Congressional Hearing ([Gallagher 1970](#)). Since then, many commentators have argued that these drugs are over-prescribed, potentially harmful and without lasting beneficial impact.⁴ These protests have grown as stimulant use has increased exponentially. Whereas the number of American children and adolescents on stimulants was estimated to 150,000-200,000 in the early 1970s ([Grinspoon & Singer 1973](#); [Safer 1971](#)), by 2000 the estimate was around four million children, many of whom were diagnosed after a cursory examination and without any prospects of receiving the recommended combination therapy of drug, behavioural and educational interventions ([Diller 1998](#); [LeFever et al. 1999](#)). In 2010, according to the National Health Interview Survey, as many as 8.4% or 5.2 million American children between the ages of 3 and 17 had been given an ADHD diagnosis ([Hruska 2012](#)). In the UK, the increase

⁴Apart from the number of children on stimulants, the actual effects of these drugs have been hotly debated for many decades. Ritalin has commonly been portrayed an effective, relatively safe and extremely well-researched drug. However, an increasing amount of research shows that though it may be efficient in reducing hyperactivity and improving school performance in the short term, its long-term beneficial effects on learning and behaviour remain to be demonstrated ([Zwi et al. 2000](#); [Molina et al. 2009](#)). In addition to frequent and immediate side effects such as decreased appetite and insomnia, potential long-term consequences of the medication are said to be dependence, cardiovascular dysfunction, as well as damage to the child’s or adolescent’s psychological sense of independence and self-control ([Breggin 2002](#); [Timimi et al. 2004](#)). Furthermore, there are long-standing concerns about the potential for later drug abuse.

was also steep. Although psychotropic drug prescription to children is still limited compared to North America, figures show a massive increase in prescriptions for methylphenidate in England alone, from 2000 in 1991, over 158,000 in 1999, to 661,463 in 2010 ([Doward & Craig 2012](#)).

1.3 The main aims of the thesis

Being linked to a specific drug treatment, hyperactivity always held unique promise for a revived biological psychiatry. Yet, the great geographical variation in diagnostic and treatment rates, as well as the significant mediating roles of ethnicity, gender and class in the diagnostic process, present convincing evidence of the influence of social and cultural factors on the presentation and identification of childhood hyperactivity. Hyperactivity/ADHD and Ritalin treatment are embedded in local historical and national contexts that nurture their development, and to better understand their contemporary roles we need to examine the local stories of how they came to be salient features of medical and educational settings in individual countries. However, when turning our attention to the bigger picture, it is necessary to look at the broader cross-national flows of information, people and cultural influences that have shaped disciplines, institutions, and practices, and facilitated the recent global growth of ADHD and paediatric psychopharmacology.

Adding a much needed historical and comparative dimension to current debates about Attention Deficit Hyperactivity Disorder (ADHD), the present thesis provides a careful analysis of the changing construction and treatment of childhood hyperactivity in Britain and the United States, focusing on the intersecting political, technological, professional, ideological and cultural dimensions of the disorder in these two national contexts in the period from 1960 to 2010. The focal point is the historical discrepancy between the two countries in diagnostic and therapeutic practices, and the question of how and why views and practices have increasingly converged over the past 20 years. While British medical

and educational professionals continued to rely broadly on environmental explanations and behavioural or disciplinary interventions for most disruptive behaviour in school children, the American concept of hyperactivity disorder from the 1960s onwards became increasingly inclusive and biomedical in orientation. This expansion was closely related to the rise of psycho-stimulants as a widely employed treatment for hyperactivity and attention problems in the US. British and other European clinicians, on the other hand, resisted drug treatments up until the mid-1990s, when rates of diagnosis and prescription grew dramatically on both sides of the Atlantic. A key aim of this study is to explore and explain the rise of ADHD and Ritalin in both the American and British contexts, looking at the interplay of political, professional, institutional and socio-cultural factors that have contributed in each case.

Because hyperactivity/ADHD has long been seen as a uniquely American problem, our understanding of various national dynamics hyperactivity is impoverished. A significant literature now exists on the history and sociology of ADHD in the US, but so far, very few people have written about how overactive, inattentive behaviour in school children has been perceived and treated elsewhere, including Europe. As regards child psychology and psychiatry overall, the history of these sub-disciplines has, with few exceptions, received limited serious scholarly attention on either side of the Atlantic, despite the by now vast literature on the history of general psychiatry, and on childhood and the family. Further, the majority of the existing historical work focuses on the period before World War II, in which hyperactivity was rarely perceived as a problem in and of itself.

The thesis will address this imbalance by concentrating on the past 50 years, and by looking at the relationship between British and American approaches, aiming not only to uncover the UK story but to also use this to reflect upon and rethink the established US narrative. Although I will provide new material on US developments, my main contribution in terms of original research will consist in an analysis of the British case, which offers an excellent opportunity to study alternative, more pluralistic views of hyperactivity, as well as the uneven process of medicalisation and associated struggles over the legitimate definition of the

problem of disruptive behaviour and cognitive impairment in children. However, in order to complicate the picture of stereotypical national differences often presented in popular accounts, I shall highlight the influence of social as well as biomedical discourses on hyperactivity in the two settings over time; the increasing communication and collaboration between medical communities in the US and the UK; parallel developments in the area of schooling; and the cross-Atlantic movement of ideas in the public sphere, illustrated for example by the emergence of American-style parent support/opposition groups in the UK in the 1990s.

1.4 Historical comparison: advantages and pitfalls

As the contribution of this thesis to the history of ADHD mainly lies in its comparative aspect, I should first like to offer a few observations concerning the inherent difficulties of doing comparative analyses. Comparative history has few detractors but even fewer practitioners. While there are several methodological treatises on the subject of comparison, including various typologies ([Skocpol & Somers 1980](#)), these works only infrequently discuss the pitfalls and the advantages of the endeavour. Comparative history is concerned fundamentally with differences and similarities, and often with questions of causality. The question of “comparability” must thus be a basic issue: are the countries, regions or institutions under examination too different or similar to yield meaningful, interesting contrasts? Deciding which countries or areas are suitable for comparison depends greatly on the questions one seeks to answer. If one wants to examine and explain differences, it is generally a good idea to choose countries which are quite similar, as this makes it easier to identify areas of discrepancy that might shed light on the research problem (in my case the highly varying rates of ADHD diagnosis) ([Vallgård 2003](#)).

With this point in mind, I have chosen to compare the US and the UK, two countries with highly developed medical sectors, where practices and views surrounding hyperactivity have been significantly intertwined, yet sufficiently

opposed to generate remarkable differences and questions, particularly in the period between the early 1960s and early 1990s. Moreover, as noted by [Cohen \(2001\)](#), potentially successful topics are those that seemed to contemporaries themselves inherently comparative – topics that were the object of international discussion, itself revolving around similarities and differences. Since the 1970s, the medical literature on hyperactivity has often drawn attention to the huge discrepancy in diagnostic rates and treatment strategies, although not exploring the possible explanations in any depth. Subsequently, with the advent of ADHD in Britain, the popular media have followed suit, frequently framing features on the disorder and its drug treatment in terms on this discrepancy and the recent “Americanisation” of British practices.

Comparative history differs from other historical methods in that it takes a specific line of questioning to compare two or more cases stemming from different contexts. The aim is either to bring out the resemblance and disparity of the cases compared, or to determine or test the scope of particular theoretical approaches. While social scientists have tended towards the latter approach and made comparison a stock in trade, for historians it remains more controversial as the methodology of comparison is in many ways seems incompatible with fundamental principles of historical study ([Bonnell 1980](#); [Haupt 2001](#)). First and foremost, while historians have traditionally evoked the proximity of their work to original sources as a special proof of its scientific nature, a comparative study (especially those comparing more than two cases) typically depends more heavily on secondary literature. To some extent, this is necessarily also the case for the present thesis which is quite wide in scale, spanning 50 years, two countries, and three sites of enquiry: medicine, education, and parent advocacy. However, apart from simply using secondary material to provide contextual information, I shall also be testing already existing narratives through my primary source material.

From the point of view of history or qualitative social sciences like anthropology, another problematical aspect of comparison is the method of isolating variables and reducing the complexity of individual cases in subjecting them to examination from a specific perspective. Comparative studies often violate

the important principle that aspects of reality cannot be understood separately from their place within a total cultural context or within a historical development. A particularly tricky issue is that of causality, which becomes acute in two-country comparisons that focus mainly on national differences (Cohen 2001). In attempting to explain why phenomenon X developed in country A and not in country B, comparative studies tend to place weight on just a few factors, and a focus on *why* thus replaces attention to *how*. Whereas historians' arguments normally tend towards the multi-causal, drawing on all the factors that can explain a particular phenomenon, comparativists are often caught in a mono-or bicausal trap. Further, it is important to acknowledge that the same variables can have divergent functions in different societies, and to examine the interplay and interdependence of various factors. Variable X may work very differently in countries A and B, depending on the context; in the latter, it may be of primary importance, and in the former only of negligible significance. So how does one isolate the critical variables, especially if similar phenomena can have different causes, and if divergent outcomes stem from apparently related factors? Certainly, every researcher seeking explanations for national or regional differences eventually confronts the problem of distinguishing the causal from the purely contextual.

Qualitative case studies examining complex phenomena like the diagnosis and treatment of psychiatric disorder are likely to identify not just a few but many relevant contributing factors or variables. In comparing approaches to hyperactive children in the US and the UK, my thesis will thus discuss multiple issues, including the growing significance of biological perspectives in child psychiatry; health care organisation; pharmaceutical industry influence; attitudes to the use of medical labels and drug treatments; the relationship between medicine and special education; the increasing pressure on schools to be both inclusive and competitive; disability rights- and parent activism; and the influence of alternative theories of hyperactivity, especially those associated with dietary management. Yet, as I will demonstrate, these factors have played different roles in the two countries, with some being more important than others in each context. It is clear that a set of unique circumstances and dynamics have informed the increasing medicalisation

of disruptive child behaviour and learning difficulty – as well as the resistance to the medicalisation process – within each country, although there are many links between the two cases.

A crucial issue facing comparative studies is the difficulty of determining whether a given development or phenomenon can best be explained by circumstances internal to a given country or institution, or whether it is better seen as a result of influences which span various cultures or areas ([Vallgård 2003](#)). At a time when some call into question the very existence of the nation, much comparative work is characterised by what seems an old-fashioned sensibility. A nation does not necessarily constitute a meaningful unit of comparison, because it rarely refers to a homogeneous, clearly demarcated cultural, social and economical entity, and because it does not always constitute a relevant context for actors and institutions. If one examines phenomena related to legislation, the nation state will often be a relevant unit of comparison, but if one looks at cultural trends and factors, this is often not the case. Some of the most severe criticisms of comparative history come from historians who themselves work across national boundaries. They propose instead a history of “transfer” that pays attention to the dynamics that obtain between countries: accounts of points of contact, of movements that travelled, of ideas and personnel resources that were exchanged. Rather than simply focusing on national similarities and differences as well as their causes, such histories can tell us about transnational circulation and international phenomena ([Roelke et al. 2010](#)).

In the case of hyperactivity/ADHD – a global phenomenon with important local variations – both the national and cross-national levels are relevant frames of analysis. While comparing and contrasting two countries, the present thesis will – in keeping with the above sentiments – emphasise the implications of the growing exchange of ideas and information between the US and the UK/Europe, both within the medical and psychological disciplines and among the lay population through information technologies such as the internet, which has come to provide a powerful new way of engaging in biomedical self-education, as well as a means of challenging the biomedical paradigm. While the increasing globalisation of

knowledge and truth claims have contributed greatly to the recent convergence of British and American approaches to hyperactive children, it has also sparked opposition and fierce debate, reflecting fundamental differences in ideologies, experiences, practices. It is therefore unlikely that national or regional differences in the child mental health area will soon be an issue of purely historical interest.

Another way of deconstructing national patterns and avoiding essentialism is to seek out alternative entities of comparison; clearly, studies of cities, regions or local institutions are potentially lower-risk strategies that preserve particularities. However, due to the broad scope of my project, I have not been able to pursue this option, at least not systematically. Nonetheless, I shall endeavour to point out local variations in perceptions and practice, when possible. Not surprisingly, regional differences are particularly marked in the US which comprises numerous states with disparate outlooks and policies, but they are also characteristic of Britain. Of the different countries making up the UK, it would certainly be interesting to look specifically at Scotland, which has many separate traditions, especially in education, and wide-ranging government powers in key areas such as health and schooling. But due to space and time constraints, this has not been feasible to any great extent.

In spite of the many methodological difficulties, comparative studies have much to offer, provided that the researcher is aware of the complexity of social phenomena, and the limitation of the unit of comparison, in this case the nation state. An obvious reason to compare is that historians, social scientists and policy makers do it anyway and often badly and unsystematically. Second, comparison can provide a first line of defense against obscurantism by forcing the researcher, at an early stage, to answer why the project matters. Third, comparative work may provide a counterfactual glimpse that illuminates a path not taken or policies not pursued, and thus relativise over-determined historical narratives. As such, it may clarify the importance of institutions and phenomena that national historians take for granted.

1.5 Primary sources

Interviews with physicians, educators and parent activists represent an important part of my primary source material. Given the sheer volume of medical books and journals available on hyperactivity or ADHD, one might think that oral history could make only a modest contribution to the project at hand. But in fact, the overwhelming amount and complexity of printed information means that it can be very helpful to use “native informants” to sort out the significant from the inconsequential. Moreover, for all its volume, the documentary record of modern biomedicine is rather barren, containing very little personal analysis or reflection. Just as patient case histories have become highly technical records devoid of revealing commentary, journal articles tend to be highly schematic and specialised. For these reasons, the written record of recent medical history is likely to be very unsatisfying to future generations of historians. The richness of oral histories, on the contrary, allow for a return to a more believable world of human beings who act and reflect, while also revealing the role of influential personalities, the “accidents” of time and place, and the context of critical decisions and points of change. There are of course limitations to consider. The chief strength of qualitative interviews lies in their documentation of personal experience and memory, not of specific facts or events (although they can also be employed to this effect in cases where written records are lacking). Historians therefore have to be careful to check the reliability of an individual’s recollections as far as possible, and to ponder the meaning of distortions and omissions.

My method for locating professional informants was to identify the key people shaping the debates over ADHD in the US and the UK, and those who have done important research on hyperactivity, either in a medical or educational context. In turn, they would refer me to other people – often practicing consultants and special education teachers – whom I would not have been able to identify through various media. One might question the focus on professional leaders, rather than, say, social workers, nurses, health visitors, GPs, or classroom teachers. However, as the project is truly about looking at the big picture, identifying and interviewing

those who have visibly defined and criticised trends in the management of hyperactive children, the key figures necessarily had to be my first priority, although I have also endeavoured to get a good impression of clinical and educational practice on the ground. The changing attitudes and practices of groups of caregivers and school personnel who have close contact with children and their families are of course highly relevant, but collecting the thoughts and memories of practitioners representing all these professions was outside the limits of this study.

As might be expected, oral history programs have tended to focus primarily on doctors and policy makers, but historians must furthermore think about the broader social context of medicine, particularly the changing nature of the doctor-patient relationship, perceptions of medical authority, and the impact of disease on everyday life. As consumers, patients now play a much more critical role in shaping the politics of medical care than they did even 25 years ago. Offering an excellent example of the trans-national influence of “parent power”, the ADHD field is no exception. While interviews with physicians provide a useful supplement to their publications and often serve to enhance and refine these sources, oral evidence often represents the only means of capturing the important perspectives of patients and parents. Thus, I interviewed a number of founders and leaders of parent organisations in both the US and the UK, and participated in a regular meeting of the Milton Keynes ADHD Support Group. Here, I took the opportunity to talk to several parent members about their experiences of living with an ADHD child, as well as their encounters with various medical and school authorities.

All interviews conducted for this project were semi-structured and open-ended; a specific list of questions was prepared for each individual interviewee, but the interview was not limited to these questions. While most interviews were conducted in person, others were for practical reasons carried out over the telephone, or, in a few cases, via email. Once transcripts had been prepared and analysed, interviewees were often sent follow-up questions to clarify or elaborate responses. Considering the topic’s controversial and politicised nature, I was not surprised to find that some of the medical experts and ADHD parent activists

seemed rather defensive and wary of political motives on my part. But the vast majority seemed happy to tell their stories and clearly appreciated the opportunity to express their views on the subject and the ways in which things have changes over time. None wished to be anonymous, although several instructed me to keep some of their information and opinions on key people and developments confidential. These wishes have of course been respected.

Here, I must note that it was not possible to conduct any interviews with the actual patients, that is, children with ADHD. It would certainly have been fascinating to hear children's own views on what it is like to live with ADHD and to take stimulant drugs, but apart from the difficulty of obtaining ethical approval for such a project, it is clear that the phenomenology of ADHD diagnosis deserves a comprehensive analysis and is sufficiently complex to form the basis of several theses in its own right.⁵

Another category of primary source material utilised here serves to represent the original research and views of the medical and educational communities in the US and the UK respectively. It includes medical textbooks, journal articles, monographs, editorials, letters to the editor, book reviews, unpublished surveys of clinical practice, discussion papers, and official position statements. These documents are supplemented by drug adverts appearing in various medical journals, and information booklets on ADHD and stimulant treatment, produced by drug companies and directed at teachers. In terms of government sources, I draw on various committee reports, surveys and reviews of health care services and education, White Papers, circulars and guidelines for clinical and educational practice, congressional hearings, and UK parliamentary debates on ADHD and stimulants.

Apart from the interview material, most of the data in the chapter on parent

⁵In fact, one of the first studies to focus on ADHD patients themselves has recently been completed by Ilina Singh and colleagues, who interviewed and compared a group of children in the US and the UK ([Singh et al. 2010](#)). See [Singh \(2011\)](#) for a discussion of the lack of empirical attention to the lived experience of ADHD in the by now significant sociological/bioethics literature on the social and ethical dimensions of the disorder, resulting in the bracketing of the possibility of children's agency, resilience, and active negotiation of stigma and labelling.

activism come from support group websites and discussion forums, as these sites constitute the main means of communication for parents looking for help and guidance from others in a similar situation. In addition, I have looked at position statements and a variety of pamphlets published by parent organisations. The pamphlets deal with a wide range of issues, from simple advice on the day-to-day management of ADHD, over information on legal rights concerning social security and special education, to instructions on the dangers of food additives.

Finally, newspaper articles and TV programmes about ADHD, Ritalin, and other related subjects, provide a key source of evidence. Rather than using news features as a source of factual information, I am mostly interested in how the media have represented the topic of hyperactivity, parenting, schools and stimulant drugs to the public. Media stories both reflect and significantly shape popular attitudes in the two countries. In the US, they played a major role in the backlash against Ritalin in the late 1980s and 1990s, and in Britain, too, coverage has tended to be rather sensationalist and polemical. One major difference, however, is the great amount of attention given by UK media given to the idea that learning and behavioural problems in children are closely associated with diet.

1.6 The child as a psycho-medical object: relevant background literature

The identification of childhood hyperactivity as a distinct and significant disorder can only be understood within the context of the multiple histories of psychiatry, psychology, paediatrics, education, and more generally the social histories of childhood and the family, including parent-child relations, family evolution, and child health (Aries 1962; Cooter 1992; Hendrick 1997; 2003a; Rose 1990; Zelizer 1985). Western family life has changed radically over the last century, with decreasing family size, growing state dependence, incursion of specialist agencies, female emancipation, declining parental authority, and emphasis on the status and rights of children. However, the late 19th and early 20th century developments which initially created the conditions of possibility for the disorder's emergence

include first and foremost the establishment of childhood as a discrete phase of life; the formalisation of compulsory education; and the emergence and institutionalisation of paediatric medicine, school psychology, child guidance and child psychiatry. Furthermore, the appearance of the broader concept of ADHD in the late 20th century depended on the rise of psychopharmacology and the wide dissemination of quantitative psychological assessment methods like behaviour rating scales.

The last 30 years have seen much work in the history of general psychiatry, including revisionist interpretations of 18th- and 19th century lunacy institutions and practice ([Porter 1987](#); [Scull 1993](#)), critical examinations of the shift from asylum to community psychiatry in the 20th century ([Grob 1991](#); [Scull 1984](#)), and accounts of the development and impact of biological psychiatry ([Braslow 1997](#); [Healy 1997](#); [2002](#); [2004](#); [Valenstein 1986](#)). Further, a number of general overviews of the history of psychiatry have appeared ([Berrios & Freeman 1991](#); [1996](#); [Freeman 1999](#); [Menninger & Nemiah 2000](#); [Shorter 1997](#)), the majority containing a chapter on the evolution of child psychiatry. However, the fields of child psychology and psychiatry have received very little serious historical attention in comparison, especially in the post-war era, in which the most significant developments in the perception and treatment of disturbed children have occurred, with marked expansion of clinical services, research, and training. Textbook chapters and articles in medical journals usually provide brief internalist accounts that offer little information on social, political and cultural contexts, and ignore the debate and discord that has characterised discussion of disorders such as ADHD amongst the medical community and the lay public ([Cameron 1956](#); [Chess 1988](#); [Hersov 1986](#); [Howells & Osborn 1981](#); [Klein 1999](#); [Schowalter 2000](#); [Slaff 1989](#); [Staples 1995](#)).⁶

As one might expect, most of the existing literature on child mental health

⁶Nevertheless, a few commendable articles are available, written by historians and by practitioners with a special interest in historiography ([Neve & Turner 2002](#); [Parry-Jones 1989](#); [1992](#); [1994](#); [Wardle 1991a;b](#)). These articles also contain useful reviews of pre-20th century literature on childhood mental and behavioural disorders, reminding us that it is misguided to seek origins simply in terms of recognizable modern specialisation.

concerns during the 20th century is in some way informed by various sociological theories of medicalisation and by Foucauldian notions of governance and social control.⁷ One important area of study has been the normalisation and medicalisation of human behavioural and cognitive differences in the late 19th and early 20th centuries ([Armstrong 1983](#); [Castel et al. 1982](#); [Donzelot 1979](#); [Rose 1985](#); [1990](#)). Generally, scholars within this field have described the emergence of categories of child behavioural pathology as the combined outcome of various social, political and professional developments, notably the interests of the new disciplines of paediatrics and child psychology/psychiatry, and the imposition of universal education, which filled the classroom with children unable to comply with the school's disciplinary requirements and offered scientific investigators unprecedented opportunities to study large numbers of children. Another influential body of work uses the conceptual lens of the medical labelling of deviance to make sense of the diagnostic process ([Conrad 1976](#); [Conrad & Schneider 1992](#)). Problematising conventional liberal theories of progress, all these accounts question the extent to which the state and the various "helping professions" have always had children's needs at the forefront of their concerns.

The historian Harry [Hendrick \(2003a\)](#) has suggested that the history of child health might be usefully examined through three dualisms – bodies/minds, victims/threats, normal/abnormal – and on a more general level through the notion of children as investments in the future. Modern childhood was in large measure legally, socially, psychologically, educationally, and politically institutionalised between the 1880s and the 1930s. Whereas economic criteria had previously been crucial in determining the value of children, the new ideal of the child became that of an emotional asset belonging in the world of domesticity, school and play. This "discovery" of childhood and the subsequent changes in the perception of children focused increasing attention on their welfare, behaviour,

⁷ According to historian of childhood, Harry [Hendrick \(1997\)](#), the role and position of children in certain periods have been neglected by historians – most notably in the inter-war and post-war eras – which means that for the more recent period, one has to draw on the work of psychologists, social policy analysts, health care specialists, and sociologists. The reason, he concludes, is not only children's lack of voice, but also that they are viewed as becoming rather than being (pp. 3-6).

and capabilities. From the turn of the century, there was a growing interest in the mental as well as physical features of children: in observing, recording, individualising, and classifying them. The focus on children's minds and behaviour can be traced from child study movement of the late 19th century, through to the child guidance clinics of the 1920s and beyond, as interests moved along a spectrum of social and psychoanalytical concerns. Among the interests and concerns were "feeble-mindedness", causes of juvenile delinquency, developmental psychology, child-rearing advice, "maladjustment", and post-war notions of maternal deprivation and bonding within families. Since World War II, a wide range of socio- economic changes – including the increasing instability of family units and the growth of the mass media – have arguably contributed to a rise in psychosocial disorders in young people (Hess 1995). At the same time, the psycho-medical focus on children and adolescents has intensified and problem behaviour in children has become increasingly medicalised.

Drawing on Foucault, Nikolas Rose has provided a number of interpretations of the key role played by the "psy" disciplines in the discursive formation of the modern self and the transformation of authority in a therapeutic direction (Rose 1985; 1990; 1996).⁸ In *Governing the Soul* (1990), which concentrates mainly on Britain and draws on various government reports and legislation, Rose explored how psychology and psychiatry have created new norms for the development and behaviour of children and new ways of conceiving of and intervening in family life. A key argument is that the new social and scientific interest in childhood as a life stage was underpinned by a concern for the future of the nation and the race. Seen from this perspective, the upsurges of concern over the young were moral panics

⁸Drawing on Foucauldian notions of subjectification, Rose challenges the humanist conception of the ethical priority of the individual, seeing the self instead as a product of various techniques, particularly psychological, which have been developed during the 20th century. He argues that the proliferation of psy-disciplines after World War II has been intrinsically linked to transformations in the rationalities of political power in advanced liberal democracies towards self-government. Therapeutic ethics promises a system of values freed from the moral judgement of social authorities; it governs while allowing us to shape our existence according to current ideals of autonomy and choice. Thus, he notes, the true significance of psychological techniques lies in the function they serve in helping individuals fulfil the "obligation to be free", entailing the right to material acquisition and self-fulfilment (Rose 1996, pp. 97-98).

that professional groups used in order to establish and increase their empires. According to Rose, the family (and especially the mother) became a key mechanism for shaping and maximising capacities and conducts in accordance with the moral and political principles of liberal society, growing increasingly autonomous and responsible, yet always open to state intervention if its products were deviant. Normalisation thus opened up the psyches of children and their mothers to a new form of regulation from within: parents would now cooperate voluntarily, socialising their children through the activation of their own hopes and fears, the misalignment between expectation and realisation fuelling the constant demand for expert assistance in the task of producing normality (ibid, p. 130).

Functioning as the hub of the movement for mental hygiene in the interwar period, the child guidance clinic was one of the most significant sites for the study, diagnosis, and treatment of disturbed or “maladjusted” children. The child guidance movement started in the US, the defining feature being the interdisciplinary collaboration between psychologists, psychiatric social workers and psychiatrists. The American team concept was soon imported to Britain where the first clinics opened in London in the late 1920s. The original goal of the clinics was to deal with the problem of juvenile delinquency, yet they rarely met with those criminally deviant cases for which they were initially intended. The existing historical studies of child guidance in Britain focus to varying degrees on the introduction and reception of dynamic psychology in the interwar period, both in the professional and the public spheres (Hayes 2008; Thom 1992; Urwin & Sharland 1992). Hayes’ study in particular highlights the inter-professional rivalries and competition for control which emerged over the management of maladjusted children, while also examining the crucial role played by lay agents such as magistrates, philanthropists, and progressive educationalists in the establishment of child guidance and therapeutic-based education in Britain. In exploring the actions of both medical professionals and lay agents, she thus reveals the tensions that emerged due to differing ideals and agendas relating to professional advancement and child welfare.

More work has been done on the American context, but again not on post-war

developments. The main works all depict the shift in the 1920s from a Progressive-inspired concern with the deprived delinquent child to a focus on the broader, less severe mental health issues raised by the middle class “problem child” (Horn 1989; Jones 1999; Richardson 1989). Theresa Richardson and Margo Horn have both thrown light on the influence of funding agencies as well as professionalisation, arguing that the desire to build a successful record helped some children, but only by excluding those most in need. On the other hand, Kathleen Jones’s study of Boston’s Judge Baker’s Guidance Center concentrates primarily on “mother-blaming” as the thread tying the progressives’ work with that of their successors (Jones 1999). Mother-blaming is usually traced to the popular dissemination of Freudian psychology in the 1950s, but Jones argues that it actually has roots in the interwar child guidance clinic which “democratised” this practice by extending it to the middle classes.

Since World War II, the psy-disciplines have increasingly provided the vocabularies with which the troubles of children have been described, and the expertise for diagnosing and treating them. Whereas psychodynamic discourse remained central to the understanding of children’s behavioural and emotional problems in the post-war period in both the US and the UK, the past four decades have seen a growing reliance on quantitative methods of detection and diagnosis, somatic theories of aetiology, and brief treatment solutions involving drugs and behavioural therapy. Nikolas Rose (2003a;b) acknowledges this development in his works on the rise of “somatic individuality”, by which he means the current tendency in the Western world to define key aspects of one’s individuality in bodily terms, and to understand and act upon that body in terms of biomedicine. According to Rose, we are witnessing the emergence of a new “neurochemical self” that can be reconfigured in a way that blurs the boundaries between health and illness, and between treatment and enhancement (see also Kramer 1993; Parens 1998). Given that biology is no longer seen as destiny and life now appears to be open to alteration on the molecular level, it is argued that strategies of normalisation of “the deviant” are being replaced with methods seeking the correction of *specific* anomalies or vulnerabilities – interventions which work not

by eliminating the autonomy, freedom and choice of individuals so affected, but by locating them in a regime requiring constant work of adjustment (Rose 2003a, pp. 34-35).⁹

Such a scenario could be construed as nightmarish, but Rose disagrees with the pessimistic accounts of social theorists who talk of the rise of a new biological determinism or a new eugenics. Firstly, he argues, in contemporary biopolitics, the vitality of the species – the nation, the population, the race – rarely legitimates interventions into the lives of citizens (Rose 2001). Secondly, rather than stressing the individualising aspects of the new biomedicine, he points to the collectivising aspects of contemporary “biological citizenship” (Rose & Novas 2005). Individuals with various corporal vulnerabilities are increasingly joining into groups and organisations, not merely demanding public recognition, but making their own claims on the deployment of biomedical technologies as well as the direction of research. The proliferation of ADHD parent support groups over the last 20 years is an excellent example of this phenomenon, which Paul Rabinow (1996) has termed “biosociality”, that is, the forming of communities around biological or somatic categories to influence state policy and science. While Rose leaves more room for agency and contestation than in his early studies, he may well be overstating the novelty and reach of current trends – a common problem with much writing in the governmentality genre. The medical, social and political developments in question can only be said to apply to the wealthy West, where people have the means to engage in “life maximisation”. Further, as we shall see, there are still important differences in attitudes to psychotropic drug treatment and artificial enhancement within the Western world, especially in the case of children.

A dissertation on the history of child psychiatry – and perhaps especially one dealing with childhood hyperactivity – can hardly avoid dealing with the work of

⁹The idea of a shift from implacable abnormalities to manageable susceptibilities is consistent with the wider reshaping of government, with the movement from disciplinary societies as identified by Foucault to post-disciplinary societies of control where control is continuous and integral to all activities and practices of existence (Castel 1991). Today, individuals are required to be flexible and to constantly work on themselves, monitoring their own health and managing risks.

Michel Foucault and his followers. Looking at the rise of expert knowledge and social control through the regulation of bodies is clearly relevant as a way of theorising general trends in the relationship between society and psychological medicine, but this literature will not provide the overall framework for the present thesis. Saying relatively little about professional rivalries and local cultural variations, it is too abstract for my purpose of exploring national differences in diagnostic and treatment practices over time. Moreover, such a framework does not leave much room for agency and contestation, which are prominent features of the hyperactivity/ADHD field on both sides of the Atlantic.

Likewise, while the medicalisation thesis is essential to understanding how approaches to child behavioural problems have changed during the 20th century, it is clear that the top-down, unidirectional models of medical power and professional dominance brought forward by early critics like [Illich \(1975\)](#) and [Szasz \(1974\)](#) are inadequate. As sociological studies of medicalisation accumulated through the 1970s and 1980s, researchers emphasised that it could be bidirectional and incomplete, and it became obvious that it was not always the product of medical imperialism, but of more complex social forces. Clearly, the rise of medical interpretations of child misbehaviour needs to be understood not only in terms of the knowledge, ambition and status of a group of enterprising medical professionals, but also in the context of broader social, educational and familial transformations that have led teachers and parents to accept, or even seek, medical definitions of child unruliness. Claiming that child psychiatric disorders are simply a myth invented by a self-aggrandising mental health establishment for the sake of professional advancement neither explains how and why certain definitions of child behavioural disorder become popular at a given moment, nor why they have prevailed over other possible definitions of the problem.

As regards medicalisation process, there are still important under-theorised areas of enquiry, including the expanding and/or constraining role of the organisational context in which healthcare is financed and delivered; the role of institutional actors, most importantly the drug industry; and the role of patients as consumers. Initially, researchers depicted the medical profession, inter-

professional rivalries, or social movements and interest groups as the prime movers of medicalisation. These have all been important in the case of hyperactivity, but biotechnology (pharmaceuticals and genetics) and managed care (in the US) are now also major factors, and whereas the active public involvement in the expansion of the medical sphere has been recognised for some time, attention has now turned towards the ways in which health care is increasingly commodified and consumed like other products and services, for example through direct-to-consumer advertising and the internet (Conrad 2005). Physicians are still important both as claims-makers and as gatekeepers to specialist services, but their role has become more subordinate, particularly in the US, where commercial and market interests are so powerful. Furthermore, as emphasised by newer developments in social theory pointing to increased social reflexivity and loss of faith in expert systems, there are important limits to medicalisation. Many recent studies thus focus on lay challenges to biomedicine and on demedicalisation, for example in the area of disability activism (Epstein 2007, pp. 17-19).

In the area of ADHD, parent support organisations have, along with the drug industry, been implicated as key engines of medicalisation in recent years (Conrad 2007). Yet, it is important to emphasise that this process is complex, partial, and shaped by specific cultural and political contexts. For parents, gaining a medical validating label does not necessarily mean denying the potential social causes of the condition, or closing off therapeutic avenues other than medication; nor does it engender a retreat to individualised, de-politicised understandings of health and illness. Indeed, medical recognition and legitimisation may open up an arena for negotiation and action in which services and social structures are often a target for critique. Being associated with significant dilemmas and uncertainties, medicalisation is rarely an end in itself; in the context of ADHD, it can perhaps more fruitfully be seen as providing a platform from which parents can influence various actors, including children, doctors, teachers, and policy makers. Further, as shown by Edwards and colleagues in their ethnographic study of French and Irish ADHD support organisations, parent groups often actively engage with various bodies of knowledge and practices in a reflexive and pragmatic manner, in light of

their own experience, and thus participate in expanding the meaning of the condition beyond the “core” medical domain. But they do so differently, and to different extents, depending on the characteristics of the existing “web of expertise” in each country ([Edwards et al. 2012](#)).

Using a comparative perspective, this work similarly aims to critically engage with the concept of medicalisation in a way which addresses the question of local cultures and practices, and, moreover, how these have changed over time, by mapping the respective forces which have worked for and against medical approaches to disruptive child behaviour in the US and the UK during the past half century.

1.7 Social critiques of ADHD

As regards work which deals specifically with hyperactivity or ADHD, most of it falls into the category of social critique, with limited historical background and analysis. The last two decades have seen the publication of numerous commentaries that explore various socio-cultural influences on ADHD symptom presentation, diagnosis and treatment, and/or reassess the science behind the diagnosis. In the late 1990s, a public backlash arose in the US in response to the increasing number of ADHD diagnoses and stimulant use. Allegations that children were being diagnosed improperly and for non-medical reasons – poorly performing schools, family problems, pharmaceutical greed – appeared in newspapers, books, television reports, and at various hearings. The critique articulated by ADHD’s detractors was not based on new insights but was instead a reprise of criticisms that had been around since the emergence of the antipsychiatry movement of the 1960s and 1970s, drawing from Thomas Szasz and the adherents of labelling theory, and the political ideology of the patients’ rights movement. The most radical commentators denied the existence of ADHD as a medical disorder, attributing its symptoms instead to a host of environmental, social or dietary causes.

One of the more prolific opponents is psychiatrist Peter Breggin, whose controversial books have described the harmful effects of various physical treatments on both adults and children (1993; 1994; 2002, co-authored with wife Ginger Breggin). Following in the footsteps of Schrag and Divoky's classic polemic, *The Myth of Hyperactivity* (1975), he has argued that Ritalin treatment keeps inadequate schools and incompetent parents in place while accumulating power and wealth for medical institutions and drug companies. Other books in the same genre include Sydney Walker's *The Hyperactivity Hoax* (1998) which primarily blames parents' lack of discipline for ADHD; *No More ADHD* (2001) by Mary Ann Block, an osteopathic healer whose clinic promotes natural alternatives to drug therapy; and neurologist Fred Baughman's *The ADHD Fraud* (1999) which criticises the science behind the diagnosis.

A related perspective has been taken up by psychologist Richard DeGrandpre in *Ritalin Nation* (1999) which claims that children's hyperactivity and inattentiveness are the result of their living in a competitive, fast-paced and media-saturated world.¹⁰ As late as 1975, most American children spent the majority of their free time outdoors, but that quickly changed in the late 1970s, with the introduction of cable TV, the videocassette recorder and the home computer. Echoing Block (1977), DeGrandpre sees the high prevalence of ADHD as a reflection of the contradictory conditions of modernity: as a society we are forced into intensified on-task behaviour at work and school, and simultaneously, with an addict-like willingness, we crave the Technicolour onslaught of modern society's digitised, shifting, and distracting images.¹¹ According to this logic, ADHD summarises the failure to adapt to these confusing circumstances. Similarly, psychologist Leonard Sax (2000) maintains that a factor behind the rise of

¹⁰However, as Singh (2002b) points out, a major problem with research in this vein is the lack of empirical data to support radical assertions that seem destined for media exploitation. Both Breggin and DeGrandpre have thus synthesised pieces of disparate research and data and cite anecdotal reports from informants to support their claims.

¹¹This critique is reminiscent of the late 19th-century theories of American neurologist George Miller Beard, who popularised and promoted neurasthenia (nervous exhaustion) as a disease of modernity, caused by the over-stimulation of American urban life, and the psychological dislocation it produced.

stimulant treatment in the UK may be that British children now also spend substantially more of their time indoors, watching TV or playing video games, than their German, French or Spanish peers do.

Disagreement over ADHD and stimulants clearly extended beyond the disorder and its drug treatment, involving people's views on a wide range of vexing social and political issues: drug abuse, government regulation of consumer products, the role of private for-profit companies in medicine, the ability of the state to override parental authority, and the ability of the nation's schools to meet the needs of children, especially young boys. The divisiveness of topic intensified once social conservatives articulated a critique that tied the disorder to a larger ideological "culture war" (Mayes et al. 2009, p. 146). Pointing to statistics showing that boys were four times more likely to be diagnosed than girls, these critics described ADHD as indicative of a society increasingly hostile towards male traits, traditional discipline, the sanctity of the family, and the autonomy of private citizens from state control. To some, ADHD was merely an excuse concocted by liberals to justify efforts to reengineer young boys to fit the feminist ideal of behaviour; if boys could not be taught to be compliant, cooperative, and quiet, then Ritalin would make them so.

Boy-oriented critics and reformers often drew from the research of a handful of social scientists studying the psychology of boyhood, such as Dan Kindlon and Michael Thomson (1999), who have argued that ADHD diagnosis often medicalises "normal" boys who fail to attain the markers of high achievement in a harsh social and academic environment. Boys are thought to react to this oppressive system with externalising behaviours and depression, the true causes of which are not acknowledged by professionals. However, although worried about over-diagnosis, these authors accept the clinical reality of ADHD. The same can be said of paediatrician Lawrence Diller, whose moderate critique, *Running on Ritalin* (1998), raises questions about the overidentification of children with ADHD and the overuse of medication. Echoing Peter Kramer's best-selling *Listening to Prozac* (1993), Diller suggests that like Prozac, Ritalin too is used for "cosmetic purposes" in a culture that expects all children to perform to spectacular heights. He points

out that whereas the desire to improve children's chances is not new, drugs present a new means to reach these desired ends, with potentially serious implications for children's free will and personal responsibility (see also [Parens 1998](#)).

With their focus on issues of performance enhancement, competition and "cosmetic psychopharmacology", the above accounts can be seen as particularly American ([Elliot 2003](#)). But a number of critical publications have also appeared in Britain during the past decade, many of them authored by child psychiatrist Sami Timimi ([2005; 2010](#)) who has discussed the rise of ADHD at length, drawing on his own experiences as a working child psychiatrist in various British communities.¹² Following [Prout & James \(1997\)](#) in arguing for a cultural perspective, he claims that the dramatic increase in behaviour and learning disorders in children reflects a fundamental ambivalence in Western culture toward children and boys in particular. Many sociologists of childhood have recently drawn attention to the emergence of a dual vision of children as both "at risk" and "risky": as victimised, innocent beings who need rescuing, and as impulsive, aggressive troublemakers who pose a threat to society ([Jackson & Scott 1999; Stephens 1995](#)).¹³ This development, Timimi argues, has resulted in an increasing preoccupation with childhood deviance, and in the medicalisation of naughtiness and learning difficulties, as medicalisation resolves the ambiguity, allowing a child to be seen as a risk (if untreated) and a victim (having a medical problem). The common thread through both visions of childhood is the suggestion that modern society has seen a collapse of adult authority, putting enormous pressure on parents and schools who, in turn, have used the medical/psychological model to divert the perceived blame onto individual children and their biological make up.

Finally, the backlash against Ritalin and ADHD must be seen in the context of

¹²The historical and present cultural differences between the US and the UK are not discussed at length, however.

¹³Sociologists have recently argued that childhood in the West is being eroded. This concern with the end of "innocence", represented by the commercialisation of childhood and children's increasing access to the adult world of information and activity, is reflected in a large number of books, the most famous of which is *The Disappearance of Childhood* ([Postman 1983](#)). According to Timimi, the growing prescription of psychotropic drugs for children can be seen as an example of the blurring of boundaries between notions of childhood and adulthood, in part caused by the capitalist economy's drive to open up new markets.

the concurrent broader attack on biological psychiatry and its close relationship with the pharmaceutical industry. By the turn of the century, the power and influence of the big drug companies was becoming a source of increasing disquiet, not just for radical critics, but also for the editors of major American and British medical journals who were concerned about the scientific standard and reliability of published studies. Richard Horton (2004), editor of *The Lancet*, thus chided academic medical journals for having “devolved into information laundering operations for the pharmaceutical industry”, while former editor of the *Journal of the American Medical Association*, Marcia Angell (2004, p. 336) saw the entire pharmaceutical industry as nothing more than a “marketing machine” with little interest in science or patients’ health. Another important figure in the debate was historian and psychopharmacologist, David Healy who has argued that a “psychopharmaceutical complex” has developed, which to a large extent determines the recognition of psychiatric diseases, the approval of treatments, and the adoption of research agendas (Healy 1997; 2004). His key point is that the discovery of the antidepressants led to the invention and marketing of depression – a once rare condition that has now been transformed into the “common cold of psychiatry”: “Although there are clearly psychobiological inputs to many psychiatric disorders [...] we are at present in a state where companies can not only seek to find the key to the lock but can dictate a great deal of the shape of the lock to which a key must fit” (Healy 1997, p. 212).

Historically informed critiques of biopsychiatry often focus on the development of the American Diagnostic and Statistical Manual (DSM) and the proliferation of officially recognised mental disorders in recent years. Spurred on by the neo-Kraepelian revolution embodied in the DSM-III and its revisions, American (and subsequently international) psychiatry embraced a categorical conceptualisation of mental illnesses as lesions that call for treatment with specific drug treatments, although the conceptual edifice rests on shaky foundations, and the efficacy of the drugs themselves is often questionable. Meanwhile, at the level of popular discourse, a “psychobabble” about complexes and conflicts has been replaced by a “bio-babble” about neurotransmitter imbalances and genetic defects

(Healy 2004, p. 264). Several authors have made the case that psychiatrists were prepared to accept such changes as a defence against the anti-psychiatry movement because the new model gave them “real” diseases to treat. Following the classical medicalisation thesis, Kirk & Kutchins (1992); Kutchins & Kirk (1999) have thus argued that the American Psychiatric Association with the DSM-III attempted to expand its professional domain, enhance its legitimacy within medicine, and maintain its dominant position in the mental health arena. From this perspective, the revision of the manual did not represent advances in scientific knowledge and new empirical data, but instead grew out of an essentially social and political process: to a deeply factionalised profession incapable of agreeing on either theories or therapies, descriptive diagnostic categories at least offered the appearance of scientific objectivity and hence consensus (see also Wilson 1993). But according to Healy, the main impetus in fact came from industry in response to the Food and Drug Administration’s adoption of randomised placebo-controlled trials (RCT) in the wake of the thalidomide disaster. Seen from this perspective, RCT encouraged a bacteriological conception of illness and its treatment which in turn came to work in the favour of industry which could use it to sell expensive “cures” for a range of dubious discrete diseases. To this development, one could add the role of the concomitant rising influence of the private health insurance industry on disease definitions and reimbursable treatments.

The possibility of applying the same analysis to the rise of hyperactivity seems obvious, given that the objectivity of idea of ADHD as a common neurological disease has been seriously compromised by the close ties between clinical researchers and the drug companies. However, there is an argument that paediatric psychopharmacology is unique in the sense that neither pharmaceutical companies nor therapists have seriously pushed the sale of psychotropic drugs to children until quite recently. Thus, rather than simply emphasising unethical drug company practices, Healy has pointed to the role of the hopes and wishes of parents, while describing the explosion in drug prescriptions for children as a manifestation of an even deeper force underpinning the market development of pharmaceutical companies: the promise that a given intervention will bring the patient closer to a

norm that carries fewer risks for their future (Healy 2004, p. 266).¹⁴ At the same time, this development was based on the introduction and promise of clinical trials and the proliferation of rating scales and behaviour checklists, quantifying aspects of children's behaviour and capacities in a way never done before.

1.8 Historical work on ADHD/hyperkinetic disorder

While a fair amount of social commentary and literally thousands of scientific articles on ADHD have appeared since the 1970s, the history of the disorder has received relatively little serious attention, and the existing work is mostly written from an American perspective. Books by prominent clinicians or researchers often sketch a history in their introductory chapters (Barkley 1997; Hallowell & Ratey 1994; Kessler 1980). However, they tend to present stories of the progress of psychiatry, gradually sharpening its nomenclature to ever greater levels of scientific validity and practical effectiveness, thus collapsing a century of changing diagnostic labels, symptoms and aetiology into a neat, coherent story.¹⁵ Despite the fact that hyperactivity was rarely discussed in either medical or educational circles until the mid-1950s, medical texts, scientific articles, and popular sources most often place the ADHD diagnosis within a history of a relatively clear-cut, distinct behavioural syndrome, dating back as far as to the mid-19th century (Palmer & Finger 2001). From these accounts, one does not get a sense of how the concept has been nurtured by geopolitical unrest, technological transformations, demographic shifts, professional rivalry, ideological arguments, cultural change, and public fears relating to criminal behaviour and educational failure among young people and boys in particular. On the contrary, they emphasise the unchanging nature of the

¹⁴It can be argued that many of the best-selling drugs in modern medicine do not treat disease but manage risks. As regards psychotropic drugs, antidepressants have been sold on the back of efforts to reduce risks of suicide and psycho-stimulants as a means of minimising risks of academic and social failure.

¹⁵As exceptions to the rule, Seija Sandberg and Joanne Barton (2002) and Russell Schachar (1986) provide considerable social, political and cultural context, and include more information on European developments than standard reviews.

disorder over time, and its independence of the historical contexts in which it has appeared.

In the sceptic camp, on the other hand, journalists [Schrag & Divoky \(1975\)](#) treated the history of hyperactivity as one of “child control”, calling the disorder a “myth” that functions as a tool of social discrimination of individuals whose human differences are labelled as mental illness. Their book contains some information about governmental and drug company practices in the 1960s and 1970s, but the account often appears unbalanced due to the authors’ radical position. The same can be said about other contemporary work in the same tradition, such as Grinspoon and Singer’s critique of amphetamine use in American schools ([Grinspoon & Singer 1973](#)). However, the labelling approach was developed a great deal further in Peter Conrad’s famous case-study of the identification of child hyperactivity in a city clinic, which by way of introduction traced the rise of the disorder to the interplay of several agents during the 1960s, including government, the pharmaceutical industry, the medical and psychiatric professions, and the parental lobby organisations emerging at this time ([Conrad 1976](#)). In their classic book on the medicalisation of various forms of deviance, [Conrad & Schneider \(1992\)](#) also included a chapter on hyperactivity as a prime example of the transformation from “badness to sickness”, but again it did not provide much historical context.

In the past decade, however, a number of historians, sociologists, and anthropologists have published more elaborate accounts of the history of ADHD, several of them focusing on early 20th century developments and their relationship with current concepts. In an article attempting to draw bold lines between past and present, Andrew [Lakoff \(2000\)](#) thus compares English physician George Still’s early descriptions of children with “defects of inhibitory volition” ([Still 1902](#)) to American psychologist Russell Barkley’s influential conceptualisation of the disorder as a disruption of the “executive functions” ([Barkley 1997](#)).¹⁶ Whereas

¹⁶The modern history of hyperactivity disorders is traditionally seen to begin with the writings of Still, but it is now generally agreed that his young patients, while presenting with some hyperactive and attentive behaviours, meet more of the current diagnostic criteria for severe conduct disorder,

Still perceived unruly, inattentive childhood behaviour as a moral defect – as “activity contrary to the good of all” (1902, p. 1008) – the latest expert model of ADHD is individualised and supposedly value neutral, emphasising faulty brain circuitry. In Lakoff’s view, the social control argument is complicated by the fact that the notion of collective interest is almost absent in ADHD discourse (Lakoff 2000, p. 165). Instead, drawing on Nikolas Rose’s work on governmentality, he presents ADHD as a case study of the process whereby new forms of government, based on rational self-management, have emerged. In order to make the psychiatric subject responsible for his own well-being, it had to be divided: illness was thus located in the brain circuitry making organisation and self-regulation possible, while the motivation to improve remained a part of the patient’s personhood.

In a sociological study of the experiences of various actors dealing with ADHD, Adam Rafalovich (2004) has similarly – and one could argue inappropriately – connected medical discussions in the late Victorian and early Edwardian periods to the emergence of hyperactivity as a mental disorder in its own right later in the twentieth century. At the centre of his account are the medical discourses surrounding imbecility and idiocy in the late 19th century, and encephalitic lethargica during the 1920s. Further, the neglected role of psychodynamic perspectives in current conceptualisations and treatments of hyperactivity is explored.¹⁷ Whereas psychoanalysis was prominent in child psychiatry in the first half of the 20th century in the form of the child guidance movement, it suffered a sharp decline in authority in the 1960s and 1970s, and subsequently had little impact on approaches to hyperactivity. Consequently, internal histories written by physicians, psychologists and even historians have acknowledged the neurological rather than the psychodynamic tradition. Through

which involve stealing, lying, violence, and sexual chicanery.

¹⁷While early influential figures such as Melanie Klein and Anna Freud attributed much overactive childhood behaviour to abnormal amounts of latency-related anxiety, later and less strictly psychoanalytical analyses also implicated anxiety as a causal factor but often described such unease as a result of brain damage and the failure to adjust to the social world as normal children do (Rafalovich 2004, pp. 36-39). Generally, psychodynamic accounts of ADHD-like symptoms portrayed anti-social behaviour as a survival mechanism employed to mask underlying anxiety stemming from trauma, either through developmental struggle or brain injury.

interviews with psychiatrists, paediatricians and psychologists, Rafalovich nonetheless wishes to show that many clinicians in the US are still ambivalent about drug medication and sympathise with the view that ADHD is strongly associated with environmental factors.

Concentrating on the post-war period, other scholars have also used the history of hyperactivity as a lens through which to view the multi-faceted process by which American psychiatry evolved from a field dominated by Freudian psychoanalysis to one rooted in the neurosciences. Echoing the work of [Wilson \(1993\)](#) and [Kutchins & Kirk \(1999\)](#) on the DSM, [Smith \(2008; 2012\)](#) for example describes how the notion of hyperactivity as a neurological condition only emerged in the US after vigorous debate during the 1960s between the three competing fields of psychoanalysis, social psychiatry and biological psychiatry. Biological psychiatry won the debate, he argues, not because its approach to hyperactivity was more scientifically valid, but rather because its explanations and methods fit the prevailing social context more readily than that of its rivals.

On the other hand, like Rafalovich, [Ilina Singh \(2002a\)](#) has emphasised the considerable legacy of psychodynamic models, arguing that the association established by dynamic psychiatry between a problem boy and his problematic mother encouraged scientific intervention in child rearing and, more specifically, that it supported mothers' acceptance of stimulant treatment from the 1960s onwards.¹⁸ According to Singh, modern American women are "historically programmed" to feel responsible and to consult expert opinion when their sons do not meet normative standards of achievement and success (*ibid*, p. 597; see also [Jones 1999](#)).¹⁹ For this reason, they remain vulnerable to medical intervention and

¹⁸This dynamic currently works, for example, through direct-to-consumer appeals to mothers to improve their relationship with their sons through stimulant medication. In important ways, Singh's argument is reminiscent of psychiatrist Jonathan Metzl's challenge of the currently accepted view that pills and neuroscience replaced talk therapy and Freudian gender representations ([Metzl 2003](#)). Examining the reception of various blockbuster psychotropic drugs such as Prozac, Metzl argues that clinical and popular talk about these medications often reproduced all the cultural and social baggage associated with psychoanalytic paradigms.

¹⁹Singh does not really explore the relationship between mothers and problematical daughters – a topic which appears relevant in the light of the fact that an increasing number of girls have been diagnosed with the disorder in recent years.

liable to accept a medical diagnosis which upholds a gendered social order (ibid, pp. 598-599). However, while maternal immaturity or pathology has certainly remained a powerful explanation for troublesome childhood behaviour right up to the present, this idea has increasingly been challenged by mothers themselves. This is demonstrated by Claudia Malacrida's comparative feminist ethnography of mothers of ADHD children in Canada and the UK ([Malacrida 2003](#)). Like Rafalovich, Malacrida uses extensive interviews to examine the intersection between public discourse and private experience, focusing on the position of mothers in the two countries as they encounter, and often contest, multiple professionals over assessment and treatment. She gives a strong voice to the mothers' perspective and it is often one of discontent with educators, who in the UK are described as especially prone to mother-blaming discourse. Her work is evidently relevant to the present thesis, providing useful analyses of attitudes and practices on both sides of the Atlantic and demonstrating the potential rewards of adopting a comparative, cultural approach. But the study only gives limited information on historical developments and macro-level psychiatric, medical and educational structures relating to the handling of hyperactive behaviour. Further, the politics and organisation of parent support groups in the two sites and are not examined in any detail.

Parental experience and the discrepancy with professional attitudes is also at the centre of Matthew Smith's study of the medical and public reception of allergist Ben Feingold's additive-free diet, which became a popular alternative treatment choice for hyperactivity among parents and some paediatricians in the US in the 1970s ([Smith 2011a](#)). Although most families employing the Feingold diet found that it worked to some degree, many physicians and medical researchers viewed it with great suspicion, and eventually, on the basis of a dozen doubleblind controlled trials, the medical community rejected the idea that synthetic food additives can cause hyperactivity. Despite being dismissed, parents were nevertheless able to keep the dietary approach alive through Feingold Associations and informal networking, and recently succeeded in encouraging a handful of researchers to examine Feingold's hypothesis once again. As a result, Feingold's

ideas have experienced somewhat of a renaissance, especially in the UK, where a confluence of many dynamics, including concern about the wholesomeness of the food supply, growing consumer wariness about pharmaceutical products, and new information technologies have reinvigorated interest in the diet as a viable alternative to conventional hyperactivity treatments. Smith concludes that these developments should prompt physicians and policy makers to reconsider how they estimate the knowledge of patients and their families in the resolution of medical debates, rather than just relying on short term controlled trials. For medical historians, the history of Feingold families reinforces the contention that physicians have not always been the primary agents and experts of health care, as people have sought their own cures when physicians were found wanting.

Researchers who have looked beyond medical and psychiatric claims-making instead emphasise the role of schools and changes in educational and social policy in the growth of ADHD/hyperkinetic disorder. Criticising the medicalisation and social problems literature for not sufficiently addressing the economic and legal context of interest group activity, Gary Kiger (1985) thus pointed to transformations in the US labour market during the late 1950s which demanded a science-based curriculum and a more attentive, compliant student body; the reduction of school personnel and decreasing opportunities for schools to expel or suspend difficult students; and the introduction of federal disability legislation in the mid-70s that resulted in benefits to schools for having children with medical rather than behavioural labels. According to Kiger, these economic and governmental factors all combined to privilege a medical rather than a social response to unruly behaviour, and make low-cost drug control seem more attractive. Recently, a similar argument was put forward by Smith (2011b) who contends that the origins of hyperactivity lie in the American response to the Cold War and the shock of the Soviet launch of Sputnik in 1957, as these events lowered the tolerance of behaviours seen to interfere with higher academic achievement, and increased efforts by schools to identify and label children with behaviour and learning disorders.

Looking at more recent developments from a policy perspective, Mayes et al.

(2009) provide a detailed account of several clinical, economic, educational and political trends and incentives which converged in the early 1990s with greater scientific knowledge about hyperactivity, as well as changed public perceptions of mental illness, to spark a dramatic spike in ADHD diagnosis in the US. Specifically, the authors show how the growing political strength of children's welfare advocates and mental health consumers, coupled with the decreasing stigma associated with mental disorders, led to three seemingly minor policy changes – in the federal income-support programme Supplemental Security Income, in the federal special education programme Individuals with Disabilities Education Act, and in the public health insurance program Medicaid – that helped trigger the surge in ADHD diagnoses and related stimulant use by improving access to treatment and support.

In Europe, too, changes to education have contributed to conceptualisations of hyperactivity in children. However, the only existing study is a thesis by Maria Theresa Brancaccio (2001) which explores how the historical emergence of various categories of child behavioural disorder in Britain, France and Italy was inextricably linked to the concerns associated with the introduction of compulsory elementary education in the late 19th and early 20th centuries, and the rise of professional groups that secured their position along the periphery of educational systems. Albeit an important contributing factor, no one has so far looked at the role of the education system in the ADHD explosion in the UK and other European countries during the 1990s. It is such gaps in the recent history of hyperactivity that this thesis will address.

1.9 Overview of the thesis

Chapters 2, 3 and 4 all examine the medical context – institutions, people, ideas, and practices – of hyperactivity diagnosis and treatment, and the multiple connections and disconnections between the “psy”-communities on each side of the Atlantic. Setting the scene, chapter 2 broadly sketches the main professional

and institutional features of child mental health care in the US and the UK during the 20th century, with particular attention to those developments that have affected the perception and management of hyperactive children. I focus mainly on transformations within the disciplines of child psychiatry and paediatrics and how these have reflected prevalent medical philosophies, patterns of professional organisation, and systems of health care in the two countries. Thus, the chapter includes an account of the rise and decline of child guidance; the growth of research from the 1960s onwards; and the increasing medicalisation of child psychiatry. Further, I analyse the background and consequences of the increasing involvement of paediatricians in the management of child mental health problems. Dealing principally with conceptual developments, chapter 3 explores US-UK interchanges, departures, and convergences in the understanding and definition of hyperactivity. Often emphasised in historical overviews as the origins of the modern ADHD concept, the late 19th and early 20th century British medical discussions on mental deficiency will be my starting point. However, focus is mainly at the parting of British and American ways in the late 1950s, when the perception of hyperactivity broadened considerably in the US concurrently with the introduction of stimulant therapy. The chapter concludes with the advent of the hugely important DSM-III in 1980, which marked a watershed in American psychiatry and introduced the concept of Attention Deficit Disorder. Following on from this account, chapter 4 examines the attempts to standardise the concept of hyperactivity, and the process by which the ADHD diagnosis has increasingly been adopted in Britain and the rest of Europe, after a highly sceptical reception. Finally, I discuss the proposition that national views on hyperactivity have all but vanished, to be replaced by a dominant biomedical construct, underpinned by cognitive neuroscience and genetics, and an emphasis on deficits in behavioural inhibition and self-control.

Moving from the context of the clinic to that of the school, chapters 5 and 6 examine the impact of schooling and educational policy on hyperactivity diagnosis and treatment in the US and the UK respectively. Throughout, particular attention is given to the area of special education which is organised quite differently in the

two countries, with significant consequences for the labelling of behavioural disorders in school children. My account of American developments emphasises the significance of the lobbying efforts of the disability movement, and discusses the ways in which geopolitical threats to the country's position as a dominant superpower has fed anxieties about underperforming students, and motivated extensive testing regimes and professional intervention. In the case of Britain, I concentrate on the role of the historical rivalry between educationalists and medics, as well as the presence of a rather punitive approach to disciplinary problems, in fostering suspicion or even outright hostility toward medical models of behavioural and learning problems in schools. It is clear that growing concerns over the nation's ability to compete in the global economy has also influenced attitudes to disruptive children in the UK. Thus, looking particularly at the effects of the introduction of market models in British education in the late 1980s, I attempt to explain the growing acceptance of categories such as ADHD in schools in recent years.

In conclusion, chapter 7 deals with the issue of parent mobilisation, which, I argue, has been a key factor in the rise of ADHD diagnosis on both sides of the Atlantic. Patient activism long predates recent developments in biomedicine, but while many earlier activist groupings fiercely opposed the powers and claims of medical expertise, today we are witnessing the formation of direct alliances with scientists and the pharmaceutical industry. For the past 25 years, the American scene has been dominated by the powerful organisation CHADD – Children and Adults with Attention Deficit Disorder – which has attracted considerable criticism for its involvement with powerful professional and financial stakeholders. The parent support field in the UK has been more diverse from the outset, but while not directly affiliated with US advocacy organisations, British grass-root activities have drawn on American models and sources of information to further their cause. Having described the rise of CHADD and in the US, I compare with the British ADHD advocacy scene, focusing especially on the struggle between the now dominant ADDISS and other pro-ADHD groups, as well as the noteworthy presence of groups adhering to diet-based alternatives to stimulant treatment.

While CHADD and ADDISS have done much to promote the neurobiological concept of hyperactivity, a final aim of the chapter is to examine the role of parent groups in both countries in nurturing the opposition against ADHD, some through the promotion of dietary theories of hyperactivity, and others primarily from an anti-psychiatry perspective emphasising the status of ADHD as a fraudulent disorder as well as parents' right to full informed consent.

CHAPTER 2

Setting the scene: the institutional and professional contexts of hyperactivity diagnosis in historical perspective

2.1 Introduction

In Britain, the past two decades have been characterised by high levels of public concern and anxiety about delinquency and self-harm among young people, as well as legislation aimed at outlawing breaches on unacceptable anti-social behaviour. Forming part of a national discourse which highlights their relationship to worsening trends in children's mental health, and the continuing shortage of services for dealing with them, this perceived crisis in children's psychological health has led to a series of policy initiatives aimed at overhauling service provision. In fact, by the turn of the century, the Labour government had made child and adolescent mental health a national priority, partly by rationalising access to assessment and treatment, but primarily by putting extra resources into preventive schemes such as SureStart and other initiatives focusing on children's services and schools in deprived areas.

A relatively high incidence of handicapping psychiatric disorders in children was already established in the UK by various epidemiological community studies in the 1960s and 1970s, which found an annual incidence of 5-10% for children

living in semi-rural communities and 10-20% for those living in inner-city areas (Rutter et al. 1970a; 1975). It was clear that only a few were receiving specialised help. Since then, according to authoritative reviews, the problem has not diminished. Thus, in the mid-1990s, Rutter & Smith (1995) concluded that there had been substantial increases in psycho-social disorders of youth since WWII in nearly all developed countries, and that this rise is particularly marked for anti-social, disruptive behaviour. According to the latest government figures, one in ten children have a recognised mental disorder, and perhaps not surprisingly, the prevalence was found to be significantly affected by social and economical factors (Green et al. 2005).

Concern about children's mental health and attitudes to treatment take different forms in developed societies depending on political culture, medical ideology, and the institutional framework of health care. The US and the UK are nations at a compatible level of social and economic development but yet they produce different impressions of the character and causes of child behavioural and emotional problems, as evidenced by the discourses on hyperactivity in the two countries. In the US, ADHD features prominently in debates about the psychological well-being of children in contemporary society, which is not strange considering that as many as 10% of US boys and 5% of girls are reported to be affected by this disability. Public debate often centres on the promotional efforts of drug companies, and politicians periodically voice concern about the growing epidemic. In spite of this, leading American child psychiatrists and paediatricians promote the optimistic view that the high figures simply result from the fact that doctors are becoming increasingly skilled at identifying children with congenital problems in need of effective treatment. This story of scientific progress is facilitated by the normalisation of disability, a cultural development fuelled by a powerful lobby and legislation against discrimination in all its forms.

Publicity about children's difficulties is expressed somewhat differently across the Atlantic where the prevalence of ADHD is much lower but still sparks considerable public anxiety. There are important similarities with the debates in the US as regards the overall questions about whether hyperactivity is primarily

the product of modern society and the ongoing tendency to medicalise human behaviour. Also, many British specialists now adhere more or less to the congenital account of hyperactivity and the proposition that doctors are now simply better at recognising it. Yet there is still more focus in the UK on the link between social class, environment, and (mental) health problems, and resistance to using what is perceived as medical “quick fixes” to problem behaviour that may well have complex causes, including social and familial ones. The major role played by the issue social inequality in shaping professional and political discourses on health in Britain is reflected in the accumulation in recent decades of systematic and comprehensive evidence on the distribution of mental disorders. The picture that emerges from national data draws attention to social deprivation as a primary factor in childhood health and illness, both physical and mental, and fits the classical profile of health inequality: children with mental health problems, including ADHD and conduct problems, are more likely to be raised by a single parent and/or unemployed parents, to grow up in underprivileged neighbourhoods, and to be exposed to stressful life events and relationships – all findings that add a potential ethical aspect to the debate about administering powerful psycho-active drugs to children.

The US and the UK are both liberal welfare states, but there are important differences in welfare institutions and health care between the two countries. Most importantly, Britain has a comprehensive health care system, in which a large group of general practitioners plays a central role as gatekeepers to hospital and specialist services, while American medicine has been characterised by competitive specialisation, technologically-informed therapeutic enthusiasm, and a more open and diverse medical marketplace. Although the government has continuously filled in the gaps in the system and also assumed much of the cost of clinical services, the US, alone among advanced nations, the US still permits the market to play a large role in shaping and distributing health care, as illustrated by the immense power of drug companies and the health insurance industry in the present era of managed care. During the 1980s, spending on mental health services and treatment increased tremendously in the US, giving rise to cost-control

responses from employers and insurers. Managed behavioural health companies emerged in the late 1980s and focused on finding less expensive ways of treating mental disorders with decreased hospitalisations, greater use of primary care physicians, limited psychotherapy, and increased use of psychotropic drugs. These new trends coincided with the introduction of new antidepressants, and, in the early 1990s, with various changes in federal disability, education, and public health insurance policy which would further encourage a large increase in ADHD diagnoses and stimulant use (Mayes et al. 2009).

In Britain, the NHS system forms a significant part of the reason why an environmental perspective gets more of a hearing, as effective health policy can best be determined in the light of valid statistical evidence on the population's health status (Hart & Benassaya 2009, p. 240). Put simply, the availability of a rich body of data gathered within the framework of social epidemiology produces an alternative environmental account which has a better chance of competing with the biological or genetic approach. Conversely, in the US, the absence of a state-funded comprehensive health care service has reduced the need to examine general public health trends with the same degree of precision and left more space for the medical profession, frequently funded by the pharmaceutical industry, to study and define the reality of disorders like ADHD within a biomedical perspective.

This leads to an interesting paradox: even though British child psychiatrists and paediatricians at least officially employ the more stringent WHO diagnostic criteria which identify only the more severe symptoms of disorder, often indicating obvious neurological dysfunction, the resulting medical discourse is still more likely to recognise a causal role for social factors. Meanwhile, in the US, the willingness to treat milder symptoms has not been associated with an environmental view of disability, at least since the 1970s when the influence of psychoanalysis and social psychiatry decreased. Thus, Neve & Turner (2002) have pointed to the irony in the fact that that hyperactivity diagnosis and the use of medication became increasingly prominent in the US, where work reflected a strong psychotherapeutic tradition, whereas the British school, which was more epidemiological and neuropsychological in orientation, generated more practical

insights, yet a less medicalised therapeutics.

The contrasting impressions described above reflect differences in medical culture, which are still present, albeit less conspicuous, in the current age of evidence-based medicine. Compared with the US, Britain continues to spend less on health overall, and also spends it differently, directing more resources towards prevention and measures to relieve rather than cure illness. Medical practice in the UK has exhibited a higher threshold for disease, more tolerance for variation, and a tendency towards parsimony, resulting in fewer routine examinations, screenings, operations, and drug prescriptions (Payer 1988, pp. 101-104). This approach reflects not only patterns of medical professionalisation and the economy and organisation of the NHS, which restricts access to specialists and leaves doctors with modest financial incentive to test and treat extensively; it also points towards broader cultural currents reflected in the health service, such as the strong British philosophical tradition of empiricism, a tendency towards paternalism, and, arguably, a certain degree of stoicism. Furthermore, the widespread acknowledgement that disparities in mental and physical well-being are socially distributed surely goes some ways towards explaining the inclination towards multi-factorial models of illness, and the more conservative attitudes to therapy in the UK.

Manifesting a more aggressive, optimistic pattern illustrated for instance by the widespread use of war metaphors in treatment discourse, American medicine has in comparison been marked by its relative intolerance of chronic impairment, by its ever-increasing interest in, and reliance on, the technical possibilities of scientific medicine, by invasive therapies, and by the prioritisation of various testing practices, often over clinical observation of symptomatology (ibid, p. 137-140). While it is true that the rise of managed care in many cases resulted in a reluctance to intervene medically, in child psychiatry it mostly encouraged the medication of a growing and social diverse group of children, who have sometimes been managed in a manner that European physicians would describe as highly risky and overconfident. In fact, reports suggest that American doctors feel less constrained about supplying the whole repertoire of psychotropic drugs, even to

pre-school children ([Zito et al. 2000](#)).

Providing a context for the conceptual history of hyperactivity which follows in chapters 3 and 4, this chapter seeks to illuminate and compare key aspects of the diverse but yet closely inter-related histories and cultures of the British and American (child) mental health communities in the 20th century. In this way, I will show that the specific historical discrepancies between the US and the UK in the uses of hyperactivity diagnosis and stimulant treatment over the past 40 years are symptomatic of much wider differences between the American and European psychodisciplines which started to emerge in the inter-war era and became obvious following World War II. Building on these insights, I chart the growth of academic child psychiatry and the increasing medicalisation of the specialty starting in the late 1960s, focusing on the ways this process has been expressed in each country. Finally, I describe the increasing involvement of paediatrics in the management of child behavioural disorders and its consequences in terms of hyperactivity diagnosis and treatment. The history of child mental health has been characterised by inter-professional tensions and power struggles, and in the area of childhood hyperactivity the uneasy relationship between child psychiatry and paediatrics is of particular importance. The latter part of the chapter therefore addresses the question of how battles over turf between these two disciplines have played out and affected the recognition and management of the disorder in the US and the UK respectively.

2.2 Apollon versus Dionysos

During the 19th and early 20th centuries, American psychiatry shared many intellectual traditions and values with British and European psychiatry, including the value placed on careful clinical observation of signs and symptoms of psychopathology. Developments on both sides of the Atlantic were strongly influenced by the psychobiological approach of Swiss psychiatrist Adolf Meyer, director of the psychiatry department at Johns Hopkins from 1910 to 1941.

According to Meyer, mental illness and mental disorder were the outcome of the dynamic interaction of individuals with their environments. Inspired by evolutionary theory and the philosophy of pragmatism, he interpreted these conditions as inadequate responses to the challenges of everyday life, or as forms of maladjustment, the origins of which could be traced by carefully investigating an individual's life history ([Gelder 1991](#)).

Meyer was a prominent figure in the mental hygiene movement, which had a great impact on Anglo-American psychiatry and wider ideas about mental illness in the first half of the 20th century. Its history began in 1909 when ex-psychiatric patient Clifford Beers founded the National Committee for Mental Hygiene in New York, with support from Meyer among others, in order to improve conditions in mental hospitals, develop measures to prevent mental illness, and popularise psychiatric and psychological perspectives. Stressing early intervention, prevention, and the general promotion of mental health, mental hygienists were especially interested in the possibility of moulding the adult character through the control of the behaviour and personality of the child. Thus, the Committee was instrumental in the establishment in the 1920s of child guidance clinics throughout the US, with financial support from the Commonwealth Fund. Initially associated with juvenile courts and the treatment of delinquency, the clinics were modelled upon the pioneering work of American physician William Healy at the Judge Baker Foundation in Boston.

In opposition to hereditarian theories centring on eugenic beliefs that bad character was inborn and deviancy incurable, Healy established the concept that criminal behaviour in children was a symptom of deeper psychological problems of emotional and social adjustment, and, in addition, was a precursor to mental disorders in later life ([Hayes 2008](#), p. 83). He quickly became widely recognised as the world's leading expert on juvenile delinquency following the publication of *The Individual Delinquent* in 1915, which provided the basis for all subsequent work relating to maladjusted children, in both the US and Britain. Of particular importance, and reflecting the emphasis on the multi-factorial nature of behavioural and emotional problems, was the principle of interdisciplinary

collaboration between psychologists, psychiatric social workers and psychiatrists – a concept that was soon imported to the UK, where the first child guidance clinics opened in London in the late 1920s.¹ Soon, the child guidance clinic became significant sites for the study, diagnosis, and treatment of a wide range of undesirable behaviours and conditions in children, from nervousness to aggression. As such, it functioned as the hub of the movement for mental hygiene and the centre of a web of preventive and therapeutic child welfare embracing the home, the school, and the courts. However, while the clinics were originally mainly intended for the treatment of criminally deviant cases, focus with time moved to younger middle class children with symptoms amenable to psychodynamic forms of therapy (Horn 1989; Richardson 1989).²

As demonstrated by the adoption of the child guidance model in Europe, the US was admired as a dynamic motor of innovation in psychiatry in the first decades of the 20th century. Although some British psychiatrists tended to associate a vulgarised, populist form of mental hygiene with America, others held up the US as an example to follow.³ In 1929, Medical Superintendent of the Maudsley

¹The first child guidance clinic in the UK, and indeed in Europe, was founded in the East End of London by the Jewish Health Organisation in 1927. A psychiatrist, Emanuel Miller, was appointed as director together with a psychiatric social worker who had trained in Boston, and a psychologist. This was followed closely by the London Child Guidance Centre in 1928 under the direction of William Moody, who had trained at the Maudsley Hospital where children were seen and treated, although a separate department for children was not established until after World War II. Miller moved to the Tavistock Clinic in 1933 where founded its department for children and parents (Hersov 1986).

²Child psychoanalysts saw behavioural problems as arising primarily from unresolved emotional conflict within the child's internal world, and emphasised the domestic environment, particularly inter-familial relationships, as the main aetiological factor. In the UK, these perspectives were highlighted in the work of individuals such as Hugh Crichton-Miller, Anna Freud, Melanie Klein, Donald Winnicott, and John Bowlby, whose contributions served to re-shape approaches to 'problem' children throughout the 1930s.

³From the start, there was suspicion within British psychiatric circles of the American mental hygiene movement and the popular embrace of the psychological in the US. Thus, even the early British psycho-analyst, Ernest Jones, reported to Freud on his visit to the US in 1908: "I am not very hopeful of the present wave of interest, for the Americans are a peculiar nation with habits of their own... Their attitude towards progress is deplorable. They want to hear of the "latest" method of treatment with an eye on the Almighty Dollar and think only of the credit, or "kudos" as they call it, it will bring them" (cited in Thomson 2010, p. 134). According to Thomson (ibid), such reactions reflected professional insecurities in relation to the popularisation of psychotherapeutic theory and practice taking place outside the control of the profession, as well as a general cultural elitism that associated a burgeoning consumerism with American vulgarity.

Hospital, Edward Mapother, went on a tour of the US to inspect the organisation of psychiatry in various sites. The subsequent glowing report (Mapother & Petrie 1930) portrayed British psychiatry as conservative, verging on backward, and American psychiatry as progressive, innovative, and enthusiastic, though uneven in its delivery. He was especially impressed with “the far wider diffusion and the much higher level of psychiatric education of all kinds in America” and the “greater tendency in America to look upon the existence of mental disorder as a problem to be solved rather than a burden to be borne” (ibid, p. 1198). Thus, a key issue was the degree of perceived therapeutic optimism in the two countries. The child guidance model, which Britain was at this point in the process of adopting, was singled out for special mention: “... there can really be no doubt about its influence in, at least, reducing unhappiness during childhood, and in averting the anomalies of character that are continuous with definite neurosis and with criminality” (pp. 1199-1200). To Mapother, the most important difference was that

America is interested chiefly in progress, England in maintenance. American attention is fixed mainly on what *will be*, English on what *has been*. American arrangements often seem unfinished, like everything that is growing, occasionally crude enough to offer an easy target to scoffers (p. 1202)... [Americans] have the national readiness to try everything once... they seem full of the enthusiasm, without illusions, that is the true scientific spirit... (p. 1204).

Hinting at a British tendency towards arrogance, he concluded that there was “little room for that complacent tolerance towards the enthusiasms and efforts of others which is apt to pass for humorous wisdom in England” (p. 1205).

Twenty years later, as a wave of enthusiasm for psychoanalysis swept through American medical schools, British views had changed somewhat. Several psychiatrists now began to comment on what they saw as a growing split between Europe and the US in the practice of the discipline, especially within general psychiatry. Aubrey Lewis, Head of the Institute of Psychiatry at the Maudsley from 1945 to 1966 and founder and director of the MRC Social Psychiatric Research Unit which became a world-leading centre for epidemiological and statistical research in mental health, described these discrepancies as “differences of quantity

and tempo”, while expressing puzzlement at the way psychodynamic approaches had come to dominate the whole of US psychiatry (Lewis 1953).⁴

Lewis was taught and much influenced by Adolf Meyer at John Hopkins University, and in his role of Chair he shaped the careers of many leading British psychiatrists, and attracted promising medical graduates from around the world to the Institute of Psychiatry. By virtue of his political connections, he was also well positioned to influence appointments in the UK. In 1953, he thus noted with considerable satisfaction that practically all the teaching posts in British medical schools were held by men “who, though they may be well-wishers, are not votaries of psychoanalysis”, and that only a fifth of the senior medical staff at the Institute of Psychiatry belonged to the British Psychoanalytical Society, which “was in keeping with the eclectic policy of the Institute (ibid, p. 404).

The British tendency towards eclecticism and careful questioning and examination was also emphasised by US-based psychiatrists who visited the Maudsley. Returned from a trip to Europe, the prominent researcher Fritz Freyhan reported the “absence of a single, dogmatically taught body of knowledge” and the cultivation of a “questioning, doubting attitude” at the Maudsley (Freyhan 1956). Although staff members were well acquainted with contemporary American dynamic approaches, the feeling was that sober and detailed study was needed in order to integrate and evaluate the findings of diverse schools. According to Freyhan, English psychiatrists lamented the obscurity of their research in the US, and some expressed their displeasure that visiting American psychiatrists were “not infrequently more eager to lecture and convert than to listen and understand.”

The British psychiatric profession’s relative lack of enthusiasm for psychoanalysis has been charted by historians: it was expensive, theoretically

⁴The Social Psychiatry Unit opened in 1958 in anticipation of the important 1959 Mental Health Act which abolished the distinction between psychiatric and other hospitals and encouraged a movement away from the isolation of the mentally defective and insane in asylums towards their integration into the community. The Act created major administrative problems resulting from the large-scale closure of institutions and thus resulted in the development of new scientific methods as it became necessary to demarcate the mental problems and needs of children and adults who had previously been confined. One of the most significant fields to develop was the technique of psychiatric epidemiology.

suspect, and no use in chronic cases (Neve 2004, p. 409). Freud's writings were well-known and much discussed, and psychoanalytic ideas were widely disseminated through the child guidance movement, and training centres such as the Tavistock Clinic where ones found figures such as John Bowlby and Mary Ainsworth who, alongside paediatrician/psychoanalyst Donald Winnicott, played a crucial role in shaping dominant postwar notions of child development, the importance of mother-child attachment, and good parenting. Psychoanalytic clinics in fact flourished in the London area, particularly after the arrival of Freud himself and his daughter Anna, who became famous for her work with children, as did her close rival, Melanie Klein. Furthermore, Freudian and Kleinian theory was central to the pioneer work with maladjusted children at independent special schools such as Summerhill and Redhill in the interwar period (Bridgeland 1971). Nonetheless, psychodynamic theory never became dominant within the walls of the mental hospitals or in academia, and relations between the Tavistock and the Maudsley were decidedly disagreeable under both Mapother and Lewis (Jones 2003).

In 1957, having just spent a year at Johns Hopkins, the later Professor of Epidemiological Psychiatry, Michael Shepherd, regretfully confirmed Freyhan's impression that the American and British psychiatric communities had indeed grown apart, with the risk of a complete future breakdown in communication between them. Firstly, there were great differences in the distribution of psychiatrists working in public and private practice respectively. Secondly, he noted, the US teaching curriculum displayed a distaste for the tracts of knowledge dismissed as "descriptive psychiatry", an antagonism to the concepts associated with the study of heredity, and a neglect of biological investigation". Whereas the concepts of psychoanalysis had been "transmitted through a semi-permeable membrane of critical examination and testing" in the UK and that the rate of absorption had been slow, in the US a remarkable attempt was made in many centres "to ingest the whole system, python-like, into the body of academic opinion" (Shepherd 1957, p. 419). Although challenges to psychoanalysis from the fields of social sciences, psychology, statistics and public health were beginning to emerge at this point, Shepherd argued that there was a marked and worrying

tendency towards extremes in American psychiatric views and practices, especially with regard to the use of drug treatment. Echoing Mapother's earlier observations, he also emphasised the greater size, popular reach, and status of psychiatry in the US.⁵ Since the early days of the mental hygiene movement, it had entered the fabric of everyday life in a way unparalleled elsewhere, as demonstrated for example by Americans' relatively low thresholds for help-seeking, and the more prominent presence of child psychiatry, with its focus on "reactions" and "adjustment".

Similarly, after joining the staff at the Menninger Clinic in Kansas in 1952, Swiss psychiatrist Henri [Ellenberger](#) (1955) remarked that people in America would often go to the psychiatrist because of a *problem* rather than because of symptoms of *disease*, or simply because they wanted guidance. Thus, children whom Europeans called "difficult" were referred to as "problem children" in the US, and "nosologic discussion, interesting as it was for a European psychiatrist, was considered idle talk and a waste of time ... The Americans did not seem to make a distinction between syndromes and underlying disease as we do in Europe." (ibid, p. 48). Although the widespread quest for "mental health" in US was often appreciated by European doctors, many clearly had misgivings about the broad and blurry concept of mental illness which informed it, and doubts about the potentially much expanded, vaguely defined role of the American psychiatrist.

Many of the sentiments of the early comparative reports described above were recently echoed by American psychiatrist Leon Eisenberg, who pioneered the controlled study of stimulants in hyperactive, inattentive children in the early 1960s. In an obituary tribute to the brilliant but somewhat reserved Professor Shepherd, Eisenberg noted that his work represented a very British kind of social psychiatry, "very British" denoting an "unswerving commitment to empiricism,

⁵On the face of it, the relatively large number of psychiatrists and other psychotherapists in the US would seem to contradict the "man-as-machine" image and penchant for medical "quick-fixes" often associated with American medicine. One could however argue that American psychiatry has also been characterised by a rather mechanistic view of the mind, which emphasises the need to "flush out" inhibitions and complexes that hold individuals back. From this perspective, psychoanalysis was approached as a means to end, rather than an intellectual, moral and educational endeavour. It was with this view in mind that the (in)famous American analyst, Bruno Bettelheim, stated that Freud's teachings lost much of their spiritual quality in the US, where the cure of mental illness was seen as the main objective of analysis ([Payer 1988](#), pp. 150-151).

one which rarely moves beyond its database; sober understatement, which makes no claim of possessing an exclusive path to salvation; sound methodology; and epistemological caution". This approach he called Apollonian, meaning "serene, rational, self-disciplined", whereas the dominant stream in American social psychiatry was described as "Dionysian" – "inspired by instinct and emotion" and "given to catch-phrases and slogans, innocent of data altogether" (Eisenberg 1997, p. 309-310). In a different article on Shepherd, he pointed out that although "we in the US clearly must bow to our French confrères when it comes to a preference for theory over fact, we do have a distressing capacity for tolerating woolly-minded generalizations" (Eisenberg 1990).

The Apollonian/Dionysian comparison is doubtlessly overdrawn and simplified, considering the significant local variations in outlooks and practices, and the fact that both countries have had their conservatives and interventionists. Nonetheless, this description points towards certain enduring, systematic differences between American and British medico-psychiatric modalities. According to Eisenberg and many other observers, US medicine (and culture in general) can be said to be characterised by an amelioristic belief system, as demonstrated by the constant search for novel effective cures, and the focus on the "recovery potential" and "motivation" of the patient (Payer 1988, p. 138).⁶ Furthermore, in psychiatry specifically, American physicians have arguably been vulnerable to shifting theoretical fads and ideologies, swinging between the extremes of "brainlessness" and "mindlessness" (Eisenberg 1986). Thus, Walter Reich (1981) noted that his colleagues, having just recovered from one ideology

⁶According to Payer (1988, pp. 127-129), the aggressive approach has been characteristic of US medicine even before American Independence, adding that although mid-19th century American physicians admired the diagnostic prowess of the French, they criticised their therapeutic pessimism, and the primacy put on the healing power of nature. There was widespread agreement that both the Americans and their diseases were tougher than the European, and that American frontier circumstances required active measures. Frontier surgeons developed radical procedures which they bragged that their old world counterparts were too timid to use, and massive purging and bloodletting characterised American medicine for many years. These therapies were promoted particularly by Benjamin Rush, physician and co-signer of the American Declaration of Independence Rush, who managed to convince doctors and patients that such approaches were manly, patriotic, and heroic.

now seemed ready to succumb to another one, namely biological psychiatry:

Seeking liberation from European fatalism [...] American psychiatrists embraced psychoanalysis. Imbued with the ideas of progress and perfectability and encouraged by a public that applauded solutions, [they] applied it not just to their clinical work but also in their teachings to every problem of social, intellectual and artistic life. However, the expected cures remained elusive, and by the 1970s a new generation of American psychiatrists began to turn to psychobiology which became the source of renewed hope and restored optimism. Now defects of nature, and not nurture, were posed as the main cause of mental illness.

In Britain, however, confidence in the power of therapy and the curability of mental disorders has been more modest. As British psychiatry began to expand after World War II, the predominant influences were the German academic tradition; a distrust of elaborate theoretical formulations inherited from Henry Maudsley and other 19th century alienists; and the holistic psychosocial model formulated by Adolph Meyer at Johns Hopkins in Baltimore ([Kendell 1990](#), p. 142). To these were added the scholarship, scepticism and empirical approach of Aubrey Lewis. It was Lewis who introduced the ideas of social medicine into British psychiatry, but his view of what social psychiatry comprised was much broader than the prevailing views of the day, including a focus on the social causes and consequences of mental illness as well as consideration of the biological substrate of disorders.

Some of the first randomised clinical drug trials were done by Maudsley psychiatrists. Shepherd's whose own credentials as a psychopharmacologist were outstanding and he and Lewis were both founding members of the Collegium Internationale Neuro- Psychopharmacologium. Yet at the founding meeting in 1957, Lewis would famously pronounce that the advances from social research had been greater than those from psychopharmacological developments: "If we had to choose between abandoning the new psychotropic drugs and abandoning the industrial rehabilitation units and other social facilities available to us, there would be no hesitation about the choice: the drugs would go" ([Lewis 1959](#)). It was his firm belief that the large mental hospitals were closing even before the introduction of the neuroleptics, and that the new drugs may at best have accelerated the process.

Shepherd, who along with John Wing can justly be termed the originator of psychiatric epidemiology in the UK, (in)famously got involved in a protracted, bitter debate with Danish psychiatrist Mogens Schou, where he persistently disputed the validity of Schou's studies showing a prophylactic effect of Lithium, and thus somewhat delayed the uptake of this drug in the UK ([Callahan & Berrios 2005](#), p. 96). In particular, he attacked the findings for not being based on proper randomisation, a technology that he and his colleagues at the Maudsley did much to develop. To him, Schou looked like a "believer", and lithium prophylaxis like yet another treatment to be promoted on a wave of enthusiasm rather than solid proof of efficacy.

Shepherd also expressed his therapeutic scepticism in academic discussions during the 1960s in the context of attempts to plan limited child mental health services most efficiently. Thus, in an important epidemiological study of child behaviour problems and child guidance provision in Buckinghamshire, he argued that specialist psychiatric help should be confined to chronic disorders likely to extend into adult life, noting that even extreme forms of behaviour disturbance, including hyperactivity, probably represented no more than exaggerations of conduct in response to temporary life situations, and that most would improve without specific treatment (views on this matter were generally more optimistic at this point) ([Shepherd et al. 1966](#), p. 382).⁷

It is important to note that Shepherd was more cautious or even pessimistic than most. Moreover, he had little direct impact on the field of child psychiatry. But the socially oriented sceptical position he and Lewis epitomised was in tune with the general intellectual climate of the Maudsley and is arguably also reflected in the critical approach to the concept of hyperactivity and stimulant treatment among British researchers. In attempting to characterise this environment, some of

⁷Shepherd was the first to undertake the systematic study of psychiatric morbidity in general practice, and a forceful advocate for strengthening the therapeutic role of the family doctor in order to provide mental health care to the whole population. For his doctoral thesis, he studied hospitalisation rates for major psychoses in Buckinghamshire between 1931-33 and 1945-47, which allowed him to demonstrate that the decline in the hospital population antedated the introduction of psychotropic drugs.

my child psychiatrist interviewees described British psychiatry and developmental psychology at Maudsley in the 1970s (in as much as it existed), as being right in the British philosophical tradition of empiricism, emphasising tight methodological designs and issues of classification, and in general the importance of “clearing the scrub away” before progressing to the next level. One personally found it “spectacularly unexciting, but very important”, describing the approach as a style which distrusted big theory and addressed very focused, relatively modest research questions in a rigorous way in order to get some precision and test common assumptions (J. Hill *int.* 2006).⁸ Others pointed out that while the spirit at the Institute of Psychiatry was eclectic and very academic, and there was a lot of discussion, much of it was argument. The epidemiological strand was dominant and although other approaches were represented – behavioural psychology, biological psychiatry, psychodynamic psychiatry and family therapy – few attempts were made to integrate them (Lask *int.* 2006). Thus, from this perspective, rather than integration the main trend was towards polarisation, also in relation to that other influential London clinic and training centre, the Tavistock, which was adverse to the scientific agenda of the Maudsley community, and vice versa.

Among my American interviewees, one expressed the view that British researchers have no doubt made major contributions in nosology, in debunking much myth, and in emphasising relevant social factors through seminal population studies. Nonetheless, even though British work never strayed far from the problems faced in the clinic, she felt that actual therapy and systematic treatment research – primarily but not only psychopharmacological research – was undervalued up until recent years (Klein *int.* 2005 see also; Healy 2000, pp. 328-329, 355-356).⁹ She also noted that she felt the focus in each country was

⁸Hill observed that while the US has witnessed rather extreme, unthinking ideological swings, where certain outlooks becomes dominant, the greater acceptance of theory and willingness to integrate theory into empirical work in America has also led to interesting conversations and interplays between biological and analytical approaches, for example in research into attachment and the impact of early experience on development, which historically have not occurred to a great extent in the UK.

⁹However, it seems that British general psychiatrists in most outpatient clinics relied quite

different, in that British researchers generally seemed more interested in brain injury and autism than in emotional disorders and common behaviour problems.

While there appears to have been an element of therapeutic scepticism at the Maudsley, arguing that treatment research – or even intervention itself – was undervalued is probably too strong. Perhaps it would be more correct to say that the Institute inclined towards treatment approaches that addressed learning and social factors in families, subcultures, schools, and institutions. Moreover, much of the early impetus for the development of behaviour therapies in fact originated with clinical psychologists and psychiatrists at the Maudsley in the 1950s (although people like Eysenck and Rachman were much less important in the US than Watson, Skinner and Wolpe). In the strongly interdisciplinary Children's Department, there was a marked emphasis on integrating research and clinical work through research-driven clinics focusing for example on autism, language disorders, head injuries, and, from the 1980s, hyperkinesia ([Witness Seminar 2009](#), pp. 25-27). The treatment approaches that were developed and applied in the department included special educational methods. From the mid-1970s, behaviour therapy and family therapy gained much popularity, and in recent decades the UK has led the development of parenting treatments – all therapies which have been widely used in the treatment of children with behaviour disorders.

heavily on drugs, especially in managing episodes of acute schizophrenia, even if they recognised their limited curative powers. A 1962 comparative study of psychiatric outpatient practice in the US and the UK concluded that whereas analytical psychotherapy was the dominant paradigm among American psychiatric residents, in Britain the great majority of cases at teaching hospital clinics would receive "some form of somatic treatment, accompanied by a discussion of the patient's immediate personal or social problems" ([Carstairs & Bruhn 1962](#), p. 110). For the registrar, this was already a rehearsal of the work he would expect to do under the NHS, focusing on psychoses, while for the American resident the clear expectation was to engage in private consulting practice where they would treat the less serious neuroses and personality disorders of the middle and upper classes.

2.3 The growth of academic child psychiatry: US and UK developments

Even if Shepherd was more critical and cautious than most, and did not have much direct influence on the development of child psychology and psychiatry as such, the socially oriented sceptical position he and his mentor Aubrey Lewis epitomised arguably goes some way in explaining the relative lack of research interest in hyperactivity and stimulant treatment in the UK up until around 1980. Of course, in any event, clinical practice cannot simply be inferred from a given country's research agenda, but if such an interest had been present in the nascent discipline, things might have looked somewhat different. In the US, where over-riding perspectives and ideologies have tended to take hold more easily, resulting in rather extreme ideological swings, the take-up of stimulant treatment was rather slow in the beginning due to the strong influence of psychodynamic concepts and the more or less radical political and social critiques put forward by various detractors of psychiatry. But once the cultural barriers diminished and the biomedical paradigm began to eclipse both the psychoanalytical and social psychiatric approaches during the 1970s, the use of drugs quickly took off, also among paediatricians working in primary care.¹⁰

In both the US and the UK, child psychiatry has historically been a different world from general psychiatry. First, the psychosocial ethos has remained more powerful and the use of medication less obviously necessary, as children's disorders generally do not present as acutely as those of adults, and because the evidence for the effectiveness of medication in children is rather unclear, with the exception of stimulant treatment for hyperactivity. Second, it is probably fair to say that different kinds of people have been attracted to the adult- and child fields respectively and this may have had a self-reinforcing effect (J. Hill *int.* 2006). In the early 1960s, when hyperactivity first emerged on the scene in the US, theories

¹⁰It seems important to note that even in the heyday of psychoanalysis, many of the leading US analysts were also biological researchers; they tried to be both, and although the two strands were not well integrated, it may have made the biological turn easier (Rutter *int.* 2005).

among child psychiatrists in both countries concerning the nature of both normal and abnormal mental development was largely influenced either by purely psychological theories of the structure and function of the mind, or by behaviourist theories that explained such development in non-mental, but also largely in non-biological terms. Medication was very little used in child guidance and child psychiatric clinics in both countries; at this point, profound hostility still existed to the idea that genetic factors has a significant role to play in behavioural and emotional problems, partly as a result of the eugenic experiments carried out by the Nazi government in the 1930s and 1940s ([Eisenberg 2001](#); [Graham 2005](#)). The relatively modest amount of research produced at the time focused mostly on different environmental factors and their role in producing childhood disorders, with subjects ranging from child-rearing practices, mothering and “maternal deprivation”, the impact of physical and mental ill-health in parent, and the quality of the parental marital relationship, with only occasional investigation of the child’s personality.

However, a few researchers were going against this trend by examining the role of the child and his particular constitutional make up, and by investigating causal mechanisms and outcomes through longitudinal research designs. In the US, where the growth of child psychiatry as an academic discipline has been almost wholly influenced by developments in adult psychiatry, the published results of the New York longitudinal study were among the first to emphasise the influence of children’s supposedly innate temperamental characteristics on behaviour. Started by Stella Chess and Alexander Thomas among others in 1956, the study pointed to the importance of children’s temperamental characteristics and highlighted the importance of children’s effects on their parents, thus undermining uni-directional models of child psychopathology ([Chess et al. 1960](#)). Chess was among a group of professionals who tried to temper the accusation against mothers, warning that it caused much guilt and anxiety to many who did not deserve it ([Chess 1964](#)). Indeed, her concept of inborn temperament offered a paradigm shift for understanding child behaviour, from a prevailing psychoanalytical model of intra-psycho conflict and anxiety in the child to a new

model in which the child's intrinsic pattern of behaviour came first, followed by parental "goodness or poorness of fit" (Thomas & Chess 1977; Chess 1999).

Another early seminal longitudinal study was Lee Robins' thirty-year follow up of children first seen in a child guidance clinic in St. Louis (Robins 1966) which found that anti-social problems had a poor outcome, whereas children diagnosed with emotional disorders had outcomes little different from normal controls.¹¹ In general, Robins concluded that conduct disordered children were neglected in spite of their much larger risk of developing serious disorders and handicaps in adult life. These findings received much attention in the US and dealt a serious blow to the child guidance system there, which was already losing influence due to organisational changes resulting in the affiliation of clinics with medical schools (Schowalter 2000).

Although academic departments of child and adolescent psychiatry were established earlier in the US than in Europe, the adherence there to the rule that everybody must undergo psychoanalytic training led to a situation where many psychiatrists treated relatively few patients.¹² In fact, psychodynamic approaches continued to dominate the profession up until the biological turn in the 1970s when research supporting drug treatment of hyperactivity started to flood the main journals. In 1963, all articles in a special series on child behaviour problems, or "acting out", in *Journal of the American Academy of Child Psychiatry* were based in psychoanalytic theory, with hyperactivity being blamed on superego impairment, which caused the child's id to dominate his ego, leading to impulsive behaviour (Rexford 1963). But children with behaviour problems were especially testing for psychoanalysts who required patients to be calm and introspective. Further, it was

¹¹Like Stella Chess, Lee Robins was also quite atypical for her time and probably closer in mindset to the British, being based at Washington University at St. Louis which was central to the move from a psychoanalytical to a more descriptive diagnostic approach in American psychiatry.

¹²The first child psychiatry department in the world was founded by the Austrian émigré Leo Kanner in 1930 under the direction of Adolf Meyer at the Johns Hopkins Hospital, Baltimore. Kanner was the first physician to be identified as a child psychiatrist in the US and his textbook, *Child Psychiatry* (1935), is credited with introducing the specialty to the academic community. However, it was not until the 1960s that the first NIH grant to study paediatric psychopharmacology was awarded. It went to one of Kanner's students, Leon Eisenberg, the second director of the division and pioneer of the study of stimulants in hyperactive children.

a painstakingly slow and expensive and therefore only a fraction of children thought to have mental problems received psychiatric care. [Smith \(2008\)](#) thus argues that the failure of analytic psychiatry to provide a viable response to hyperactivity epitomised the difficulties of the whole psychiatric discipline in responding to the perceived mental health needs of Americans, and goes a long way in explaining why it could not remain relevant compared to the quicker and less expensive drug solutions.

Similarly, social approaches were also eventually deemed impractical and unrealistic, even though the Joint Commission on the Mental Health of Children in 1968 had emphasised the importance of socio-economic conditions in the prevention of mental ill health ([American Psychiatric Academy 1969](#)). One of the main factors in social psychiatry's decline in the 1970s, and thus its minimal impact on the field of hyperactivity research in the US, was that it required a wholesale change to the structure of American society. Many psychiatrists, though sympathetic, felt that it was the politician's job to change environmental causes of mental illness, and although biological psychiatrists and psychoanalysts debated about the validity of their respective theories, most agreed that psychiatrists should act as doctors, not political activists, and that medical authority relative to the allied mental health professions should be maintained (*ibid*, p. 547).

The increasing significance of the bio-medical perspective in post-war child psychiatry is most clearly expressed in the growing use of controlled clinical trial methodology which played an important role in connecting child psychiatry with mainstream medicine and science. The history of paediatric psychopharmacology naturally centres on the US as this is where the subspecialty has developed, starting in 1937, when the American paediatrician Charles Bradley discovered a "paradoxical" calming effect of Benzedrine on children with behaviour disorders ([Bradley 1937](#)).¹³ In the 1950s, the biological revolution in general psychiatry began with the appearance of antipsychotic and antidepressant agents and a burst

¹³Not a single drug therapy was described in the first textbook of child psychiatry ([Kanner 1935](#)), which advised against using "toxics and sedatives" to control children's behaviour.

of psychopharmacologic research in adults. In child psychiatry, such studies remained rare until the 1970s when there was a massive leap in the quantity of psychopharmacological research in youth. First and foremost, research on the effects of stimulants on hyperactive children grew exponentially, making this treatment the most studied in the history of the discipline. At the start of the 1980s, the general use of drugs in children was still limited, but a decade later child psychopharmacological treatment had entered everyday practice in the US. Further, the shift from tricyclic antidepressants towards specific serotonin reuptake inhibitors (SSRIs) proceeded contemporaneously with their swift deployment in adults, and the latter rapidly became a very commonly used drug treatment for depression and anxiety in children and adolescents (Popper 2002).

Hand in hand with this development came the introduction of an increasingly detailed classification system. In the post-war period, classification and differential diagnosis were seen as relatively unimportant in child psychiatry, especially in the US, where the influence of psychodynamic thinking was particularly strong. Thus, the first two editions of the *Diagnostic and Statistical Manual* (DSM), contained little specifically about children. Inspired by Kanner's rudimentary classification, the DSM-II (APA 1968) presented only six behaviour disorder categories of childhood, all defined as "reactions", such as "hyperkinetic reaction".¹⁴ This convention reflected the then dominant dimensional conceptualisation of the whole scope of childhood behaviour as the end product of familial, and in some cases social influences (Klein & Healy 2000). The same was true for the 8th revision of the WHO's *International Classification of Diseases* used in Europe (WHO 1967) which was the first edition of the manual to include child psychiatric disorders, but apart

¹⁴Inspired by Adolf Meyer, the prominent child psychiatrist Leo Kanner, credited with writing the first textbook in child psychiatry (Kanner 1935), classified child psychiatric problems under broad "reaction types". Kanner emphasised that many child patients do not oblige by fitting themselves into any sets of criteria: "In our own specialty, we are still confronted with many child patients whose profiles cannot be easily matched with those for which a joint heading already exists... the children, unfamiliar with those books and articles, simply do not have their symptoms arranged to indicate which are basic and dominant and which are incidental and derivative... It is up to us to go on studying those children ...] without pressing them into any preconceived diagnostic and etiologic dogma, and with the hope that thus we shall from time to time discover more profiles which speak for themselves" (Kanner 1969, p. 10).

from an elaborate classification of mental retardation, and categories for symptoms like stammering, tics and enuresis, only one category was provided for the behaviour disorders, and even this was not subdivided. During the 1970s, however, pressure increased for an a-theoretical and multi-axial system of diagnoses that could potentially be used in the same manner by different clinicians and researchers. This eventually spurred the development of the ICD-9 ([WHO 1978](#)) and the hugely influential DSM-III ([APA 1980](#)), which revolutionised American psychiatry. Both strived for greater reliability and emphasised a descriptive approach based on symptomatology but differed in the number of diagnoses included, with the WHO representing a more parsimonious, hierarchical approach.

Whereas there was little focus on classification in the US up until the late 1960s, diagnosis remained an important area of research in British psychiatry. Thus, Michael Shepherd was instrumental in organising the WHO programme on the standardisation of psychiatric diagnosis and classification in the 1960s ([Shepherd et al. 1968](#)) and several British psychiatrists have acted as consultants to the WHO. As Kendell points out, British psychiatry has never had any important diagnostic concepts of its own in the way that French and Scandinavian psychiatry still do, and as a result of their involvement, the format of the ICD has been influenced in many ways by British views and prejudices, among other things their fondness of parsimony which resulted in fewer diagnoses ([Kendell 1990](#), p. 149; [Shaffer int. 2005](#)). In the child area, Michael Rutter was a leading force, playing a key role in developing the WHO's multi-axial scheme (now ICD-10) and subsequently in encouraging compatibility between that and the American DSM. In 1965, he published the first tentative sketch of a generally acceptable classification of child psychiatric disorders, arguing that the lack of such a system had been a severe obstacle to the scientific progress of the discipline ([Rutter 1965](#)).¹⁵ While the classification of adult mental disorders had been deemed

¹⁵Rutter contended that an adequate taxonomy must be based on behavioural manifestations and not on theoretical concepts that lacked empirical substantiation. Further it should be operationally defined, have predictive value, and provide adequate and externally validated differentiation between conditions. He emphasised that the hyperkinetic syndrome posed extra difficulties as a high level of activity is normal in young children. Hyperkinesis was therefore described as "a

unsatisfactory ([Stengel 1959](#)), the situation in child psychiatry was described as even worse, the predominant view being that classifications tended to obscure and prevent more penetrating understandings of disorders.

Although paediatric psychopharmacology was not prioritised at the Maudsley, the international growth of child psychiatry as an academic discipline owes a great deal to the scientific work done in the UK under the leadership of Michael Rutter. As demonstrated in his influential critique of popular categories of neurological deficit for which little empirical evidence exist ([Rutter 1982](#)), Rutter's approach has been characterised by scepticism, rigorous enquiry, and a consistent emphasis on the complexity of risk and protective factors that determine the expression of biological risk ([Taylor 2003](#)). He and his colleagues in the Social Psychiatry Unit and Child Psychiatry Department became very influential in the fields of autism (using a wide range of scientific techniques and disciplines, including DNA study and neuroimaging), classification, temperament, school and family influences, longitudinal and epidemiological research, and, in the past couple of decades, developmental psychopathology at the Social, Genetic and Developmental Psychiatry Centre ([McGuffin & Plomin 2004](#)).

In the UK, epidemiological studies experienced a period of expansion in the 1960s in the wake of the 1959 Mental Health Act. Perhaps most significant was the first comprehensive population survey of 9-11 year-olds ([Rutter et al. 1970a](#)), carried out on the Isle of Wight in the mid-1960s at which point there was little interest in research in American child psychiatry. According to [Eisenberg \(2001\)](#) "child psychiatric epidemiology as such didn't begin until the Isle of Wight study was published".¹⁶ The study addressed questions that have continued to be of key

syndrome characterized by severe and disorganized overactivity together with impulsiveness and a very short attention span and often extreme distractibility", often associated with epilepsy or other overt evidence of neurological abnormality.

¹⁶This is not strictly the case – a number of population studies existed before that time, but Rutter's study was innovative in a number of ways. It used epidemiology both to plan services and to examine risk and protective mechanisms for psychopathology; it measured a number of risk factors previously thought to be difficult to assess; and it investigated physical, social, intellectual and educational data, thus making it possible to study overlap between disorders and impairments. But perhaps most crucially, it included direct interviewing of children – something which had not been attempted previously ([Witness Seminar 2009](#), p. 26).

importance: rates of psychiatric disorders, taxonomy, the role of intellectual development and physical impairment, and the concern for potential social influences on children's adjustment. Interestingly, only found two hyperkinetic children out of a population of 2000 were identified. Together with subsequent studies in London, it underlined the importance of representative samples for examining causal processes, and showed that detailed measures of the psychosocial environment could be applied on a population-wide basis.

A strong thread in British child psychiatry has been the empirical study of psychosocial factors and an emphasis on adverse experiences in the precipitation or production of psychiatric disorder ([Hersov 1986](#), pp. 794-795). One good example is John Bowlby's famous 1951 WHO monograph on homeless children, *Maternal Care and Mental Health* ([1951](#)), which popularised the notion of "maternal deprivation". Bowlby was influenced by the object relations school of Melanie Klein, but profoundly disagreed with the prevalent psychoanalytic belief that infants' responses relate to their internal fantasy life rather than real-life events. Thus, reviewing the evidence from various clinical studies of institutionalised and hospitalised children, he warned that inadequate maternal care and the distress resulting from separation significantly increased the risk of children becoming either emotionally disturbed or delinquent.

Reinforced by the experience of the wartime evacuation schemes, Bowlby's work had a very powerful influence on theories of child development, child care policy, and social work in the UK, and affected clinical practice in the direction of a family approach to treatment ([Hendrick 2003b](#); [Hersov 1986](#)). His findings also led to much discussion and sharp controversy among psychiatrists and psychologists because of the claim that early adverse experiences of this kind had universal far-reaching effects on later mental health. Significantly, these debates generated a wealth of careful research studies both in the UK and North America on the effects of a variety of deprivations on child development. Best known is Rutter's 1972 reappraisal which was critical of formulations of child psychopathology as specific manifestations of early attachment disruptions between mother and child. Among other things, Rutter argued that anti-social disorders were linked with broken

homes, not because of the separation involved, but rather because of the discord which led to the break. Further, factors outside the home, such as schooling and geographical area, and factors within the child, such as inborn temperament, were found to be important in modifying responses to hardship and emotional trauma. However, despite such qualifications, there is no doubt that attachment theory based on Bowlby's early formulations has remained central in many disciplines within child mental health; indeed, with its insistence on the negative emotional and behavioural consequences of insecure early attachments, it is today seen by many as one of the critical explanatory models to put against the neurobiological notion of ADHD ([Cooper int. 2005](#); [Prior int. 2006](#)).

In terms of deprivation effects, the intergenerational transmission of psychopathology is an area of research that has been strongly developed in the UK, starting with Rutter's study of the association between parental ill health, including psychiatric illness, and psychiatric disorder in children ([Rutter 1966](#)). This work shed light on complex pattern of stressful and protective factors affecting children coming from backgrounds of disadvantage and presenting with a variety of disorders, mainly conduct disorder – a diagnosis which has been demonstrated to overlap great with ADHD in the US ([Prendergast et al. 1988](#)). At the Nuffield Psychology and Psychiatry Unit in Newcastle, Israel Kolvin and colleagues carried out longitudinal epidemiological studies of cycles of social disadvantage over three generations, using a cohort known as the Newcastle 1000 family study, which had begun in 1947. In following up 300 of the original subjects, then in their early 30s, they identified significant continuities in the risk for deprivation in their offspring but were also able to demonstrate that some could overcome their disadvantage, for example through the presence of positive characteristics such as an easy temperament, social skills, academic ability and competent parenting ([Kolvin et al. 1990](#)).

While the Maudsley has been the main driver in the establishment of child psychiatry as an academic discipline in the UK, other institutions have also contributed with important work. Child psychiatry was until recently a rare speciality throughout the whole of the north of England but from mid-1970s a

growing number of Chairs were set up in departments in the major cities outside London. Among the most prominent in the were the unit in Newcastle under the leadership of Kolvin, and the University of Manchester, where Richard Harrington established one of the world's most active research groups during the 1990s ([Bailey 2004](#)). Harrington was one of the few British child psychiatrists doing sophisticated treatment research, including drug trials. At the time of his untimely death in 2004, he was engaged in a multi-site randomised controlled trial of antidepressants with and without cognitive-behavioural therapy, and a series of studies into the management of antisocial, aggressive behaviour. He also challenged the idea that depression does not exist in children by demonstrating that depressive conditions in the school-age years persisted and recurred in over 30% of cases, and that although depression starting in adolescence is likely to be partly genetic in origin, depressions in childhood are due almost exclusively to adverse environments. Greatly shaping evidence-based clinical practice in the area, his team developed "model" cognitive-behaviour therapies as well as systematic methods for evaluating the outcome of psychological treatment for affective and behavioural disorders such as hyperactivity, including parent training groups.

In the field of hyperactivity research specifically, Park Hospital in Oxford played a significant early role through the work of Medical Director Christopher Ounsted, who shaped British views on the subject up until the late 1980s. In the 1950s, he described and delineated "hyperkinetic disorder" in epileptic children and thus became the first British doctor to take a serious interest in pervasive hyperactivity as a separate disorder ([Ounsted 1955](#)). Park Hospital was among the first centres in the UK with an academic child psychiatry unit, but in comparison with the Maudsley which initially concentrated on epidemiology and phenomenology, it took a more developmental approach and became a leader in this area, focusing on the progressive development of disorders throughout the life span. This perspective, which has since then come to inform the concept of ADHD, was later adopted by the Maudsley, as evidenced by the establishment of the MRC Social, Genetic and Developmental Psychiatry Centre at the Institute of Psychiatry in the early 1990s.

However, in terms of collaboration across professional boundaries, the most noteworthy was probably the child psychiatric department at Great Ormond Street Hospital. In its heyday from the early 1970s to the early 1990s, this institution occupied a middle position between the supposedly progressive academic stronghold at the Institute of Psychiatry South of the Thames, and the “whacky” Tavistock Clinic in North London, which remained deeply committed to the idea of the inner world taking priority over the outer world of the child, with an emphasis on Kleinian approaches.¹⁷ In both places, many trainees’ impression was that “people had a lot of time to just discuss things”, as they had no community commitments at this time and therefore did not treat many patients ([Keen int. 2006](#)). Apart from this, they had been at polar opposites since the interwar era, and continued to snipe at each other in the post-war years when behaviourists like Hans Eysenck touched off an acrimonious debate between those for and against psychoanalysis.¹⁸ In contrast, several of my interviewees who held prominent positions at Great Ormond Street described it as an action-orientated, creative place, characterised by genuine disciplinary and theoretical cross-fertilisation, and by the policy that waiting lists were unnecessary ([Graham int. 2006](#); [Lask int. 2006](#)). Whereas Michael Rutter basically embodied child psychiatry at the Maudsley for two or three decades, the much smaller Great Ormond Street department had a publication output which, although not as weighty, was voluminous and highly varied, as they published with all departments in the hospital, and paediatrics especially. According to Professor Bryan Lask, the paediatric-child psychiatric alliance was weak for many years in the UK partly because of the major influence of the Maudsley and the Tavistock, neither of which had any real contact with paediatric practice. Great Ormond Street differed

¹⁷The Tavistock remains psychoanalytic today, but its practice is more varied now. In the 80s, for example, family approaches became quite popular. They arose out of psychoanalysis but were much more concerned with real life issues, focusing on coping with current circumstances rather than dealing with internal conflicts originating in childhood ([Hersov int. 2005](#)).

¹⁸It is important to keep in mind that this argument was a very London-centred one, as was in fact the whole culture of child mental health care in the inter- and post-war periods, leading to vast differences in quality of services and level of training between the North and the South (J. [Hill int. 2006](#)).

because the department of psychiatry was within a large children's hospital and part of their remit was to provide a service in psychological medicine for paediatrics.

Considering the unique environment at the hospital, it is perhaps not surprising that the first British randomised controlled trials of diet treatment in hyperactive children were done there in the mid- to late 1980s by a team including amongst others Philip Graham and the somewhat eccentric Professor of Immunology, John Soothill ([Egger et al. 1985](#)). Soothill was convinced that many child disorders, including several psychiatric syndromes, could be seen as allergic in origin, and that various foodstuffs could create immunological responses in the entire the body. However, his approach differed from that of Ben Feingold – the more famous proponent of the food additive theory of hyperactivity in the US – in the sense that it involved an elimination diet, in which trial subjects were initially put on an elemental diet of one or two food items, and then gradually had substances added, in order to spot the irritant. To everybody's surprise, the first study suggested that a selective group of children were indeed adversely responsive to different substances, especially dyes and additives, but in sometimes also tomatoes, chocolate, and sugar. The study was replicated a few years later in a second trial involving Eric Taylor, who by this time headed a hyperactivity clinic at the Institute of Psychiatry and had become a high-status figure in the field ([Carter et al. 1993](#)). Although the effects were not quite as convincing, the authors concluded that the “few foods” diet could be an effective treatment for a small number of hypersensitive children. However, these findings did not affect the attitudes of paediatricians and psychiatrists to any great extent, as they did not square with most clinicians' presumptions, nor indeed their experience ([P. Hill int. 2005](#); [Graham int. 2006](#)).

2.4 From child guidance to child and adolescent mental health services

Stimulating a more systematic approach to child mental health problems, the rise of academic child psychiatry not only altered the theoretical understanding of disturbed child behaviour, but also contributed to the organisational changes which led to the demise of traditional community-based child guidance as child guidance clinics were integrated with medical schools and hospital services. Perhaps most relevant in terms of explaining the increasing levels of diagnosis and prescription, the growth in research has been a major aspect of the shift towards differential diagnosis, more focused therapy, treatment evaluation, and so-called evidence-based practice. However, this process must also be seen against the background of the ever-present problem in child mental health care of matching scarce resources with growing demand, particularly over the past few decades. Indeed, one of the reasons for the eventual demise of the child guidance model was that it did not offer an acceptable way of dealing with the increasing number of children and families in need.

By the early 1970s, leading American and British psychiatrists agreed that child guidance clinics had not been able to prevent adult mental illness as the mental hygienists of the early 20th century had hoped. It was argued that it wasted precious funds on very few patients with long waiting lists as a result as well as a tendency to exclude those unable to respond to a treatment which required perseverance and high verbal ability. Especially in the US, there seemed to be an increasing overemphasis in the clinics on neurotic children who tended to get better on their own accord, while disruptive, hyperactive children were neglected in spite of their much larger risk of developing serious disorders and handicaps in adult life ([Horn 1989](#); [Richardson 1989](#); [Robins 1966](#)). According to the critics, an important part of the problem was the team approach in itself, firstly because it was inefficient, entailing duplication of work and “countless extra hours going into interdisciplinary communication in situations where one professional could more effectively manage the problem without ending up talking to himself” (Eisenberg

in [Black 1983a](#), p. 644). Secondly, various authorities noted its deleterious effect on the unique skills of the different professionals involved, as the influence of psychoanalysis led to a set of common assumptions about the origins of psychiatric disorder and methods of intervention.

These problems were arguably compounded by the isolation of the clinics from other health facilities which resulted in a low level of innovation and development ([Black 1983b](#)). Thus, for many years the major treatment modality in both the US and the UK was individual psychotherapy or play therapy for the child combined with social case work for the mother.¹⁹ Looking back on his experience in a Brixton child guidance clinic in the early 1970s, British child psychiatrist Peter Hill recalls that it was “hard to justify a medical presence” as it was difficult to distinguish from social work. The majority of the patients had problems with anti-social behaviour and were referred either through education or social services. They were neither physically examined nor prescribed for, the common procedure being the application of the label of either conduct disorder or emotional disorder with a “very superficial dynamic analysis” ([P. Hill int. 2005](#)). Nonetheless, reflecting developments which had already occurred in the US, there was at this time a general change towards a more pragmatic approach, with new treatments such as behaviour modification techniques based on operant conditioning being introduced in some clinics. In the UK, family therapy became especially popular in the 1970s and 1980s, but Hill adds that this perspective did not make diagnosis or drug prescription any more likely.

In the US, the main forces that first pulled child psychiatry into the medical sphere were organisational, as the increasing number of physicians working with mentally disturbed children sought official recognition of their specialty ([Schowalter 2000](#)). The major attachment to medicine occurred officially in 1959 when the American Board of Psychiatry and Neurology approved the certification of child psychiatrists as legitimate sub-specialists. Before this time, control over

¹⁹In the UK, this pattern was most common in child guidance units in and around London where child psychotherapists were added to the team and was regarded by many as the only effective form of treatment.

training rested in the hands of the American Association of Psychiatric Clinics for Children, which was made up of free-standing child guidance clinics that were not connected with medical schools and hospitals. With the certification, it became impossible to get approval for a training program that was not medical school affiliated. Some clinics turned into community mental health centres and others into university-affiliated programmes ([Eisenberg int. 2005](#)). Nonetheless, even more than American general psychiatry, the discipline remained strongly psychoanalytical during the 1950s and 1960s. As illustrated by a quick survey of the journal literature, children's problems – whether emotional or behavioural in character – were typically seen as expressions of intra-psychic conflicts or family pathology.

In the UK, the child guidance system was institutionalised with the 1944 Education Act – which formally recognised maladjustment as a handicap while redefining it as an educational category²⁰ – and the emergence of the National Health Service in 1946. Prior to the war, in 1939, there were 46 clinics all in all, most of which were funded by local education authorities, as the demand came largely from educators and school doctors faced with unruly children, but sometimes by health authorities or charities ([Black 1983b](#)). Considerable confusion reigned concerning the provision and functioning of the clinics, but policy makers agreed that they were essential in the efforts to manage the problem of child maladjustment, which became even more visible with the wartime evacuation experience ([Hendrick 2003b](#)). Thus, the importance placed on the role of the Child Guidance Service within the 1944 Education Act was yet again highlighted with the publication in 1946 of the Blacker Report which examined the mental health services as a whole in the light of the impending establishment of the NHS. The report concluded that child guidance was crucial in preserving the mental health of the nation and called for an expansion of services. By December 1954, 300

²⁰Following the introduction of the 1944 Education Act, maladjustment was included in a revised list of statutory handicaps. The “maladjusted child” now replaced the “moral imbecile”, whilst “educationally subnormal” superseded “feeble-minded”. This was the first formal acknowledgement of the condition as a form of emotional handicap that could restrict an individual's life choices in the same way as a physical disability.

clinics had been established in England and Wales, 204 of which were provided by local education authorities, while the rest were set up by voluntary bodies, regional hospital boards or teaching hospitals (Hayes 2008, p. 298). The development of teaching hospital-based services for children at this time occurred largely separately and eventually resulted in a situation where, by the 1970s, a number of towns had two kinds of services – one offered by the NHS in hospital settings and the other offered by the local authority in the community. In some instances there were overlapping staff, but no coordination existed (Hersov 1986, p. 784).

However, although the provision of child guidance clinics did accelerate from 1946 onwards, the expansion was limited in comparison to the demands placed on it.²¹ In the early 1970s, contrasts started to be made in academic and professional circles between the availability of services and research findings on the prevalence of disorder in children. Kolvin for example found that less than 1% of the child population were receiving help, yet 7-20% were identified as suffering from a psychiatric disorder (Kolvin 1973). Like Robins' studies in the US (Robins 1966), these epidemiological figures clearly showed that the clinics had only been scratching the surface of an enormous problem of child and family misery. Further, critics emphasised their widespread failure to tackle the problems of diagnosis, coupled with a lack of realism regarding the effectiveness of treatment (Shepherd et al. 1966; Tizard 1973). In both countries, it was agreed that the need for rigorous studies evaluating outcome was pressing.

Child guidance in the UK was also affected by a series of structural changes during the early 1970s that had the effect of leaving the clinics "leaderless and bewildered" (Black 1983a, p. 644).²² A 1974 circular on child guidance effectively

²¹To this was added a change in the nature and organisation of many of the clinics due to economic or staffing pressures. In many cases, the structure of the operation began to move away from the original triple-team US model, meaning that many clinics working under local education authority control, for example, operated largely using single psychologists while the majority of clinics attached to hospitals were without a fully qualified psychologist or psychiatric social worker and remained dominated by a psychiatric approach (Hayes 2008, p. 299).

²²In 1974, local government and the health service was reorganised simultaneously. With the reorganisation of the public sector in England and Wales in 1974, the new Area Health Authorities took over much of the responsibility for public health from the local authorities. School medical services passed to the new health authorities as did most of the medical staff who worked in child

abolished medical directors but made no alternative recommendations, while concurrent local government and NHS reorganisations changed the managers of many of the staff, and in some instances even the ownership and administration of the premises. This led to chaos in the management of the clinics, which were already experiencing difficulties due to mounting, and often unreconcilable, philosophical differences between individual practitioners and disciplines. By the 1980s, there was a strong feeling that the child guidance system had lost its way. Black (ibid) thus called it an “anachronism” that produced professional dissatisfaction and outdated treatment practices, and called for child psychiatric services to be reattached to medicine and general psychiatry, as they were by then in the US.

Nonetheless, the eventual demise of community child guidance owed less to explicit policy change than to piecemeal fragmentation in a period of economical downturn. As [Williams & Skeldon \(1992, p. 143\)](#) note, the inherent structural difficulties in the multi-disciplinary model where staff were employed by, and the capital found by, at least two different authorities, contributed powerfully to reductions in services and the consequent move away from the tripartite model when financial pressures on public services began to bite hard. From the mid-1980s, overt involvement of social service departments in child guidance declined, mirroring the increasing pressure on overstretched local authorities to deal effectively with physical, sexual and emotional abuse inflicted on young people. In parallel, the abilities of educational psychologists to invest time in child and adolescent mental health work also declined when they moved into indirect therapeutic work with schools and faced growing administrative tasks related to changes brought about by the 1981 Education Act dealing with special educational need and the introduction of the National Curriculum.²³ As a result, investment in

guidance clinics while the employment of all social workers based in the NHS passed in the other direction to local authority social service departments ([Williams & Kerfoot 2005](#), pp. 15-16).

²³In fact, the changes to the roles of social workers and educational psychologists contributed to the rise in importance of nurses and clinical psychologists within child and adolescent mental health care in the UK. During the last 20 years, there has been a rapid growth in the number of nurses appointed to out-patient services, so that in 1999, it was found that nurses formed the single largest professional group in specialist child and adolescent mental health services ([Williams &](#)

child and adolescent mental health care remained low for many years, even if the level of services gradually increased.²⁴

However, beginning with the Conservative administration and gathering pace under New Labour, there was a substantial change in the attitudes of central government in the 1990s. The first of a long succession of reviews came in 1994, when Kurtz and colleagues published a survey whose findings were generally not very complimentary to child psychiatric services (Kurtz et al. 1994). The year after, the NHS executive commissioned a thorough needs assessment and the Health Advisory Service produced a substantial document entitled *Together We Stand* (HAS 1995), which paved the way for the development of multi-disciplinary child and adolescent mental health services (henceforth CAMHS) within an integrated four-tiered framework that would replace the largely uncoordinated dual system of community child guidance and hospital-based clinics. In addition to this came reports from the House of Commons and the Audit Commission which concluded that provision was deeply insufficient both in quality and geographical spread.

In sum, a great deal of attention and extra resources was given to child and adolescent mental health services from 1995, but although the area has moved a great deal nearer centre stage than it ever was before, the gap between demand and capacity is still a pressing issue. Specialist services and utilisation have grown considerably in the UK in the past 15 years, but due to rising levels of need, about 30% more children are currently not being treated than was the case 30 or 40 years ago (Graham 2005). The pressure on services also means that many CAMHS are now psychologist or nurse-led, as there is a shortage of child psychiatrists, while long waiting lists lead to quick assessments and arguably provide a strong incentive to prescribe more powerful treatments with an immediate effect, such as stimulants. Although there were relatively few resources in child psychiatry in the

Kerfoot 2005, p. 17). This development is also reflected in ADHD-clinics, many of which are now nurse-led.

²⁴In England and Wales, there was more than a five-fold increase in the number of full-time consultant child and adolescent psychiatrists, from 81 in 1963 to 467 in 2003. There has also been a large increase in the number of clinical child psychologists, and although the number of social workers in the field has declined, this has been compensated for by the rise in the number of child psychiatric nurses (Graham 2005).

1970s and 1980s, some of my interviewees reported that they felt less constrained then in terms of time, funding and bureaucracy ([Lask int. 2006](#)).

It is difficult to say exactly to what extent the reorganisations of child mental health care in the UK affected hyperactivity diagnosis and prescription. Like in the US, some of the most significant factors in the rise of the diagnosis and its drug treatment are to be found outside the immediate professional and institutional context of medicine, for example in the global spread of democratising technologies like the internet and wider social processes that have resulted in decreasing tolerance and room for inattentive, troublesome child behaviour in Western societies. However, together with the growing emphasis on biologically orientated research and evidence-based treatment practice, the development of hospital-associated services inevitably caused more medical involvement, as the practice of child psychiatry moved away from its relatively isolated position in the community.²⁵ In fact, Professor of Child Psychiatry Robert [Goodman \(1997\)](#) argued that by medicalising simple maladjustment and distress, British child mental health services were overextending their remit in the process, encouraged by the wish to fill the vacuum created by the successive funding crises that led social services and education to withdraw from much of their traditional child and family guidance work. He emphasised the diagnosis of conduct disorder as a good example of a social problem best dealt with by social workers and educators that had been redefined as a mental disorder to be managed by busy doctors, who should instead be focusing on severe conditions such as autism, OCD, schizophrenia and anorexia. When Goodman's opinion piece was published in the *BMJ* in 1997, the hyperactivity epidemic had not yet quite taken off in the UK, and many of the conduct disorder cases he referred to would later be diagnosed as ADHD.²⁶

²⁵It must be noted that there continues to be much disagreement as to what to make of so-called "evidence" in psychiatry, as this information can be very distant and irrelevant to the realities of clinical practice ([Rutter int. 2005](#)). Further, it has repeatedly been shown that the purported evidence for the efficacy of a particular treatment may be unsound, for example because of drug company manipulation of study results and their publication.

²⁶Respondents to the editorial emphasised that the aggressive, anti-social behaviours included under the term conduct disorder are notoriously difficult to deal with for any professional and that

2.5 The rise of the “new paediatrics”

Significantly, in both countries, the decline of the tripartite community-based child guidance model also coincided with the involvement of new groups of professionals in child mental health care, and most importantly paediatrics, although this process started much earlier in the US.²⁷ Indeed, the historical rise of hyperactivity must be seen on the background of professional transformations within paediatrics as well as child psychiatry, and the battle over turf that have played out between them. The interaction between child psychiatrists and paediatricians has historically been characterised by mutual annoyance and mild hostility, and up until recently there was little collaboration between them in either country. Child psychiatry as a discipline emerged from the community-based child guidance and juvenile justice systems, which were rather removed from mainstream medicine. By 1927, there were 200 child guidance clinics in the US, but paediatricians did not participate in these, partly because they did not speak the same clinical language. Paediatric commentary at the time suggested that they tended to see child psychiatrists as rather unpractical and inefficient, but with time paediatricians began to wonder whether they could incorporate the new psychiatric methods into their own work, especially since they were now seeing a growing number of children presenting with problems pertaining at least in part to the child’s personality and interpersonal relationships rather than somatic illness as such.

Yet, leading paediatricians revolted against the “theoretical controversies, fantastic schemes, weird claims, peculiar terminologies, and unbridled enthusiasms” that accompanied the growth of child psychiatry and prevented most

parent training and school problems are not sufficient for this group of children. Considering that the British diagnosis of conduct disorder and the American diagnosis of ADHD have been shown to overlap considerably, this perhaps gives a clue as to why stimulant treatment increasingly became a favoured solution.

²⁷In the UK, the decreasing involvement of social workers and educational psychologists in child mental health was also counterbalanced by a sharp increase in the participation of nurses and clinical psychologists, who have become heavily involved in ADHD management in many parts of the country ([Browning 2005](#)).

physicians from utilising psychiatric methods in their practice ([Kanner 1938](#), p. 72). The revolt came to a head in 1931 when Dr. Joseph Brennemann delivered an acerbic address to the New England Pediatric Society entitled “The Menace of Psychiatry” ([Brennemann 1931](#)) which touched upon issues that are still relevant today, both in terms of the continuing divide between the professions and in terms of the ongoing debates about the pathologisation of child behaviour. Brennemann pointed to the “menace that lies in the too intensive injection into the lay mind [...] of a mass of complicated, confused, and as yet unsatisfactorily unorganized material”, and accused child psychiatrists of overcomplicating things that before seemed simple and self-evident. Echoing present-day concerns, he emphasised the “creation” of behaviour problems in children through the construction of ideal mental and behavioural patterns:

It is as unreasonable as it is undesirable and unnatural for a child to be as good as we seem to want him to be. Both as a result of their individual chromosome inheritance and of their environmental influences, children normally vary as much mentally and in behaviour as they do in height and weight. It would be a drab and uninteresting world if they were all alike, especially if they were equally good (*ibid*, p. 388).

Schools were faulted for contributing to this development, some by being too disciplined and for putting too much emphasis on academic skills and measurable intelligence, others by being too modern and progressive, dissolving organisation and discipline altogether. Finally, like so many social commentators after him, Brennemann also mentioned the speed of modern life as a precipitating factor in many, if not most, psychiatric problems.

After WWII, several leaders in child psychiatry called for more teaching of paediatricians by child psychiatrists, although the potential for the reverse flow of knowledge was rarely mentioned, namely the paediatrician’s knowledge of the physical disorders, biologic functions, and development of the child ([Kanner 1938](#)). On the other hand, investigators in the US paediatric literature often indicated the advantage practicing paediatricians have in diagnosing and managing common behavioural problems, as their long-term knowledge of the

family allows for interventions at appropriate times, in contrast with mental health professionals who see the family only on referral. By the 1960s, several US departments of psychiatry and paediatrics had developed a liaison type of service, but at this point in the pre-drug treatment era, the gulf between the disciplines was still wide, especially since most psychiatrists were informed by analytic thinking and treated only a few patients for long periods of time (Haggerty & Friedman 2003). Later attempts at integration included the creation of joint training programmes at selected universities, partly in order to tackle the enormous shortage of child psychiatrists. However, paediatrics was already undergoing a transformation from within, as dramatic developments in therapeutics were pushing the profession beyond the traditional remit of medicine and into the territory of child mental health.

The history of paediatrics clearly illustrates how professions undergo continual modification in response to changes in the context of their work. Whereas the specialty started out focusing solely on somatic disease and later on prevention, since the 1950s, paediatricians have become increasingly involved in managing troublesome child behaviour. One reason may be the rise in the prevalence of psycho-social problems among children since World War II, but probably the most significant catalyst of change has been the dramatic reduction in infant and child mortality and drastic transformation of child illness brought about by important medical advances and general improvement of living conditions. As a consequence, physicians and parents became more aware of other, less acute problems that were interfering with family happiness and children's functioning. This was obviously seen as a positive development, but for paediatricians it necessarily led to an active search for a new mission as they worried about their declining status. In the US, where the majority of paediatricians worked in primary care, the declining morbidity and mortality even threatened to destroy the largest segment of the specialty. Thus, primary care paediatricians survived in a competitive market milieu by broadening the scope of their practice to incorporate the behavioural, emotional and social problems of children, such as poor school performance, hyperactivity, shyness, aggressive and anti-social behaviour, and

temper tantrums ([Pawluch 1983](#); [Haggerty & Friedman 2003](#)).

When paediatrics became an organised branch of medicine in the US in the late 19th century, rates of infant and child mortality were exceedingly high due to social problems caused by rapid urbanisation and mass immigration. At this time, more than a quarter of all children in the US died before the age of five, mostly due to infectious diseases like dysentery, cholera, diphtheria, scarlet fever, pneumonia, and tuberculosis. Around the turn of the century, humanitarian and political interest groups heightened public awareness of these issues through intense activism on behalf of children, resulting in child labour laws, compulsory education, juvenile courts and reforms in health and welfare services for children. The new medical specialty of paediatrics was formally recognised in 1879 when the American Medical Association formed a Diseases of Children section, but the organisational growth of the discipline was paralleled by plummeting mortality rates due to improved living conditions and sanitation, the development of vaccines for many child-killing diseases, research into the effects of vitamin deficiency, and specific health reforms based on new knowledge about infectious diseases and nutrition. The most dramatic change occurred with the development and introduction of antibiotics in the 1940s, after which mortality rates dropped even further, which meant an even greater emphasis for practicing paediatricians on prevention and health supervision rather than illness treatment. The era of curative paediatrics had come to an end.

As prevention gradually displaced treatment, paediatricians began to complain to each other, and in letters to leading journals, about boredom, a lack of prestige, and the unprofitability of a medical practice concentrated on health supervision. Many wanted to relieve the tediousness of routine care by encouraging independence among mothers, but recognised that this may be poor economics. One doctor admitted that “the paediatrician would do better financially if he permitted the parents to have a little anxiety and encourage them to depend on him through frequent office visits” (Coddington in [Pawluch 1983](#), p. 456). Paediatrics was losing its appeal among medical school graduates, and another ominous trend was the increasing competition from general practitioners

and family doctors. Anticipating the dilemma ahead, some urged their colleagues to look out for borderline problems, “shades of difference between health and disease, conditions whereby the child is not invalidated, but his social and individual efficiency is decreased” (Stafford in [Pawluch 1983](#), p. 457).

Soon new, broader definitions of the specialty appeared, covering the active promotion of child health in all its aspects, stressing in particular the child’s mental, emotional and social development. Referring to the “new paediatrics” and “social and community paediatrics”, paediatricians thus began to point to the “unmet needs” of the child, referring not only to children with handicaps, but also those whose optimal functioning was impaired by school problems, juvenile delinquency, parental abuse, and behavioural problems of all sorts ([Haggerty & Friedman 2003](#)). Most importantly, the “new paediatrics” was a way for paediatricians to distinguish themselves from general and family practitioners, and at the same time being seen as less costly and more efficient than child psychiatrists.

Factors outside the specialty also contributed to the expansion of its mandate beyond the prevention to the promotion of child health in all its dimensions. First, changes in family structure and the demand for more children to perform well and stay longer in school increased the recognition, and perhaps also the prevalence, of behaviour problems in children. Second, in the 1960s, the introduction of psychotropic medications such as Ritalin made conditions which had previously been the province of psychiatry and time-consuming expensive “talking therapy” more amenable to traditional medical intervention. Thus, it is unsurprising that hyperactivity quickly became a top priority in the new subspecialty of “developmental-behavioural paediatrics”, first defined in 1975 as “an area within paediatrics which focuses on the psychological, social and learning problems of children and adolescents” and where interdisciplinary work with psychologists, child psychiatrists and social workers is essential (*ibid*, p. 4). The overlap with child psychiatry is significant but whereas child psychiatrist are trained to manage the more severe mental pathologies of children and today has become an expert on psychopharmacology, behavioural paediatricians address the more common

behaviour problems of children and tend to be more “activistic” and positive in their approach ([Diller int. 2006](#)).

Far from everybody felt comfortable with the expansion of paediatrics; in fact, there was resistance towards the formation of a separate subspecialty both inside and outside the profession. On the one hand, generalists were concerned that paediatricians would lose an essential skill that must be a component of all paediatric practice, and on the other hand, there were fights with child psychiatry over turf. Despite the fact that child psychiatrists have never been able to address any but a small percentage of the overall need, many of them have persisted in their concern that paediatricians would not be able to care adequately for disturbed children. For others, the guarding of professional boundaries was clearly the main issue. In 1982, in the newsletter of the American Academy of Child Psychiatry, one psychiatrist commented that the support for behavioural paediatrics “ignores the overall threat that this group may have to the future viability of Child Psychiatry” (Curran in [Haggerty & Friedman 2003](#), p. 3). The fact that this resistance has continued up until recent years was demonstrated by the reluctance of child psychiatrists to support the approval by the American Board of Medical Specialties of the certification of developmental-behavioural paediatrics in the late 1990s.

2.6 Paediatrics and the growth of ADHD in the UK

In the UK, the advent of antibiotics and the rise in the standard of living also changed the face of paediatrics, but the transition was not as dramatic due to the different organisation of health care, i.e. the primary role of British paediatricians as academicians or hospital consultants salaried by the NHS, rather than as primary care practitioners, or “specialoids”, who had to vie for customers. The distribution of physicians in general practice and paediatric roles in England and the US highlighted the different roles that had evolved in the two countries. Whereas the UK came to rely on GPs in primary care, in the US general practice lost out to specialism. In the mid-1970s, there was one paediatrician in England

per 36,000 children and one GP per 700 children out of a population of 14,000,000 between 0-15 years of age. The corresponding numbers for the US were 1/3500 and 1/1250 out of a child population of 70,000,000 (Cornfield 1978, p. 501).

However, in Britain too, the relationship between child psychiatry and paediatrics has been marked by tension, and there are important similarities with US developments when one looks at the way in which the rise of ADHD in the 1990s has been paralleled by the increasing involvement of paediatrics in child mental health. Partly due to the pressure it put on child mental health services – and partly because of the initial reluctance of many child psychiatrists and paediatricians to treat overactive children with stimulants – ADHD was certainly a key catalyst in the rapid development of the subspecialty of developmental-behavioural paediatrics over the past 15 years in the UK (Bramble 2003).²⁸ Thus, while hyperactivity has not played a central role in an actual struggle for professional survival like in the US, at least one could argue that the disorder has also become a means of expansion for British paediatrics, as well as an important focus for quarrels over professional boundaries.

The first step toward incorporating the management of child behaviour and learning disorders into paediatrics in the UK was the formation in the 1960s of a separate paediatric neurology branch focusing on disorders of the nervous system such as epilepsy, cerebral palsy, brain trauma and neuromuscular disease. Beginning in 1958, the Spastics Society sponsored a series of multidisciplinary international study groups on child neurology and cerebral palsy in Oxford. These meetings, led by Dr Ronnie Mac Keith, gave rise to two groups with a more specialised interest in paediatric neurology: a British Paediatric Neurologists Association (BPNA)²⁹ with close links to the British Paediatric Association, and a

²⁸As in the case of the training of junior child psychiatrists, the postgraduate syllabuses for paediatricians today include the requirement that trainees develop the requisite skills in psychotropic medication use (Bramble 2003, p. 171). The overlap in expertise between community and behavioural paediatricians is significant, the main difference being that the latter focus solely on children's behaviour and development, and specialise in the medical management of so-called neurodevelopmental disorders, like ADHD or Autistic Spectrum Disorders. Also, they are more closely aligned with mainstream paediatric medicine.

²⁹Developmental Medicine and Child Neurology became the officially designated journal of the BPNA in 1979 and Paediatric Neurology was formally recognised as a specialty in its own right

European group of paediatric neurologists, formally created in 1970. Thus, through the Oxford International Study Groups, the UK played an important part in developing the field of paediatric neurology in Europe ([Lancet 1974](#)).

However, whereas paediatric neurology consultants would solely be hospital-based and manage serious chronic conditions like epilepsy, more common behaviour problems like hyperactivity would become the domain of GPs and community-based paediatricians. Community paediatrics in the UK arose in the wake of the 1976 Court Report, which reviewed existing child health services and made proposals for a new integrated level of care. The report pointed out that like in other countries across the Western world, the major health problems affecting children in the UK were no longer acute and episodic illness but rather chronic illness, handicaps, psychiatric disorders, and ill health arising from family stress and break-down (“the new morbidity”). It also emphasised the high significance of social and geographical factors in determining healthy development and thus recommended a further development of a new type of community paediatrician with special skills in developmental, educational and social paediatrics who would practice as a consultant to the GP and the school doctor. Another suggestion was the creation along the lines of US practice of a new specialty of general practitioner-paediatricians, but this route was not taken.³⁰

In the early 1990s, data showed that paediatricians in the UK were treating more emotional and behavioural disorder in children than any other single professional group, in spite of their limited training in this area ([Kurtz et al. 1994](#)). Behaviour problems in fact formed about one in five referral to community paediatricians, who frequently perceived the local CAMHS services as woefully inadequate and restricted, and often not useful, for example in not providing brief interventions. Before this time, children referred to paediatricians with ADHD-like symptoms would likely have received other neurodevelopmental diagnoses like

later that year.

³⁰At the point of the publication of the Court Report, it had not yet become mandatory for GPs to have specific training in child health problems, which was recognised as problematic since GPs provided the bulk of paediatric care in the UK ([Cornfield 1978](#), p. 500).

dyspraxia or specific learning disorder (most often dyslexia), but slowly awareness of the disorder was starting to grow within the profession ([Harpin int. 2006](#)). A 1994 survey of practices relating to ADHD and hyperactivity among paediatricians and child psychiatrists found that most of the respondents accepted the diagnosis, though it was still rare compared to those of learning disorder, emotional disorder, and family dysfunction ([Kewley et al. 1994](#)). Although this was a common feature in both groups, more paediatricians than psychiatrists made the diagnosis on clinical impression alone, without relying on defined diagnostic criteria, but when employing any criteria, they tended to use the American DSM. As they did not feel confident in their education on the subject, including the prescription of stimulants, the paediatricians generally preferred not to treat hyperactivity or ADHD themselves. Instead, they favoured non-medical forms of intervention such as behavioural management techniques, schooling strategies and diet modification. A considerable number were apparently also unaware of the main side effects of stimulant medication, such as decreased growth, depression and tics.

However, during the course of the decade, hyperactivity or ADHD came to represent a growing and sometimes major component of the caseloads of the average community paediatrician, and, increasingly, many hospital-based paediatricians. Today, things have changed to such an extent that paediatricians run many – if not most – of the ADHD clinics that have sprung up across the country, although the local variation is great. A 2000 survey of the Trent region showed that community paediatricians and child psychiatrists were seeing approximately equivalent numbers of new ADHD patients, but that service provision was both uneven and inequitable, and also reliant upon local specialists with a “special interest” in the field, rather than springing from any explicit or coordinated planning initiatives ([Keen et al. 2000](#)). There were marked disparities in caseloads of individual paediatricians, child psychiatrists, and clinical psychologists, both within and between disciplines.³¹

³¹This was in keeping with patterns already established in the US. In Michigan, which was among the American states with the highest per capita consumption of methylphenidate in the 1990s, a report from 1995 showed that the percentage of boys aged 10-11 years being treated with stimulant

Given the uneven service delivery and the initial unwillingness of many British child psychiatrists to prescribe, UK investigators complained that children presenting to the NHS with psychiatric disorders who might benefit from drug therapy faced a “treatment lottery” (Bramble 2003). A survey of the differences between CAMHS and paediatric approaches to ADHD not surprisingly found that the paediatric approach was heavily biased toward physical investigation and stimulant treatment, whereas child psychiatrists prioritised mental health assessment and had access to a much wider range of psychological treatment options (Salmon & Kemp 2002). Like many other researchers (Bramble 2003; Browning 2005; Keen et al. 2000), the authors emphasised the pressing need for more collaboration between agencies and for increased GP involvement, thus echoing past calls for better integrated, coordinated services for children.³² The need for multimodal treatment was also highlighted, but with the admission that this remains an ideal, as social work and educational resources have increasingly been drawn away from CAMHS, and as child health services often do not have direct access to forms of treatment other than medication.

Like in US, there has been much debate in Britain about which professionals should take the lead responsibility for the treatment of ADHD. The general consensus now seems to be that paediatricians can deal with “straightforward” cases of ADHD but that further referral to CAMHS is necessary in “complex” cases characterised by concurrent mental health problems. While GPs have traditionally seen hyperactivity disorder as the task of a specialist, and therefore have not felt

drugs was 3-5%, with a tenfold variation between counties (Rappley et al. 1995). Primary care physicians wrote 84% of all prescriptions, while paediatricians wrote 59% of prescriptions for patients younger than 20 years, with half of these being written by 5% of the paediatricians in the state. Similar results were also found in Australia, where ADHD emerged as a major medical and social phenomenon in the late 1980s, not least due to the active campaigning of individual paediatricians (Kean 2009). These data suggested that paediatricians and primary care physicians had taken a pragmatic approach and were filling the void left by their more cautious mental health colleagues (Levy 1997).

³²The current model of cooperation, if present, depends very much on the local setting; in some places paediatricians work in CAMHS which will run the ADHD clinics, in other places there is almost no collaboration between CAMHS and child health services, and in yet other places there is a more coordinated system of communication between the various agencies, including general practice (Keen int. 2006; Steer int. 2006).

comfortable diagnosing and prescribing, this is currently changing with the introduction of shared-care protocols. However, many commentators have questioned the widespread prescription of drugs for ADHD by paediatricians, as well as the involvement of general practitioners, because of their perceived lack of adequate training.³³ Indeed, various surveys conducted in the 1990s showed that a large proportion of Britain's child psychiatrists were unhappy about non-psychiatrists initiating stimulant therapy ([Bramble 2003](#)). Several of my child psychiatrist interviewees, who otherwise occupy different positions in the ADHD debates, expressed similar sentiments:

Because you've got these behaviour check-lists and you have a reasonably protocol driven treatment, then the assessment and treatment of ADHD has been delegated to low level staff. So what used to be called conduct problems is now often reframed as ADHD and these kids are being put into an ADHD clinic and they're not properly assessed. Nurse therapists or sometimes paediatricians[...] there are all sorts of people are doing these clinics now [...] the problem with paediatricians doing it is they don't have any idea of developmental psychopathology or mental state or anything. No idea at all [...] they call themselves behavioural paediatricians, so they go on behaviour check-lists, but they don't look at the sort of internal world. So that is a bit of a worry, but there are steps being taken to try and change that ([Anonymous int. 2006a](#)).³⁴

Of course one further thing that has happened, which is to me the most worrying aspect – this is where I think child psychiatry's effectively shot itself in the foot – because we've conceptualised ADHD as a neurodevelopmental disorder [and] that's paediatrics' territory, of course most ADHD clinics are now set up by paediatricians, and as much as I have grave reservations about

³³At the British Association of Psychopharmacology's consensus meeting on paediatric psychopharmacology in 1997, American child psychiatrist Rachel Klein expressed a similar view: "You have to understand that we started our studies in 1969 with psychoanalytic child psychiatrists who said that if it is emotionally based we shouldn't give them medication [...] We started where you are, but the experience objectified has shown that these concerns are simply not valid. Whether the environment causes it or not is irrelevant. Should you ignore it in the treatment plan? Of course not. Should it be part of your concerns? Yes. Should it cause you to withhold medication? No. So it is not either or. My plea to you is to make sure you support this as mental health professionals because if you don't, the GPs and the paediatricians will do it and they will do it badly" ([BAP 1997](#)).

³⁴The Royal College of Paediatrics has had a Mental Health Group for over 25 years which is now very active. Those involved are very active in developing the mental health curriculum and driving the idea that paediatrics is at the heart of mental health. The group was originally started around the work done at Great Ormond Street and incorporated people from various professions.

child psychiatrists going into the idea of diagnosing and medicating a lot of... if it was my child and I had to choose between a child psychiatrist and a paediatrician I know I would choose a child psychiatrist, because paediatricians have no mandatory training in psychological approaches, in family approaches, you know, in assessments and contexts basically, and so the treatments that they deliver are, generally speaking, medication, and medication only... usually a bit of behaviour therapy advice, kind of common sense stuff ([Anonymous int. 2006b](#)).

Meanwhile, paediatricians in the UK have viewed child psychiatrists as unpractical, a bit precious, and in some cases even useless, summing up child psychiatry as the discipline of watching a family interacting through a screen and over-interpreting various behaviours that are really just expressions of the mother's exhaustion and desperateness ([Bramble int. 2005](#); [Steer int. 2006](#)). The paediatrician's pragmatic approach – which is often highlighted by child psychiatrists as a potential concern – is emphasised as an advantage that allows paediatricians to stay more in touch with the needs of the “people on the ground”, thus making them attractive to school personnel and general practitioners who now often go to paediatricians directly, rather than involving mental health services or educational psychologists ([Prior int. 2006](#)). Apart from the fact that this often presents a quicker route to treatment, it might also mean that there is a move away in schools and in primary care from seeing ADHD as a “mental health” rather than a purely developmental problem ([Keen int. 2006](#)). Although collaboration and knowledge exchange between child psychiatry and paediatrics has increased the past 15 years, doctors and parents still express frustration that widespread territorial jealousy and guarding of professional boundaries creates obstacles to efficient treatment of ADHD children, with child psychiatrists being singled out as particularly protective of their field of expertise, as they attempt to avoid being overwhelmed with problems which they consider relatively trivial. Whereas American specialists have often fought each other over who should treat certain groups of patients, UK consultants employed by the NHS have little incentive to attract more patients, as it is difficult for them increase their salaries, unless they also work in private practice (which, it should be noted, some consultants in the ADHD area do). Thus, some British specialists have tended to try to define their

specialties as narrowly as possible in order to keep their workload down (Payer 1988, p. 106).

When moving from practice to theory, leading neurodevelopmental paediatrician, Daphne Keen, notes that the near absence of paediatricians in conceptual development and academic debates has been instrumental in bringing about an uneven power relationship between the two professions in the area of behaviour and learning disorders (Keen int. 2006). Thus, she argues that the demise of the MBD category disempowered paediatricians in relation to the treatment of hyperactive children and children with learning disabilities in particular, while child psychiatry on the other hand got into ever finer categorical classification in the 1970s and 1980s. Since then, classification has remained the prerogative of child psychiatry and consequently, ADHD has predominantly been seen as a mental disorder, although that is changing. Like many of her colleagues (Harpin int. 2006), Keen thinks that paediatricians should be more visible in theoretical debates and official guidelines, since they dominate the practical management of the disorder. In the US, a similar view is held by paediatrician Larry Diller, writer of the best-seller *Running on Ritalin* (1998), who is surprised at the low number of serious paediatric ADHD researchers; whereas paediatricians have taken care of the practical side of things, he says, child psychiatry has had a near monopoly on theory, and this in spite of the fact that hyperactivity was predominantly a paediatric phenomenon in the US from the late 60s to the mid-80s, before child psychiatry turned more biological (Diller int. 2006).

2.7 Conclusion

In order to set the scene for the following chapters on medical approaches to hyperactivity in the US and the UK, I have here sketched the main institutional, professional, and intellectual developments within the area of child mental health in the two countries. Thus, starting in the 1920s, it includes an account of the rise and transformation of child guidance; the growth of academic child psychiatry and

psychology from the 1960s onwards; and the increasing medicalisation of child psychiatry, illustrated by its reattachment to medicine and hospital services, and the increasing emphasis on biomedical explanatory models and pharmacological research and treatment. Further, I have analysed the growing involvement of paediatrics in the management of child mental health problems, and the ways this process has affected hyperactivity diagnosis in both countries.

The chapter has shown that one finds broadly similar trends in each country over time, with influences going mostly from the US to the UK and the rest of Europe, although Britain was highly instrumental in developing the field of child psychiatric research after WWII. However, I have also endeavoured to emphasise the issue of national differences in research and treatment agendas as a reflection of diverging medical ideologies, modes of health care organisation and delivery, professional incentives, and levels of market influence. Given that many clinical interventions are not properly supported by clinical evidence, even in present-day Western democracies, the role of culture in medicine must not be overlooked. In fact, observations made by various psychiatrists during the interwar period on the fundamental differences between European and American psychiatry reflect many of the values we would still associate with the countries' respective medical communities. In brief, one can say that the whereas the history of American psychiatry has been characterised by extreme and enthusiastic swings between psychological and biological models of mental disorder, and by a rather aggressive therapeutic mindset, in the UK one finds a more continuous interest in both psycho-social and organic causative factors, and a more conservative approach to treatment. In turn, these differences are consistent with, on the one hand, the existence of a competitive medical market place coupled with substantial philanthropic and government funding of innovative health intervention and medical research programmes in the US and, on the other hand, the strong public health tradition and the presence since 1946 of a national comprehensive health care system in the UK, which has prompted government to monitor health trends and their socio-economic correlates within the population in order to plan and rationalise services. However, just like the American pragmatic "can-do" attitude

and tendency to promote technological solutions over prevention cannot simply be explained as results of the play of market forces, the cautious British attitude does not only reflect the economic rationality of the NHS, but also broader social and cultural currents. As we shall see in chapters 3 and 4, the history of childhood hyperactivity in the two countries may serve as a particularly useful lens through which to view the national perspectives juxtaposed and explored in this chapter.

CHAPTER 3

From volitional inhibition to attention deficit disorder: continuities and breaks in British and American conceptualisations of childhood hyperactivity, 1902-1980

3.1 Introduction

In the late 1970s, a group of child psychiatrists and psychologists at the Institute of Psychiatry at the Maudsley Hospital in London started a series of studies examining the validity of the hyperkinetic syndrome and its relationship to the broader range of disruptive conduct disorders in particular. The group was motivated by an issue that had been a source of considerable puzzlement for some time, namely the gap that had developed between Britain and the US in hyperactivity rates since the early 1960s. In contrast to American prevalence estimates of between 5-20%, the famous Isle of Wight epidemiological study, published in 1970, had only identified two hyperkinetic children in a general sample of 2199 ([Rutter et al. 1970a](#)).¹ Reflecting actual diagnostic rates, figures from a British psychiatric case register gave a ten-year period prevalence rate of 112 per 100,000 children (half of whom were intellectually retarded and would

¹This comparison is however not exactly fair, as these higher figures were based chiefly upon teachers' reports, while the Isle of Wight data included the diagnosis of a psychiatrist.

therefore have been excluded from the American studies), while only 1.2% of child patients at an English psychiatric teaching hospital clinic received the diagnosis (Taylor 1986, pp. 11-13). In comparison, a community survey found that 1.3% of all elementary school children in Grand Rapids, Michigan, had at one point been diagnosed as hyperactive (Bosco & Robin 1980). The label was clearly applied to a large proportion of the clinic population in the US, perhaps as many as 30-40% of cases (Safer & Allen 1976). Overall, this translated into a startling twenty-fold national difference that begged explanation.²

Treatment also differed markedly between the two countries. From the mid-1960s, psycho-stimulants such as methylphenidate (Ritalin) had been increasingly used in the US as a means of managing disruptive child behaviour. This practice was viewed with horror as a form of “chemical warfare” against children by some British child psychiatrists (Hersov int. 2005; Lask int. 2006), very few of whom used any psychoactive drug treatments, except in in-patient units, and even here little (Graham 2005; P. Hill int. 2005). The sceptical or even hostile British views on drug therapy and American concepts of hyperactivity were expressed in a series of editorials throughout the 1970s, noting the contraindications for, and dangers of, the use of stimulants in the vast majority of cases as well as the importance of restraint on the part of the doctor (Bax 1972; 1978; Chapple 1973; MacKeith 1974). Without exception, these articles all highlighted the curious cross-Atlantic differences: “In contrast [to British practices], we hear in America of schools full of children receiving methylphenidate or amphetamine-like drugs for hyperactivity. Are the Americans ahead of the British, or behind them, or do their children’s brains dysfunction in such an ostentatiously exotic transatlantic fashion that they require drug therapy?” (Lancet 1973, p. 487).

According to one of the researchers, the Maudsley hyperactivity group was reacting to the “American enthusiasm for seeing hyperactivity everywhere”, and to

²Hyperkinetic disorder was rarely recognised not just in the UK but also in the rest of Europe. In France and Italy, where psychodynamic theories of child psychopathology have a strong historical presence, the diagnosis was even less used than in Britain (Brancaccio 2001; Taylor 1987).

the way in which hyperactivity – or minimal brain dysfunction (MBD) as it was also termed in the US during the 1960s and 1970s – had come to refer to a supposedly distinct, easily identifiable, and common condition caused by some form of neurological dysfunction or disease, despite the modest amount of evidence supporting this position ([Schachar int. 2005](#) see also; [Rutter 1977](#), pp 1-2). In particular, the group felt provoked by the notion, propounded by figures such as American psychiatrist Paul Wender, that a positive treatment response to psycho-stimulant drugs like methylphenidate (Ritalin) could be used as a diagnostic tool ([Wender 1971](#)).³ They were shocked at the way the disorder had become “the flavour of the month”, and the expectation was that with some clever, well-crafted research, it should be possible to clarify the US-UK discrepancy.

One conceivable explanation was the potential existence of a real difference in the way American and British children behaved, as a result of divergent child rearing practices and/or stresses on children.⁴ However, this theory was largely dismissed, as was the alternative possibility that discrepancies in perceptions and tolerance thresholds of referring teachers or parents were responsible.⁵ One might also point to differences in referral practices and health care systems. Many of those children who were treated as hyperactives by paediatricians or child psychiatrists in the US would not have been referred by their general practitioner to a specialist who could or would prescribe in the UK. It is not that there was a lack of focus on child behaviour problems and the risk they posed to the individual and society generally in Britain during the 1970s and 1980s. But on the whole, British parents were less encouraged to seek medical help for their children’s hyperactive behaviour, be it by health visitors, teachers, or popular sources of

³The notion that stimulants specifically treat or reverse hyperactivity was strongly buttressed by the long-standing idea of their remarkable ‘paradoxical’ calming effect on hyperactive children, first remarked upon by paediatrician Charles Bradley in 1937.

⁴Another possibility is that British and American children are genetically dissimilar. This idea has not been seriously entertained by mainstream ADHD researchers, but the authors of a leading popular ADHD text go so far as to speculate that the American gene pool is “loaded” for the main behavioural components of the disorder, including positive aspects such as adventurousness ([Hallowell & Ratey 1994](#)).

⁵Questionnaire ratings of hyperactive behaviour completed by parents and teachers have not differed significantly between the US and the UK ([Taylor & Sandberg 1984](#); [Taylor 1986](#)).

parenting advice, and the ones who actually did consult their GP most likely received the impression that these difficulties were matters of child-rearing rather than of medicine as such (Taylor et al. 1991, pp. 132-133).

Even if referral practices were somewhat different, so that more American children with various difficulties saw specialists, and so that children seen in clinics in the two countries were not completely similar, in both sites referrals generated a large caseload of children, predominantly boys with apparently comparable externalising aggressive and/or overactive behaviour problems and learning problems (ibid).⁶ For this group, different medical conceptions of disruptive child behaviour, as well as attitudes to treatment, have clearly been important in producing diverging diagnostic patterns. Thus, in the mid-1980s, British researchers investigating these patterns (Taylor 1986; 1987; Prendergast et al. 1988) emphasised the relatively widespread American practice of treating with Ritalin, and the effects of differing diagnostic criteria in the hyperactivity area, as reflected by the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM) and the WHO's *International Classification of Diseases* (ICD), which has been heavily shaped by British perspectives (Kendell 1990, p. 149). When the APA renamed the syndrome Attention Deficit Disorder (ADD) in the DSM-III (1980), these discrepancies became even more obvious, as the American definition was much broader than its ICD-9 counterpart, Hyperkinetic Disorder (HKD).

This chapter and the next will chart important historical developments in the understanding and definition of hyperactivity from a transatlantic perspective, focusing on US-UK transfer of people and ideas, and on departures and convergences in conceptions and practices. The conceptual history of childhood hyperactivity, today most often referred to as Attention Deficit Hyperactivity Disorder (ADHD), is relatively well described in the Northern American context (Barkley 2006; Diller 1998; Smith 2008; Mayes et al. 2009; Rafalovich 2004). However, there is very little literature on the perception and management of

⁶Presumable, in the US, specialists would have seen more children with hyperactivity and concentration difficulties as their primary problem, while in the UK more children would have presented with a range of severe problems, including anti-social conduct problems (ibid).

hyperactivity outside the US, and even fewer works with an explicitly comparative approach.⁷ Here, I want to expand and complicate the existing US-biased literature, first by discussing the recurrent claim that the origins of ADHD lie in late 19th century British medical discussions on mental deficiency and moral imbecility; second by focusing on the parting of British and American ways, starting in the late 1950s when conceptions of the disorder broadened considerably in the US concurrently with the emerging use of stimulant drug therapy; and thirdly by exploring the British critiques of the concept of minimal brain damage. In chapter 4, I shall examine the background for the advent of the DSM-III and Attention Deficit Disorder, as well as the heated debates it provoked both in the US and the UK and in Continental Europe.

3.2 From moral deficiency to minimal brain damage

As indicated above, medical and psychiatric conceptualisations of hyperactive child behaviour have historically been characterised by the persistence of the idea of biological determination, although this theory has remained controversial and without conclusive evidence. In both the US and the UK, there is a long history of interest in the organic origins of overactivity and inattention in children. But as I shall show in the following, the relative importance placed on biological versus social factors in explanations of a common syndrome of hyperactivity has differed considerably, both within each country over time, and between the two settings.

Although the current biomedical concept of ADHD is typically associated with American psychiatry, and despite the fact that hyperactivity was rarely discussed in professional circles until the mid-1950s, several medical researchers ([Barkley 2006](#); [Sandberg & Barton 2002](#); [Schachar 1986](#)) and sociologists ([Lakoff](#)

⁷The only existing work to specifically compare the UK and North America is Claudia Malacrida's sociological study focusing on mothers and their conflict-ridden relationships with various "helping professions" ([Malacrida 2003](#)) which only gives limited information on historical changes and the psychiatric and medical structures impacting on the treatment of hyperactivity in the two settings.

2000; Rafalovich 2004) have traced the origins of the disorder to the early 20th century writings of Sir George Frederick Still, best known generally for being one of Britain's first pediatricians and for describing Still's disease, a form of juvenile arthritis. Sometimes another British figure is also mentioned, namely Alfred Tredgold, expert on mental deficiency and an ardent supporter of the eugenics movement. Both men's theories reflected class-based anxieties emerging from the rapid process of industrialisation, and the concurrent rise of scientific positivism and social Darwinism. Rather than being avant-garde, they can be seen as a conglomeration of numerous medical discourses surrounding "idiocy", "feeble-mindedness" and "moral imbecility" around the turn of the century, illustrating in particular contemporary concerns about behavioral and intellectual disability in children who were not so impaired that they could be placed in an asylum. As described by Jackson (2000), individuals who occupied "the borderland of imbecility" were believed to be a burden on society and a potential threat to social order. These children had been made more visible by the education legislation during the 1860s and 1870s, which required that more children attend school and exposed those who had difficulty learning, and this in turn contributed greatly to the interest in and classification of marginal learners.

In a lecture series delivered to the Royal College of Physicians in 1902, Still presented a series of cases of children with normal or near-normal intellect, but with "defects of moral control". This deficit could, he proposed, be understood as a severe lack of reserve signalled by violence, shamelessness and wanton mischievousness, the keynote quality of their behaviour being "the immediate gratification of the self without regard either to the good of others or to the larger and more remote good of self" (ibid, p. 1009). They were restless and fidgety and had "an abnormal incapacity for sustained attention" that would often cause school failure (ibid, p. 1166). Lawlessness and indifference to punishment were also mentioned as common characteristics, as was the high proportion of males to females in the sample. Still's central hypothesis was that the moral deficit displayed by the children represented the manifestation of "a morbid physical condition" which was probably hereditary but the result of pre- or postnatal brain

injury in others.

To Still, the moral control of behaviour (“the control of action in conformity with the idea of the good of all”) was closely tied to the concept of volition, which in turn was described as inhibitory in nature. He saw “inhibitory volition” as the cornerstone of civilised behaviour, as a capacity which ideally developed gradually in the normal child. But as “a late development both in the individual and the race” it was particularly liable to malfunction (ibid, p. 1011).⁸ Still believed that deficits in inhibitory volition and moral control were causally related to each other and to the same neurological defect.⁹ Furthermore, this impairment could potentially be associated with other “stigmata of degeneration”, such as anomalous craniological characteristics. Special attention was thus paid to the disproportionately large head circumference of many of the children as well as their relatives’ histories of alcoholism, insanity, and criminal behaviour.

Alfred Tredgold was a key member of the Royal Commission on the Care and Control of the Feeble-minded who published widely on the subject in Galton’s journal, *Eugenics Review*. His main concern was with the explanation and management of social evils such as alcoholism, prostitution, scholastic underachievement and pauperism, which he largely attributed to inherited intellectual deficits. Like Still, he clearly separated “idiocy” from more particular moral difficulties in children by pointing out that the majority of mentally deficient children were “high-grade feeble-minded” capable of benefiting from the individual instruction and attention given in special classes (Tredgold 1914, p. 157). He also emphasised abnormal physical features such as large head size and malformed palates, in addition to poor co-ordination, excessive activity levels and distractibility. Worryingly, some of these children repeatedly committed anti-social and criminal acts despite being raised in an environment where “all the conditions

⁸To support his evolutionary theory, Still emphasised Darwin’s description of a South Sea Islands native chief who “cried like a child” when a sailor accidentally spoiled his favourite cloak.

⁹The biological characteristics of immorality – more specifically criminal behaviour – was a central topic of medical discussions in the late 19th century. Cesare Lombroso’s infamous *L’Uomo Delinquente* from 1876 was an unquestionable influence, but Still’s description differs from Lombroso’s in that he proposes an uncharted hidden neurological focus of scientific study, rather than just the morphological features of these children.

have been favourable for the development of the higher sentiments and ideals of behaviour” (ibid). As for the aetiology of this behaviour, primary importance was placed on the transmission of a hereditary defect in the higher levels of the brain – a neuropathic diathesis – which could result in a variety of pathologies such as overactivity, neurasthenia, hysteria, migraine and epilepsy. Tredgold discarded the possibility that environmental factors such as poverty played an important role and focused instead on the question of how to curb the rate of propagation among mental defectives, which he believed was higher than in the general population. To accommodate Still’s finding that many of his hyperactive patients had no obvious brain lesions, he hypothesised that some brain injury caused by difficult labour or mild anoxia had occurred and passed unnoticed at the time, only to become apparent with the demands of the early school years (Tredgold 1908). Thus, he began to formulate a concept of minimal brain damage which was to become widespread by mid-century, mostly in the US.

Whereas Tredgold is not widely known and discussed today in the context of hyperactivity, Still’s present renown clearly rests in large part on his comments on inattention and its relation to a lack of volitional control. As evolutionary social science declined during the early decades of the 20th century, medical and psychological interest in the relation between attention, will, and moral behaviour faded, only to reappear as a major question seventy years later with the emergence of hyperactivity/ADHD as a significant medical and social problem (Lakoff 2000). Today, the most prominent expert model of ADHD in fact depicts that disorder as a developmental failure in the brain circuitry underlying behavioural inhibition and self-control (Barkley 1997) – a definition that sounds somewhat like Still’s “disorder of the will”. Thus, researchers hail him as the father of ADHD, foreshadowing current views of the disorder before the long interruption of psychodynamic and behavioural views which overemphasised the role of child rearing (see for example Barkley 2006, p. 5).

However, it is misleading to attempt to draw a direct line from the recently formed concept of ADHD to the behaviours of the severely disordered children described by late 19th and early 20th century physicians, as these descriptions only

bear a modest resemblance to the behaviours and difficulties displayed by children diagnosed with ADHD during the past 30 years. Most early articles that mention hyperactivity concentrated on behaviours exhibited by children suffering from brain injuries, infections, or allergies, rather than children whose hyperactive behavior was unexplained. A number of others were written about children whose previous psychiatric problems were such that they were already confined to psychiatric institutions. As for [Still](#), he had to make a “special effort to seek out” the twenty children that made up his study, as such cases were “by no means common” ([1902](#), p. 1079). Second, hyperactivity was not seen as a disorder in itself, but only mentioned as one of a wide range of more striking symptoms of underlying pathology, such as the extreme violence, criminal behaviour, sexual chicanery, and self-harm.

These observations also apply to the next commonly cited milestone in the history of hyperactivity, namely the encephalitis epidemic that spread across Europe and North America in 1917-1918 ([Barkley 2006](#); [Sandberg & Barton 2002](#)). In its aftermath, many clinicians encountered children who, having survived the infection, presented with a range of behaviour problems, catastrophic changes in personality, and cognitive deficits. In the US, [Hohman \(1922\)](#) and [Ebaugh \(1923\)](#) noted how some recovered children underwent major personality changes, becoming extremely overactive, irritable, antisocial, sexually precocious, and unmanageable in school. At this time, similar reports had appeared in the UK providing detailed case notes on a series of children with “post-encephalitic syndrome” whose mental changes varied from “complete idiocy to slight mental deficiency” ([Paterson & Spence 1921](#)). The intellectual capacity of some was hardly affected, but yet they were mischievous and untrustworthy, displaying a “definite affection and alteration of the moral sense”. The series of symptoms included was even more diverse than those described by Still, but the cause of the disorder echoed [Still](#)’s description of “morbid defect of moral control associated with physical disease” ([1902](#), pp. 1077-1078). British doctors explicitly referred to Still’s lectures in their discussion of the mental effects of encephalitis. In fact, his ideas provided the overarching conceptual framework in an article by [Auden \(1922\)](#) who

described the chief interest of the cases as “the question of the relationship they appear to establish between an organic lesion of the brain and the power of moral control”, which involved the “the power of foregoing immediate gratification for the sake of a future advantage, the capacity for weighing the consequences, immediate and remote, of an action or of abstention from such an action” (p. 903).

The encephalitis literature provided support for the view among paediatricians and child psychiatrists that hyperactive behaviour patterns generally have a neurobiological rather than a psychological basis.¹⁰ However, again, these patients were quite different from children diagnosed as hyperactive or inattentive today – only the problems of a few of them would fit the present-day criteria for ADHD. Evidence only existed for an association between severe brain damage and severe behavioural sequelae, but with time this was subsequently extrapolated to mean that a similar connection existed between mild damage and lesser degrees of disordered conduct.

In the 1920s and 1930s, doctors began to investigate other forms of brain injury and their neuropsychiatric manifestations (Sandberg & Barton 2002, p. 12). The topics covered included complications from Sydenhams chorea, lead toxicity, epilepsy, and head injury. But, as noted earlier by both Still and Tredgold, the organic aetiology was not always obvious. In an influential paper published in the *New England Journal of Medicine* in 1934, Kahn and Cohen coined the evocative term “organic drivenness” in order to describe a group of hyperactive children and adults of normal intelligence, most of whom had no history of brain injury but where “the impression that one gets when observing [them], that here is an ‘organic’ condition, is overwhelming” (ibid, p. 750). Four elements characterised the patients’ unusual behaviour: hyperactivity with “choreiform” or tic-like movements; an extreme difficulty in remaining quiet or still for even short periods of time; clumsiness; and explosiveness in voluntary activity. Although some of their colleagues were sceptical of the study’s use of generalisation and pointed to

¹⁰Interestingly, even the writings on encephalitis were influenced by evolutionist thinking, as some doctors believed that certain individuals because of their constitutional inferiority were predisposed to developing the disease (Schachar 1986, p. 24).

the lack of supporting evidence, Kahn and Cohen proposed the existence of an abnormality in the organisation of the brainstem which would cause a flood of impulses to overpower the inhibitory functions of the higher brain and render the individual unable to suppress movement. They proposed that this brainstem-defect was often caused by trauma or by a prenatal or birth injury, but in other cases they simply hypothesised a congenital defect which might also characterise “quite a few individuals who are now labelled psychopathic personalities”.

Whereas child patients figuring in paediatric discussions of overactivity at this time often displayed severe behaviour disturbances, milder forms of hyperactivity in the community were typically attributed to psychological causes involving faulty child rearing practices or a delinquent family environments. Psycho-social perspectives were central to the conceptualisation of behaviour disorders in the child guidance movement, which flourished both in Europe and the US during the inter-war period ([Horn 1989](#)). Run by psychiatrists, psychologists and social workers in co-operation with juvenile courts, child guidance clinics had a largely social and, later, psychodynamic, approach to deviant child behaviour ([Jones 1999](#), pp. 44-45). For psychoanalysts, the troublesome period of latency engendered psychic struggle which commonly appeared as neuroses. Thus, Anna Freud attributed many of the behaviours today associated with ADHD to an abnormal amount of latency-related anxiety which in turn was connected to problematic family dynamics and a fragmented ego ([Rafalovich 2004](#), pp. 37-38). Sometimes, child psychiatrists and psychologists working within a psychodynamic framework would acknowledge an organic contribution, but nevertheless the behavioural symptoms were seen as secondary to emotional states, i.e. anxiety. However, by the 1950s, these psychological interpretations were losing ground to neurological perspectives invoking subtle brain dysfunction.

A major step in this direction was taken by neuropsychiatrist Alfred Strauss and colleagues whose work on “brain-injured children” in the late 1940s gave rise to the influential concept of “minimal brain damage” (or later minimal brain dysfunction) and the possibility of inferring damage from behavioural symptoms alone ([Sandberg & Barton 2002](#)). Although their research on behaviour and

learning difficulties was based on children with marked learning disabilities, they extended the conclusions to children of normal intelligence, and the diagnosis of brain injury was sometimes given solely on the basis on psychological testing. But despite these weaknesses, the impact of their writings was substantial in the US. Extensive recommendations for educating brain-injured children were given in a classic text by [Strauss & Lethinen \(1947\)](#), which served as a forerunner to the special educational services adopted much later in American public schools. Among other things, their advice included the careful regulation of the learning environment and the reduction of distracting stimulation in the classroom to an absolute minimum. One might speculate that the appeal of his approach stemmed partly from a growing sense of frustration among paediatricians with the poor results of psychoanalytically based therapy ([Schachar 1986](#)). Further, it removed the blame from parents by emphasising subtle brain injury rather than environmental influences or simply faulty inheritance.

During the 1950s, the link between hyperactivity and brain damage was further strengthened by the work of psychiatrist Benjamin Pasamanick and colleagues in the US. Based on teachers' descriptions and birth records of children referred to special education in Baltimore, their research purported to demonstrate a strong association between prematurity and complications of pregnancy – particularly those related to anoxia – and later behavioural, medical, and educational problems, ranging from cerebral palsy, epilepsy, and mental retardation to all types of behavioural and learning disabilities, depending on the severity of damage ([Pasamanick et al. 1956](#)). Postulating a “continuum of reproductive causality”, they thus lent empirical support the notion originally introduced by [Tredgold \(1908\)](#), namely that pervasive overactivity and distractibility in children often result from adverse gestational and perinatal events.

In sum, it is important to note that contrary to medical textbook and many popular versions of the history of the disorder, hyperactivity as a separate medical condition only received scant attention up until the late 1950s. There was for example no mention of hyperactivity in the first three editions of Leo Kanner's

Child Psychiatry (1935; 1949; 1957), the first American child psychiatry textbook. One may argue that the attempt to extend its history is influenced by the current mainstream position that hyperactivity is a genetically determined neurological disorder rather than a concept shaped by socio-cultural factors, and by the desire to portray the history of ADHD as illustrating the progress of medical science (Smith 2010). Nevertheless, even if early 20th century descriptions of hyperactivity are far removed both in content and context from present-day accounts of ADHD, one could still argue that the pre-WWII focus on children with pre-identified medical conditions often involving more or less subtle brain lesions came to inform the narrow British concept of hyperkinesis. This diagnosis continued to signify a rare pervasive syndrome confined to childhood and characterised by hyperactivity and impulsivity as well as inattention, often in the context of overt neurological problems, while in the US the diagnosis broadened from the 1960s onwards. Highly significant among the possible explanations for this expansion was the development and introduction of stimulant treatment, although the usefulness of this intervention was not immediately recognised.

3.3 The beginnings of stimulant therapy

Most existing histories of hyperactivity pay special attention to the accidental finding of Charles Bradley in 1937 that amphetamines seemed to have a remarkable “paradoxical” calming effect on a group of disturbed child patients (Bradley 1937). This finding was the first among a series of discoveries made by doctors at the Emma Pendleton Bradley Home in Rhode Island which were seen to give powerful validation to the organic theory of childhood hyperactivity. The Bradley Home opened in 1931 as the nation’s first neuropsychiatric hospital for children, caring for patients with a variety of neurological and behaviour problems, including post-encephalitic syndrome.¹¹ From the outset, it was a

¹¹The hospital was named after George and Helen Bradley’s only child, Emma, who was born in 1879 and stricken with encephalitis at the age of seven. The disease left her with multiple disabilities, including epilepsy, mental retardation and cerebral palsy. As hospitals were solely for

unique setting in which therapists combined educational, psychological, and neurological approaches, and where experimentation was encouraged. While there had been reports on the effects of stimulants on mood in adults, Bradley first prescribed Benzedrine in an attempt to relieve the headaches caused by the spinal taps routinely performed on children at the centre. After a week of drug therapy, however, he noted a surprising change in the children's behaviour, with some becoming "distinctly more subdued, more placid and easy-going", as well as a remarkable improvement in school performance in fourteen patients (*ibid*). In fact, a few children soon began to refer to the medication as the "arithmetic pills" ([Laufer 1975](#), p. 108). A decade later, following more extended observations of a larger number of children, Bradley published a second report concluding that, among the children treated, those most likely to respond were characterised by short attention span, mood lability, hyperactivity and poor memory ([Bradley 1950](#)).

Although doctors at the Bradley Home quickly started using amphetamines on a routine basis, this practice initially did not spread widely to other treatment settings. In child psychiatry and child guidance clinics especially, there was a strong reluctance to use drug therapy for fear that drugs would "dull perception, stifle learning and disrupt the therapeutic relationship" ([Fish 1960](#)). But Laufer, who succeeded Bradley as clinical director in 1948, was eager to solve the question of the obvious efficiency of the drugs in some inpatients, and to redress what he and his colleagues felt was an overemphasis on the parental contribution to childhood hyperactivity. Thus, an experiment was conducted in which a mixed group of patients were divided on the basis of the presence or absence of hyperactive behaviour (only one third of the hyperkinetic group showed signs of brain damage). The aim was to study the effects of the so-called "photo-Metrazol" method. Here, the drug metronidazole was administered while flashes of light were presented to the child, and the amount of drug required to induce a muscle

adults and paediatric services were not yet available, Emma had to be cared for at home and never improved significantly. Wanting to help other families in the same situation, both George and Helen Bradley requested in their wills that the Baton House, the family's Providence estate, be converted into a treatment facility for children. In accordance with the terms of George Bradley's will, the facility gave first preference to poor, needy children from Rhode Island.

jerk of the forearms, along with a spike wave pattern on the encephalogram, was noted. It was found that the hyperactive children required less Metrazol than those without hyperactivity to induce this pattern of response. However, the difference disappeared when the hyperkinetic group was given amphetamine. Based on this evidence, [Laufer & Denhoff \(1957\)](#) referred to these children as having “hyperkinetic impulse disorder”, and reasoned that the central nervous system dysfunction occurred in the thalamic area where poor sensory filtering allowed an excess of stimulation to reach the brain, causing the child to behave in an overactive manner. The condition depicted bore all of the hallmarks of what is today recognised as hyperactivity. As a treatment, they recommended methylphenidate (Ritalin), which had been synthesized a few years earlier by the pharmaceutical company Geigy.

Laufer’s work not only provided a new scientific rationale a brain-based theory of hyperactivity¹², it also heralded a period of growing interest in the use of stimulant treatment for problem children. However, this interest only emerged after two decades during which Bradley’s original discoveries largely went unnoticed. His observations were published in prominent journals and reported in the media as well but 25 years passed before anyone attempted to replicate them and stimulants became widely used for ADHD. During the 1940s and 50s, only a small number of open paediatric drug studies were conducted, examining the effects of amphetamines and the new tranquillisers on heterogeneous groups of children with various emotional and behaviour problems ([Bender & Cottingham 1942](#); [Fish 1960](#)).¹³ It may be that the positive results at the Bradley Home were not always easily reproduced elsewhere; in Britain, for example, paediatricians reported that they could not replicate the same excellent results with amphetamine ([Ounsted 1955](#), p. 305). The fact that psychoanalytical thinking was immensely

¹²Laufer did not quite anticipate these effects of his research; he later indicated that he had neither intended all disruptive behaviour to be attributed to central nervous system abnormalities nor expected amphetamines to replace non-biological treatments ([Laufer 1975](#)).

¹³See also [Freedman \(1958\)](#) and [Fisher \(1959\)](#) for early reviews of individual studies and descriptions of basic conceptual and practical problems in the new field of paediatric psychopharmacology.

influential among psychiatrists in the US at the time may also help explain why this profession was slow in the uptake of new drug treatments.¹⁴ At any rate, most psychiatrists and child psychoanalysts paid little attention to children whose primary symptom was pervasive hyperactivity, as they were seen as “organic cases” connected with the so-called minimal brain damage syndrome ([Eisenberg int. 2005](#)).

Finally, one could point to a lack of demand as a further possible reason for the delay. Had there been a greater perceived need for alternative treatments for hyperactive children during the late 1930s, Bradley’s original article would likely have had an immediate impact. The fact that it did not, suggests that these children were not perceived to be of major concern until much later, when various political, demographic and educational changes converged to provide a social and cultural environment which was favourable to the widespread diagnosis of hyperactivity. American society underwent many profound changes during the 1950s and 1960s, including transformations in the structure and function of families, schools, and workplaces which undoubtedly played substantial roles in expanding and rendering visible the number of behaviours thought to be pathological and in need of psychiatric treatment. Following this line of argument, some commentators have suggested that the deepest roots of the disorder are to be found in the launch of Sputnik in 1957 and the politics of the Cold War generally ([Kiger 1985](#); [Smith 2011b](#)). As the Soviet Union developed hydrogen bombs and launched the first satellites and humans into space, many influential Americans grew convinced that the United States was losing the “brain race” and, unless the scholastic performance of all American children improved markedly, they would lose the Cold War altogether.

In the early 1960s, spurred on by the growth of adult psychopharmacology,

¹⁴In line with the multidisciplinary, holistic philosophy of the Bradley Home, Laufer underwent psychoanalytical training at the Boston Psychoanalytical Institute. He recalls the strong feelings of conflict and isolation he experienced here: “even to hint to fellow candidates that there might be an organic component of significance [...] was an invitation to be dealt with in a manner remarkably close to ostracism” ([Laufer 1975](#), p. 110). Interestingly, he notes that his exposure to the more eclectic British psychoanalytical tradition finally allowed him to gradually reconcile and integrate dynamic and organic concepts.

the field of paediatric psychopharmacology took off in earnest, largely due to the work of an influential group of researchers at Johns Hopkins University who employed a more sophisticated methodology involving double-blind, placebo-controlled cross-over designs. Most prominent among these were psychiatrist Leon Eisenberg and clinical psychologist Keith Conners.¹⁵ Following a series of studies showing that tranquillisers were no better than placebos in managing “neurotic and hyperkinetic” children (Eisenberg et al. 1961), they decided to do extended trials assessing the efficacy of dextroamphetamine and methylphenidate (Ritalin) in samples of institutionalised delinquent children, many of whom were hyperactive. The positive results were first published in 1963 in the *American Journal of Psychiatry* (Conners & Eisenberg 1963). Inspired by Bradley’s work, the two researchers subsequently conducted a trial on schoolchildren with learning difficulties and concluded that though Dexedrine had no measurable effect on “intellectual ability” as such, it had produced significant improvement in teacher ratings of “classroom behavior, attitude towards authority, and group participation” (Conners et al. 1967).¹⁶

Marking the beginning of an era, the Hopkins studies fanned interest in the paediatric use of stimulants and irrevocably associated Ritalin with the treatment of childhood hyperactivity or MBD (minimal brain damage or dysfunction), which was the most commonly used label at this point.¹⁷ The work of Conners and

¹⁵Perhaps because most American child psychiatrists were strongly in favour of psychodynamic approaches, much of the early research on drug treatment in children was actually conducted by psychologists, including leading figures such as Keith Conners and Rachel Gittelman-Klein, who was instrumental in the creation of the child section of DSM-III. Leon Eisenberg on the other hand was hailed as a visionary hero by the small community of research-oriented psychiatrists in St Louis, and today he is often acknowledged as the father of paediatric psychopharmacology. But ironically, despite contributing significantly to the neurological theory of hyperactivity and acting as a catalyst for the subsequent tremendous amount of drug research, he always strongly supported the principles of social psychiatry.

¹⁶The children in this study were all poor blacks attending the fifth and sixth grades in two Baltimore ghetto schools. Thus, the authors admit that many of their problems could have been related to conditions of economic and social deprivation.

¹⁷Ritalin was first licensed for use in children with behaviour problems in 1963, but at this time the drug was prescribed for various conditions, such as narcolepsy, “environmental depression”, “tired housewife syndrome” and general fatigue (Moon 2009). However, mostly because of concerns over inappropriate use, by the end of the decade, a number of federal guidelines began to limit the indications of methylphenidate to its youngest users. In 1970, when it was categorised as a schedule II controlled substance, Ritalin was essentially synonymous with the treatment of hyperactivity.

Eisenberg prompted the National Institute of Mental Health (NIMH), and later the drug companies, to support more research in the area, and from the 1970s the body of work on stimulants and hyperactivity grew exponentially. The identification of an effective drug treatment both stimulated an increase in stimulant prescription for children and affected diagnostic practices; as the use of Ritalin rose, so did the rate of MBD and hyperactivity diagnosis in clinical and school settings. Indeed, the belief that the drug had a paradoxical, specific effect on hyperactive children brought some researchers and many practitioners to the tautological conclusion that the drugs could be used as a diagnostic tool: if a child responded appropriately to the drug, he had the disorder; if he did not, then he was not afflicted. It is furthermore clear that the availability of a quick, inexpensive and seemingly efficient treatment helped buttress biological explanations for the disorder, as did the cautious optimistic attitude biological psychiatrists adopted when presenting their research. Increasingly, they stressed that their approach was the most scientific, giving psychiatry the medical and scientific status they had lost in the preceding decades (Smith 2008, p. 551).

When hyperactivity emerged as a significant social and medical problem in the 1960s in the US, psychoanalytical and social psychiatric frameworks dominated child psychiatry. Various drugs including antidepressants, anti-psychotics, and minor tranquillisers were occasionally used to manage severe behaviour disorders in children (Gallagher 1970, pp. 53-55), but they were marketed and employed mainly as means to establish accessibility to psychotherapy for the hyperactive or “emotionally unstable” child (Figs. A7-9). As impatience grew with these time-consuming approaches and their failure in dealing conveniently with what seemed like an increasing number of difficult children, the pharmaceutical industry played an important role, not just in promoting the use of stimulants, but also the ailment that the drugs were supposed to treat.¹⁸ From the 1950s to the 1970s, children’s

¹⁸The history of pharmaceutical drug marketing shows that the latter is often closely related to the former. A good example is the story of Prozac and depression. Until the mid-1980s, mild nervous symptoms were most often labelled as anxiety and treated with benzodiazepine tranquillisers. However, following serious public concerns about the addictive potential and long-term safety of the minor tranquillisers, doctors switched to using the supposedly safer, non-

use of psychotropic drugs was still so controversial that pharmaceutical companies as a rule did not finance research in the area; the only substantial source of research funding for paediatric psychopharmacology during this period was the National Institute of Mental Health (NIMH) (Eisenberg *int.* 2005). Nevertheless, both the producer of Ritalin (Ciba Geigy) and the producer of the stimulant Cylert (Abbott) actively promoted a very inclusive concept of MBD in aggressive marketing campaigns aimed at doctors. In the early 1970s, numerous ads appeared in medical journals, including the *American Journal of Psychiatry*, which outlined the syndrome's main features and their disabling consequences, often in terms of poor school performance (see Figs. A1-6). The ads were supplemented by a 96-page handbook for physicians on screening as well as educational fliers for parents. Here, the disorder was defined very broadly: "MBD is never exactly the same in any two children, and the precise cause is not known – so MBD is difficult to pin down to a simple definition" (quoted in Schrag & Divoky 1975, p. 85).

It is important to emphasise that these developments did not occur without considerable public and professional resistance. Following sensationalist media reports in 1970 that 5-10% of 62,000 high school children in Omaha, Nebraska, were being treated with "behavior modification drugs" (Maynard 1970), a congressional hearing was convened to investigate the extent of government involvement in this practice and testimonies of various respected government officials were given (Gallagher 1970).¹⁹ Even if it had little impact on legislation, the hearing provides a useful window on contemporary sentiments, illustrating that by 1970 stimulant treatment was widespread enough to be a public concern of

addictive SSRI antidepressants, including Prozac. In order to make this switch, patients' symptoms had to be re-characterised and re-diagnosed to correspond with the new drugs which were licensed and promoted as anti-depressants in spite of clinical evidence that they were more effective in the treatment of some anxiety disorders (Healy 1997). According to critics, this was to avoid the negative connotations anxiolysis had acquired through the benzodiazepine scandal of the early 1980s. Notably, a key feature of Lilly's marketing campaign for Prozac was to re-brand and market the concept of depression as a common but yet disabling condition, rather than a serious, relatively rare disorder requiring periods of hospitalisation. The result of this manoeuvre was that the diagnosis of anxiety had been largely replaced with that of depression by the late 1990s.

¹⁹The committee found that the numbers had been exaggerated; the 5-10% seems to have represented the estimated prevalence of learning disabilities – or Minimal Brain Dysfunction – among school children in Omaha, but not the number receiving medicine.

considerable proportions which inspired highly emotionally charged debate. Among other things, this debate must be seen on the background of the rise of the civil rights movement and the campaign against oppression of minority populations; the increasing focus on inner-city poverty and crime as highlighted by proposed pre-school screening programmes to detect anti-social, violent tendencies in children²⁰; anxiety about schools and the quality of American education; the growing preoccupation with learning disabilities and the school system's obligation to accommodate learning disabled students; and last but not least the general concern about recreational drug abuse among young people. According to Congressman Gallagher, the "paradoxical" calming effect of Ritalin on hyperactive children was just one of many paradoxes surrounding the drug: "From the time of puberty onward, each and every child is told that 'speed kills', and that amphetamines are to be avoided. Yet, this same child has learned that Ritalin, for example, is the only thing which makes him a functioning member of the school environment and both his family and his doctor have urged the pills on him" (ibid, p. 1).

In particular, the hearing demonstrated the high degree to which the disorder and the drug treatment were bound up with issues of schooling and coercion. Even at this early stage, the media frequently brought stories of families (most often the mother) who had been "harassed and pressured" by the local school to put their children on drugs (Hunsinger 1970). Articles in major US magazines carried titles such as "Drugging and Schooling", "Pills for Classroom Peace", "Chaining Children with Chemicals", and the "Educator as Pusher – Drug Control in the Classroom" (cited by Grinspoon & Singer 1973; see also Gallagher 1970, pp.

²⁰In 1970, Dr. Arnold Hutschneker, President Nixon's former physician, proposed to the White House that all children between 6 and 8 years of age be psychologically tested for criminal potential. Those children singled out would be put through a comprehensive psychiatric program, with the hard core being confined to camps where they would learn more socially acceptable behaviour patterns. Nixon's counsel asked the Department of Health Education and Work (HEW) to advise on the possibility of setting up pilot projects, but they rejected the proposal. However, as Gallagher noted, the HEW was at the same time funding various studies screening the blood of delinquents and Black children in inner-city areas for the "super-masculine" XYY chromosomal pattern still thought by some experts to be associated with aggressive behaviour (Gallagher 1970, pp. 136-145).

152-175). In the late 1960s, some school districts had indeed become sites of conflicts between school authorities, physicians, parents, and the general public, with Omaha, San Diego and Michigan being singled out as places where matters had reached crisis proportions (Johnson et al. 1976). On the other hand, *Newsweek* (1970) reported that while some teachers had clearly been overly zealous about recommending treatment, it was often the parents who were the most keen to obtain pills for their children and who pressured doctors to prescribe.

The actual number of children receiving the medication was not known exactly, but a 1973 study showed that between 2 and 4% of Chicago elementary school children had received drug therapy for hyperactivity during the 1970-71 school year, while another study in Baltimore, Maryland, found an incidence figure of 1.7% (Sprague & Gadow 1976, p. 111). Chief of the NIMH clinical studies section, Ronald Lipman, reported to the congressional committee that some 150,000-200,000 American children were treated with stimulants and – more shockingly – that up to four million children in the US could potentially benefit from these drugs (Gallagher 1970, p. 156). But apart from the sheer number being labelled and medicated, controversy centred on the question of the children's racial and socio-economic background; at the time, allegations were put forward by civil rights activists and black protesters that drug interventions were used primarily in deprived, black children as a cheap way of controlling them – or even worse as a large-scale medical experiment – while white, affluent children had the benefit of first-class, expensive psychotherapeutic interventions (Eisenberg int. 2005).

Another common claim related to the issue of social control was that therapists would medicate children to make them perform and behave better in school and thereby seek to placate the system, instead of trying to understand the problem students and alter the school setting to accommodate them better. Five years after the initial mass media coverage of the stimulant story, two freelance authors sensationalised the issue again in their polemical book, *The Myth of the Hyperactive Child* (Schrage & Divoky 1975), which received a great deal of publicity across the country. Their main argument was that leading educators and researchers, along with some drug companies, had worked together to shape the

opinions of parents, doctors and teachers to accept the notion of organically based learning disabilities, leading to the labelling of many children who were denied the right to be naturally creative and active. For critics like Schrag and Divoky, the growing popularity of stimulant treatment symbolised the contemporary despair and impatience on the one hand with the Great Society proposals for social reform, and the increasing faith on the other in the medical model of screening, diagnosing and treating individuals.

3.4 The US and the UK part ways: British critiques of Minimal Brain Damage and Hyperactivity

As indicated above in relation to Ciba Geigy's promotional activities, an important precondition for the introduction of stimulant treatment on a wide scale was the concomitant widening of the minimal brain damage (MBD) concept during the 1960s to include children with a variety of behaviour and learning problems who showed insufficient evidence of brain pathology. In 1966, a task force set up by the National Institute of Neurological Diseases and Blindness recognised at least 99 symptoms for Minimal Brain Dysfunction (the milder term now preferred by researchers) and argued for the *pragmatic* acceptance of the diagnosis (Clements 1966). However, at this point a number of critical voices had already appeared, questioning the logic fallacies and vagueness of the concept (Birch 1964). Rather than focusing on speculative underlying neurological causes, clinical investigators instead started shifting their emphasis to one of the key components of the syndrome – that of hyperactivity.

Whereas Laufer & Denhoff (1957) had proposed a possible mechanism for their “hyperkinetic impulse disorder”, child psychiatrist Stella Chess paid little attention to theories of aetiology in her influential 1960 publication, but rather focused on classification and clinical descriptions of hyperactive children. She offered a straightforward definition of hyperactivity: “The hyperactive child is one who carries out activities at a higher rate of speed than the average child, or who is constantly in motion, or both” (Chess et al. 1960, p. 2379). Her early article is

historically significant, firstly because it opened the possibility of seeing hyperactivity as a *behavioural* syndrome that sometimes arose from organic pathology but could also occur in its absence. Thus, she explicitly separated the concept of hyperactivity from that of brain injury. Secondly, the article openly diverted blame for the child's problems away from the parents by criticising psychoanalytical theories and therapies stressing the mother's role in the genesis of the disorder (Chess 1964). Existing uneasily alongside neurological explanations, theories of psychological causal mechanisms were still widespread in the early 1960s, at least among therapists treating mild to moderate cases of hyperactivity in the community (Smith 2008). Chess instead recommended a multi-faceted treatment approach, incorporating parent counselling, behaviour modification, psychotherapy, medication and special education.

In 1968, the hyperactivity syndrome was included in the official American psychiatric classification as Hyperkinetic Reaction of Childhood (DSM-II 1968). Following the lead of Chess, it was briefly described as a developmentally benign disorder characterised by overactivity, distractibility, and short attention span, which usually diminished by adolescence. In the US, hyperactivity would now become viewed as a fairly common behavioural disturbance of childhood not necessarily associated with demonstrable brain pathology or mental retardation. However, it was still associated with brain dysfunction, although of a smaller magnitude than previously believed. In fact, the influential researcher Paul Wender (1971) persisted with a broad concept of Minimal Brain Dysfunction which stressed the feature of hyperactivity but also included factors such as clumsiness, cognitive impairment and parent-child conflict. He postulated that as many as 50% of children seen in child guidance and psychiatric clinics suffered from the syndrome, while at the same time emphasising the absence of any neurological signs of abnormality in over half of these patients. Rather than viewing MBD simply as a lesser variant of gross traumatic or infective brain damage, Wender saw the disorder quite differently as a qualitatively distinct genetically determined condition probably involving abnormalities in the metabolism of serotonin, dopamine and norepinephrine – a theory that was partly

“read off” from the assumed mode of action of stimulants. Indeed, he stressed a distinctive response to stimulants as one of the hallmarks of the syndrome and recommended medication as the first treatment of choice.²¹

However, Wender was careful not to make overly bold statements about the status of hyperactivity research and emphasised that it was a work in progress. He thus objected to the more extreme views expressed by doctors like Camilla Anderson who in *Society Pays: The High Costs of Minimal Brain Damage in America* (1972) promoted an excessively inclusive concept of MBD. She contended that the disorder was extremely common and responsible for a wide variety of psychiatric and social pathologies in adults, including psychosis and sociopathy. In an unfavourable review, Wender called for hard data to substantiate these claims and noted that Anderson “made some rather sweeping assertions” that “psychosocial *krankheiten* are the products of biological deficits rather than social and psychological oppression – a view contrasting sharply with the prevalent mood... [which] will combine to make this book one that is rejected out of hand” (Wender 1973, p. 736). Objecting more to the lack of evidence rather than the eugenic undertones of the book, he did however concede that the author probably had “some useful clinical hunches” and that it would be “unfortunate if the baby – however small – is thrown out with the bath water” (ibid, p. 727).

But while the notion of a widespread, characteristic, and medically treatable behavioural syndrome resulting from subtle brain defects was taking hold and applied to an increasing number of children in the US, British physicians for the most part continued to apply the diagnosis of *hyperkinesis* only very infrequently and to children with obvious damage or dysfunction, such as epilepsy and mental retardation. The great majority of disruptive children – those without clear-cut neuropathology – were thought to have a non-specific behaviour problem arising from adverse social and family influences, and were often labelled as

²¹Wender (1971, p. 88) specifically mentioned that the common responsiveness to amphetamines constituted one the main reasons behind his decision to group a very heterogeneous group of children together under the term “minimal brain dysfunction”. This response, he noted, also suggested the name “congenital hypoamphetaminemia”.

“maladjusted” (primarily in child guidance and education) or as suffering from “conduct disorder” (Thorley 1984).

Considering the organic emphasis, it is not surprising that the restricted British concept of hyperactivity was heavily influenced by the work of two paediatricians, namely Christopher Ounsted (1955) at Park Hospital in Oxford, and Thomas Ingram (1956) at the Department of Child Life and Health in Edinburgh (Rutter int. 2005; Schachar int. 2005; Taylor int. 2005). Neither Ingram nor Ounsted believed this syndrome to be specific to brain damage or a necessary result of it. However, the fact that both studied the phenomenon among neurologically handicapped children reflects the prevailing belief about its cause. In vivid and detailed case descriptions, both doctors delineated a severe and uncommon condition of ceaseless activity and inattention usually associated with epilepsy, a history of meningitis, or birth injury. Most of the children were boys, had a lower than average IQ and displayed frequent rage outbursts, alternating with euphoria. Assaults were common; “For example, one 4-year-old attacked his father with a bread knife inflicting a deep wound; then, as the mother said, “he skipped away laughing as usual” (Ounsted 1955, p. 304).²² Further, a lack of fear, shyness, and regard for social rules was mentioned. Some children even showed calculated rudeness: “One boy would welcome fundoscopic examination with a chuckle. He would wait until the face of the unsuspecting doctor was poised above him, and then he would spit, accurately, at that eye which was unprotected by the ophthalmoscope” (ibid). In an attempt to reproduce the good results of Bradley and others, Ounsted administered dextro-amphetamine but on the whole this treatment was found wanting, as some of the children seemed remarkably oversensitive to the drug and showed “a reversal of symptoms resulting in a deeply

²²It was not only the children’s pathological reactions which concerned Ounsted. Much in line with the contemporary focus on harmful family influences, he devoted a whole section to a discussion of parental reactions, not surprisingly especially those of the mother, who, it was felt, would often exacerbate the problem by becoming “fiercely defensive” and utterly absorbed with her child: “Excessive parental devotion” is not a phrase suitable for inscription in clinic notes, for parents are sharpish and apt to read what is written, upside down, as they give the history. We have therefore, been compelled to employ the grim neologism “hyperpeadophilia” to record this parental attitude” (Ounsted 1955, p. 309).

depressive reaction”.²³

While the papers by Ounsted and Ingram might have led to an emphasis on minimal brain damage, this concept came under strong attack from paediatricians and psychiatrists in British research centres from the early 1960s. Staunch critics like Desmond Pond, Professor of Psychiatry at the Maudsley, noted that “there are no absolutely unequivocal signs, physiological tests or psychological tests, that prove a relationship between brain damage and any particular aspect of disturbed behaviour” (Pond 1961, p. 1455). Stressing the role of social and environmental factors in mediating the effects of brain damage resulting from prematurity, he argued that the nature and severity of chronic psychological disorders following brain damage were largely determined by the handling or mishandling of the handicapped child by parents or society in general. Among other things, Pond criticised Pasamanick and colleagues’ studies on the “continuum of reproductive causality” for not adequately controlling for the low social class of many of the affected families: “Until the social status and quality of the parental care of these children...which they call misleadingly ‘hyperactive, confused-disorganised’... no firm conclusions can be drawn about organic factors” (ibid, 1457).

However, since many still felt the need for some generic term, a paediatric neurology study group in Oxford suggested “minimal cerebral dysfunction” as a replacement, but with the clear recommendation that an attempt be made to classify the heterogeneous group of children subsumed under this label into more homogenous subgroups (Bax & MacKeith 1963). Phenomena such as language delay and clumsiness were seen as the outcome of many serious conditions, not one mild one. A decade later, there was a move to abandon the MBD diagnosis altogether. British psychiatrists never developed a real interest in the concept, and only a few paediatricians in clinical practice used the term, albeit in a highly idiosyncratic fashion (Lancet 1973; P. Hill int. 2005; Taylor int. 2005). Summing up the predominant attitude in the UK at the time, Ingram (1973) memorably

²³Depressive reactions to amphetamine treatment were later stressed by other British doctors, among other Martin Bax (1972).

declared that the tendency to look for a conglomeration of so-called “soft” neurological signs²⁴ of “minimal brain damage” was “diagnostic of soft thinking”. To him, MBD was “not a diagnosis [but] an escape from making one”. One editor noted that many Americans seemed “fond of that particular escape route” (*Lancet* 1973, p. 487).

But in the US too, MBD slowly faded from clinical and scientific and scientific usage. Critics complained that it was very hard to distinguish between commonly used labels such as MBD, Learning Disability (LD) and Hyperactivity. In the words of American psychiatrist Roger Freeman, the field was a “mess” and “characterized by rarely challenged myths, ill-defined boundaries, and a strangely seductive attractiveness” (Freeman 1976, p. 5). He emphasised the role played by professional interests in the rise of hyperactivity, noting that as funds were made available, “almost every conceivable field tried to participate in the bonanza. Some centers or clinics were renamed; new ones were started. Papers started to appear telling the professionals in each discipline how to screen for MBD/LD/HA, what training the students in that discipline should receive, the part they should play on the ‘team’, and their essential role in therapy” (ibid, p. 14). In fact, quoting British child neurologist Martin Bax, Freeman explicitly mentioned Britain and the findings of the seminal Isle of Wight epidemiological study as a sane contrast: “There is a great need for epidemiological study in America [...] it does seem amazing to me to go on waffling about something which comes up to 4-10 percent without taking some steps to find out whether this prevalence is correct. I mean, if it were smallpox, people would be jumping about” (ibid, p. 11).

Eventually, the fading of MBD from clinical and scientific usage was greatly helped along by the reviews and critical lectures of pioneering British child psychiatrist and researcher, Michael Rutter (Rutter 1977; 1982). Pointing to the findings of the neuropsychiatric Isle of Wight study (Rutter et al. 1970a;b) and other epidemiological investigations in London (Rutter et al. 1975a), he established

²⁴“Soft signs” usually designate developmental delays in functions such as language, motor coordination, right-left differentiation or perception.

that contrary to 25 years of theorising to this point, children with known cerebral damage did not display a uniform pattern of behavioural deficits and emotional problems, and children with symptoms of restlessness rarely demonstrated substantiated evidence of neurological damage.²⁵ The Isle of Wight project involved an initial screening of the entire school-age population of the island from which were extracted all children likely to be affected. These children were then subjected to intensive investigation by a team of physicians, psychologists, and social scientists. The main unequivocal finding was that brain damaged children showed a clear excess of most types of psychiatric symptoms but that there was nothing specific about these symptoms. While actual brain damage was a strong risk factor, it was also a diffuse one, and one whose manifestations depended critically upon interaction with the psychological environment. Rutter concluded:

It seems that most of the features, such as impulsiveness and over-activity, which are reputed to be indicators of brain damage are in fact merely very common features of psychiatric disorder regardless of the presence of neurological abnormality. It may be concluded that the behavioural stereotype of the brain damaged child must be firmly rejected. Brain damaged children show a heterogeneous range of psychiatric disorders without specific features... (Rutter 1977, p. 11).

Psychosocial influences were also found to be important as family and social disadvantage much increased the risk of psychiatric disorder when present. For example, “neurotic disturbance” in the mother and “broken homes” were both strongly associated with psychiatric problems in the children. In the London studies, similarly, overcrowding, marital discord, and psychiatric disorder in the mother were all significantly related to the presence of psychological disturbance (ibid, p. 13).

²⁵It must be noted that this conclusion applied to the behavioural trait of hyperactivity, rather than the much rarer and more severe syndrome of hyperkinetic syndrome, which was thought to be more specifically linked to brain damage. All in all, two cases of hyperkinesis were identified out of the general sample of 2199, but Rutter noted that this diagnosis was so closely related to mental retardation that “much of the association between brain damage and these rarer diagnoses may be a result of the cognitive impairment which follows from the brain damage, rather than a direct effect of the brain damage as such” (Rutter 1977, p. 10). This was very much in line with the prevalent British view of hyperkinesis as rare, pervasive and linked to low IQ (see also Rutter 1975, pp. 262-267).

When it came to the concept of the hyperactive child syndrome, which was to some extent interchangeable with MBD in the US at the time, British attitudes were just as sceptical. Throughout the 1970s, the leaders of the 1962 Oxford International Study Group on Child Neurology published several critical commentaries on the blurring of the boundary between the highly active school child and the child with “true hyperkinesia”, as evident in the US (Bax 1972; 1978; MacKeith 1974). Both emphasised the importance of carefully considering all possible causes for overactivity in children, including neurotic disorders such as anxiety or depression, specific learning difficulties, social and cultural background, the educational milieu, or simply the presence of highly active, extravert personality patterns. Corroborating the views of Bax and MacKeith, Ounsted (1974) described the hyperkinetic syndrome in epileptic children as a “clear-cut disease entity” and called for the abolishment of the “graeco-latin bastard” term of “hyperactivity”, which ought to mean nothing more than increased levels of activity but had all too often come to indicate a neuro-behavioural syndrome that required medical treatment. He stressed the role of anticonvulsants such as phenobarbitone in actually *inducing* hyperactive behaviour in epileptic children, and added that “d-amphetamine sulphate is a dangerous drug... I have seen no child benefit from this cerebral stimulant for more than 10 years, and during this time at least 6000 children have been referred to my service” (ibid).

As the quote above indicates, the very low number of hyperactivity cases in the UK was related to the fact that British doctors had no pressing reason to make a diagnosis of hyperactivity, as they were more reluctant to treat children with drugs than their American colleagues, relying instead on behavioural interventions, counselling, family therapy, and remedial teaching and work with schools.²⁶

²⁶This does not mean that psychotropic drugs were not used in children at all. In the British Journal of Psychiatry through the 1960s and 1970s there were advertisements for vary anticonvulsant drugs which portrayed them as useful in the management of disturbed behaviour in children, including hyperactivity and aggressive behaviour. Stimulant treatment was attempted in extreme cases and individual practitioners also prescribed tranquillisers and sedatives for severely disordered children (Taylor int. 2005). At St. Thomas Hospital, one of William Sargants pupils, child psychiatrist Eva Frommer, was an ardent advocate of using antidepressants in the treatment of children with various ‘functional’ physical complaints and externalising behaviours, the theory being that such symptoms often signalled an underlying depressive illness. She even conducted a

Moreover, emphasis was put on simply teaching both the child and his or her parents to adjust to, and live with, the cognitive and behavioural handicaps that may be present ([Rutter 1977](#), p. 14). Dismayed with the developments in the US, editorials emphasised the need to make sure that such American practices would not take hold in Britain ([Lancet 1973](#), p. 488). Apart from being concerned about possible side effects, most had strong reservations about the whole notion of a *specific* treatment for problems of hyperactivity and attention problems. Nonetheless, Rutter did note that good evidence had been provided for the short term gains of stimulant treatment, except in cases of clear-cut brain damage in which they tended to make matters worse ([Rutter 1975](#), p. 344; see also [Ounsted 1974](#)).

Surveys in the 1970s and 1980s showed that European adults took psychotropic medication as often as American adults, but nonetheless there was a prominent and general hesitancy across the continent to prescribe stimulants to treat hyperactivity ([Safer & Krager 1984](#), p. 143). There is even some evidence to suggest that particular concerns existed in the UK about the use of amphetamines due to their addictive properties and the wide-spread recreational abuse of these drugs during the 1960s and 1970s ([Lancet 1986](#), p. 74). The issue of amphetamine psychosis, a condition first described by British psychiatrist Philip Connell in 1958, certainly received considerable attention at the time ([P. Hill int. 2005](#)).²⁷

One might also speculate that a more general cultural reluctance to prescribe “uppers” was at play. While Americans have been record-consumers of performance-enhancing substances, perhaps partly because of the prevalent sense of competition in the US, European doctors have historically preferred to prescribe sedatives such as minor tranquilisers ([UNIS 1999](#) see also; [Payer 1988](#), pp.

few paediatric antidepressant trials, the first of their kind in the UK, in spite of the fact that depression was viewed as very rare or even nonexistent in children at this time; Eva Frommer, ‘Treatment of Childhood Depression with Antidepressant Drugs’, *British Medical Journal*, 1967, 1, 729–732. However, although Frommer was well-liked, she was generally viewed as an eccentric personality by her peers, and her work never became influential ([Rutter int. 2005](#)).

²⁷For an account of the context and impact of Connell’s work, see Nicolas Rasmussen’s history of the amphetamines, *On Speed* (2008), 140–143, 172–173.

112-116).²⁸ In the UK, this observation could be tied to the high value placed on self-restraint. During the 1960s, several comparative diagnostic studies thus showed that British psychiatrists tended to be especially worried about symptoms such as aggression, agitation, and irritability, all of which indicated that the patient had lost emotional self-control (Payer 1988, pp. 112-116). Bearing this in mind, perhaps the very idea of using an amphetamine to settle kids down seemed especially counterintuitive and unappealing to British child psychiatrist and paediatricians.

3.5 The advent of attention deficit disorder

The British conservative perspectives described above were clearly reflected in the diagnostic guidelines for the category of hyperkinesis in ICD-9 (1978). Here, emphasis was on a rare syndrome of “extreme” and cross-situational overactivity, distractibility, and inattention, often associated with neurodevelopmental delays. In a British WHO classification study preceding the publication of ICD-9, the diagnosis of “hyperkinetic syndrome” was made in 20% of mentally retarded children but in only 1% of children of normal intelligence (Rutter et al. 1975). Further, the diagnosis could only be made in the absence of other underlying disorders, such as conduct disorder. This was a central point, as it was becoming increasingly clear at the time that the broadly conceived category of hyperactivity in the US overlapped greatly with the diagnosis of conduct disorder in the UK.

This stringent approach differed considerably from that taken in the American DSM-III, published two years later. The new term of Attention Deficit Disorder (ADD) introduced here built on the work of psychologist Virginia Douglas at McGill University. As well as being critical of the concept of MBD, Douglas was sceptical about the utility of the definition of hyperactivity disorder proposed by Chess and through empirical research, her goal was to reach a more valid, coherent

²⁸For a country with low overall drug use, minor tranquiliser use was relatively high in Britain until the NHS took action in the early 1980s in response to the mounting evidence of massive problems of addiction (Payer 1988, p. 113).

definition. Using a wide range of psychometric tests to measure cognitive and behavioural aspects of the disorder, she and her research team argued that deficits in sustained attention and impulse control were more likely to account for the children's difficulties than hyperactivity alone (Douglas 1972). While they demonstrated difficulties in sustained attention, hyperactive children in her studies were found to be no more distractible than normal children. This finding was further supported by the fact that previous experiments with the stimulus-reduced classrooms suggested by Strauss failed to improve academic performance. On the contrary, children with hyperactivity disorder often became more overactive in environments that were stripped of all potentially distracting stimuli.

Significantly, this hypothesis was strengthened by the research of Douglas' colleague Gabrielle Weiss (Weiss 1983; Weiss & Hechtman 1986) which supported already existing suspicions that the symptoms were not transitional in nature. Since the 1960s, paediatricians and child psychiatrists had questioned the long-standing idea that many pathologies of childhood and adolescence would resolve with time. Instead, the fear was that disorders such as hyperactivity would persist into adulthood and hinder the individual's employability and work performance. Although the hyperactivity of children in Weiss' follow-up studies often diminished by adolescence, problems with vigilance and impulsivity remained, increasing the risk of academic and social maladjustment considerably. These findings received a great deal of attention and only contributed further to the notion that hyperactive behaviours needed to be identified and corrected.

The radical shift in focus from motor restlessness to attention deficits in the US meant a widening of the disorder category, as both children *with* and *without* hyperactivity could now be diagnosed; in fact, the American Psychiatric Association (1980) estimated the prevalence to much as 3-5% of the childhood population. Although little empirical research existed to support this at the time, the committee behind the child section of DSM-III decided to divide ADD into subtypes based on the presence or absence of hyperactivity (+H/ -H) and wait for further research to test the concept. A similar procedure was used when setting the prevalence figure of 3-5% of the child population. There was little child

epidemiological research to go by, so the committee responsible for the child section had to rely on clinical judgement. As recalled by committee member Rachel Klein, who prepared the text for the ADD (+/- H) category: “Well the 3-5% actually is in the DSM, you know we made that up! We were sat around a table much smaller this and Paul Wender probably said 10% and I probably said 2% and they said well how about 3-5%, yes we could all live with that” (BAP 1997). According to Klein, Paul was essentially responsible for name Attention Deficit Disorder, while she herself had suggested that the behavioural aspects of the disorder be better represented by calling it “hyperactive impulse disorder” – a designation much akin to the one originally suggested by Laufer and colleagues in their important 1957 papers (Klein int. 2005).²⁹

The new diagnostic criteria were furthermore noteworthy for their creation of explicit symptom lists, for their specific cut-off scores, and for their specific guidelines for age of onset and duration of symptoms. However, at this point the introduction of quantitative measures had already reshaped the diagnosis and treatment of hyperactivity. In the late 1960s, researcher Keith Conners used complex statistical methods and large samples to develop standardised behaviour rating scales, some designed to be filled out by parents and others by teachers (Conners 1969). Originally intended mainly for use in stimulant drug trials, these scales became widely adopted in North America and regarded for over twenty years as the “gold standard” for clinical assessment as well as research.³⁰ The Conners scales not only facilitated a growth in research demonstrating the efficacy of stimulant drugs; it also helped make diagnosis appear less dependent on the doctor’s clinical impression, by supplementing his observations with structured and seemingly objective evaluations from other relevant people close to the child,

²⁹In DSM-III-R, there was agreement by the committee to change the name. However, it did not happen because the influential paediatrician Bennett Shaywitz asked that it remain as ADD, since paediatricians found it a user-friendly name which was compatible with their focus on mental development and facilitated communication with parents about the child’s difficulties. This again demonstrated the extent to which final decisions depended on pressures from the many constituencies that had to be accommodated (Klein int. 2005).

³⁰In the UK, the Conners questionnaires were increasingly adopted in research, as interest in the subject of hyperactivity grew during the 1980s. Today, revised versions of the scales are furthermore widely used in clinical practice to diagnose ADHD.

such as teachers. In fact, contrary to European practice, the DSM-III dictated that teachers' reports should be given primary consideration in the diagnostic process. Thus, the new technology of the standardised questionnaire helped to stabilise the disorder and make it reproducible, binding together various actors – researchers, doctors, teachers, and (in the US) managed care administrators. Nonetheless, the ratings were still based on subjective judgments – albeit in the form of numerical scores – and in the end it was up to the clinician to decide when symptoms were “developmentally inappropriate”. As we shall see in the next chapter, this was one of the many reasons why DSM-III was on the whole not reviewed favourably in Britain or Europe generally.

3.6 Conclusion

This chapter has attempted to illuminate continuities and breaks in the way hyperactivity has been conceptualised on each side of the Atlantic from the early 20th century up until the advent of the Attention Deficit Disorder with the publication of DSM-III in 1980, which represented a watershed in American psychiatry. I have focused particularly on the recurrent theme in both countries of a close relationship between symptoms of hyperactivity in children and the notion of subtle brain damage, and the gap that developed between British and American approaches in the 1960s, propelled first and foremost by the introduction and marketing of stimulant treatment. From that point, the US concept increasingly expanded to include milder forms of overactivity and inattention, while the British view of hyperkinesis as a rare condition, most often related to obvious neurological damage, remained relatively unchanged during the following three decades.

Proponents of the neurobiological/genetic model of ADHD often draw on the writings of early 20th century physicians in order to boost their argument that the disorder has always existed, but that it was only recently adequately recognised as a specific neurodevelopmental disorder. British physician George Frederick Still's 1902 lectures have been described by leading ADHD researchers as especially

prophetic, stressing the “immediate gratification of the self” as a keynote quality of these children’s behaviour; their insensitivity to punishment; their relative incapacity to consider the long-range consequences of behaviour and to act accordingly; and the hypothesis that deficits in “inhibitory volition”, “moral control”, and “sustained attention” were causally related to each other and to the same underlying neurological deficiency. Some even argue that much of what modern science does is to merely reaffirm in a more rigorous way many of Still’s astute observations ([Barkley 2006](#)).

This portrayal of a timeless, static entity, unaffected by social, political and technological developments, is deeply ahistorical; it is clearly important to emphasise the crucial differences between the discussions of severe restlessness which appeared sporadically in medical journals in the first half of the 20th century, and the milder concept of ADHD that emerged in the late 1950s in the US. However, I have argued that the early descriptions of hyperactivity in relation to various forms of brain damage have much in common with the narrow concept of hyperkinesis which continued to inform British and for that matter other European perceptions of pervasive overactive child behaviour up until the 1990s.

For Still and his contemporaries, volition was founded on the civilised capacity to inhibit immoral or unnecessary desires, “the overpowering of one stimulus to activity [...] by another stimulus which we might call the moral idea, the idea of the good of all ([Still 1902](#), p. 1008). While anthropologist Andrew [Lakoff \(2000\)](#) contends that this idea of “the good of all” – the notion of collective interest – is no longer at stake in contemporary individualised and medicalised discourses surrounding ADHD, I would argue that it is still present, albeit on a more implicit level. Part of the reason why the British concept of hyperactivity eventually broadened to include milder cases lies in the wider panic surrounding children’s psychological health ([Timimi et al. 2004](#)). Professional experts, politicians and social commentators often suggest that society is witnessing unprecedented levels of disturbed and disturbing behaviour in children, and this deterioration is repeatedly connected to various social problems and to notions of increased lawlessness. Even if the government of children’s behaviour today

operates more at the level of the individual and the nuclear family, there is little doubt that general risks to society posed by hyperactive children in the form of future crime or unemployment has certainly been an important motivating factor in the diagnosis and treatment of the disorder both in the US and the UK, especially since various studies have established that hyperactivity is most often a chronic, debilitating condition which requires early intervention.

Looking at the more practical reasons why British child psychiatrists and paediatricians have increasingly chosen to adopt American terminology and biomedical conceptions of hyperactivity, one could point to fact that the biomedical ADHD concept lends itself much more easily to standard medical research than conduct disorder, which has strong psycho-social underpinnings. For clinicians, the concept of ADHD moreover opened up the possibility of quickly and more efficiently controlling unwanted behaviours in a much greater group of children who would previously have been labelled as “maladjusted” or “conduct disordered” – areas where medical treatment had little to offer. In the next chapter, I shall discuss British physicians’ turn to ADHD in more detail and provide a clearer view of the multidirectional influences that have facilitated the global standardisation of concepts and practices we are witnessing today, while at the same time revealing remaining differences in ideologies, experiences, and practices.

CHAPTER 4

Towards a globalised concept of hyperactivity: the contestation and assimilation of the DSM, 1980 – 2010

4.1 Introduction

Bringing the preceding account of conceptual developments up to date, this chapter will examine of the history of the present psychiatric taxonomies and their hyperactivity categories, and furthermore discuss the process through which the American ADHD concept has increasingly been adopted in Britain and the rest of Europe. The history of the American diagnostic manual, DSM, is well-analysed by now, especially the circumstances leading to the publication in 1980 of the DSM-III, which generated a dramatic paradigm shift in American psychiatry from a psychodynamic to a predominantly descriptive approach which assumes biological causation ([Healy 1997](#); [Mayes & Horwitz 2005](#); [Kirk & Kutchins 1992](#)). However, historians and sociologists have given relatively little attention to the WHO's ICD scheme, including the contributions of British researchers which foreshadowed many of the American innovations. Further, not much has been written on the international reception and assimilation of DSM-III, least of all in child psychiatry. In order to address this gap, I will discuss the broader European reaction to DSM-III, as these responses give a good indication of what was considered to be at stake, and further analyse how the initially critical attitudes of British child psychiatrists

to the American construct of ADHD have subsequently mellowed considerably. In conclusion, I examine recent attempts to harmonise and standardise concepts of hyperactivity, culminating in the emergence of a dominant biomedical construct underpinned largely by US-led research in cognitive neuroscience and genetics, and a focus on deficits in behavioural inhibition and self-control. This account will be followed by a discussion of the proposition that we are moving towards a global discipline of child psychiatry, where national views on hyperactivity have all but vanished.

During the 20th century, there has been an increasing traffic of ideas, people and practices between the psychiatric communities on each side of the Atlantic. Communication decreased while psychoanalysis dominated in the US, but when “Mid-Atlantic” schools such as Washington University at St. Louis supplanted the psychoanalytical establishment as the dominant force in American psychiatry, the exchange intensified, even if the ensuing radical switch from psychoanalysis to biology brought different divisions. Thus, partly as a result of international collaborative efforts to enhance the compatibility of the main diagnostic manuals, psychiatric diagnosis has become much more standardised. Another crucial contributing factor is the homogenising pressure created by the internet, which has allowed both doctors and the lay public to access a mass of information on various disorders and treatments, as well as providing a powerful political tool for patient (in this case parent) mobilisation. Finally, the transnational drug industry has played a central role, both in producing and distributing knowledge about mental disorders and in sponsoring patient activism around neurobiological concepts of disease. Over the past 30 years, drug companies have increasingly come to shape the terms of research and clinical practice worldwide, and they have certainly contributed to the growth of ADHD in Britain via effective “educational” campaigns and their support of various proponents of the diagnosis, including medical researchers and parent activists.

Critics often discuss the globalisation of biomedical psychiatry as a form of neo-colonialism, involving the dominance and imposition of Western concepts, values, customs and practices on non-Western cultures – a development mainly

driven by the interests of the pharmaceutical industry and powerful professional elites (Timimi 2008; 2010). In *Crazy Like Us: The Globalization of the American Psyche* (2010), Ethan Watters for example describes how American psychiatry is sweeping the globe like a virus, bringing Anorexia to Hong Kong, Post Traumatic Stress Disorder to Sri Lanka, and Western-style depression to Japan, often with disastrous consequences. While such accounts offer valuable insights, they typically overlook the heterogeneous nature of mental health ideologies and practices within Western medicine itself. While it may make sense to talk about “Anglo-American” psychiatry from an abstract global perspective, this tradition is itself highly heterogeneous. This point is well illustrated by the history of childhood hyperactivity, both within the US, where the history of psychiatry is characterised by considerable fluctuations, and when broadening the focus to include European countries such as Britain, where the condition has been – and still is – understood and treated quite differently. Although British researchers have made crucial contributions to the study and delineation of psychiatric disorders, including hyperactivity, one could actually argue that the recent spread of ADHD to the UK is also an example of cultural imperialism, reflecting the globalisation of a new biomedical psychiatric paradigm – based on neuroscience and the DSM – which has its scientific, institutional and economical base in the US.

However, the considerable remaining resistance in the UK testifies to the fact that the American ADHD “package” has not been accepted wholesale; important differences remain in medical and educational responses to disruptive behaviour and learning problems, as well as public attitudes to treating children with psychotropic drugs as opposed to alternative approaches such as dietary intervention. It must also be emphasised that strong pockets of opposition have existed in the US since hyperactivity first emerged as a serious concern in the 1960s and became subject to anti-psychiatry and labelling critiques. Thirty years later, in the late 1990s, a major public backlash occurred in reaction to the explosion in the number of children – the vast majority of them boys – diagnosed with ADHD. Aside from the moderate critics who emphasised the dangers of over-identification and over-treatment, there were those who questioned the very

existence of the disorder and the safety of stimulant drugs at any dose. Among the most fervent critics were conservative commentators and politicians protesting the feminisation of society, the growth in disability accommodations, and the interference of government in family life, for example through “forced drugging” in schools. Although positioned outside the mainstream, a number of American clinicians also remained highly sceptical of developments in the ADHD area (Baughman 1999; Carey 2002; Diller 1998). In turn, this body of work was picked up in the UK by commentators like Sami Timimi, who has used it to back his own social and professional critique (2005; 2010). Therefore, it would be misleading to focus too much on national contrasts, both as regards the resistance to, and the promotion of, ADHD. As this thesis shows, there have been pro- and anti-medical sentiments on *both* sides of the Atlantic, but different sides have dominated in each setting from the 1960s up until the 1990s, when a general global shift in balance towards the biomedical viewpoint occurred.

4.2 The reception of DSM-III

As described by numerous commentators (Kirk & Kutchins 1992; Kutchins & Kirk 1999; Mayes & Horwitz 2005; Wilson 1993), the DSM-III represented a turning point in American psychiatry; in a remarkably short time, American psychiatry shed one intellectual paradigm and adopted an entirely new system of classification, thus reorganising itself into a discipline where diagnosis was of fundamental importance. Significantly, the manual was developed under the leadership of representatives from a handful of institutions that had retained the more traditional British-European approaches. Sometimes referred to as the “Mid-Atlantic”, they included Washington University at St. Louis, Johns Hopkins in Baltimore, Iowa Psychiatric Hospital, and New York psychiatric Institute in New York City (Andreasen 2007). Despite their relative isolation, the Mid-Atlantic made several influential contributions during the 1970s, including the development of the Research Diagnostic Criteria, which came to inform the major

diagnostic categories of DSM-III.

Psychiatry had enjoyed enormous prestige in American society in the immediate post-war years, but by the late 1960s it was under intense attack on a number of different fronts. From within the profession itself, an attack was mounted on both psychoanalysis and social psychiatry by biologically minded research psychiatrists who bemoaned the lack of progress in treatment and sought to remedicalise psychiatry and bring it into the mainstream of scientific enquiry. Similarly, but from a different angle, behavioural psychologists such as Hans [Eysenck \(1953\)](#) in Britain challenged the fundamental reliance on intrapsychic phenomena and the lack of quantitative and experimental research in psychiatry. Conversely, the radical anti-psychiatrist and libertarian Thomas Szasz argued that mental illness was a “myth” used to disguise moral conflicts while psychiatry itself functioned as an authoritarian extension of the state ([Szasz 1974](#)), and sociologists such as Thomas [Scheff \(1966\)](#) suggested that mental disorder was merely another example of how society labels and controls non-conformists. These “non-conformists” in fact protested themselves, most prominently when gay activist vehemently challenged the listing of homosexuality as a mental disorder in DSM-II.

An entirely different line of attack stemmed from the insurance industry and the federal government which both lamented psychiatry’s lack of financial accountability and clinically demonstrated effectiveness ([Mayes & Horwitz 2005](#)). The economic basis of the therapeutic relationship was no longer solely between therapists and clients but had increasingly come to involve private as well as public third party payers ([Mechanic 1998](#)). Psychotherapy was consuming ever larger amounts of total health care spending, but there was little persuasive scientific evidence that it actually worked. With time, it came to be viewed as a financial bottom-less pit requiring potentially uncontrollable resources, as patients (whose status as “medically ill” was often questionable) could spend years in treatment. For these reasons, both insurance companies and federal programmes such as Medicaid demanded clearer diagnoses and treatments that were measurably valuable. Lastly, while the psychiatric profession was facing severe criticisms by

the 1970s, it was also experiencing more demand for its services, stemming from roughly two decades of deinstitutionalisation. One important consequence of this process was the significant increase in the use of psychotropic drugs by psychiatrists in rapidly expanding private and public mental health care settings.

The DSM-III was a bold move designed to deal with all the problems described above. Critics have claimed that its eventual success did not reflect scientific advances, but rather its ability to meet changing demands both internal and external to psychiatry; despite the scientific rhetoric accompanying its release, the manual did not represent new data or solve the problem of diagnostic unreliability¹, but instead grew out of an essentially social and political process (Healy 1997; Kirk & Kutchins 1992; Kutchins & Kirk 1999; Wilson 1993). To a factionalised psychiatric community incapable of agreeing on either theories or therapies, descriptive diagnostic categories at least offered the appearance of scientific objectivity and consensus, as well as expanding the opportunities and funding for clinical research. Further, they represented an effective response to the growing competition from non-medical mental health professionals represented by the large number of clinical psychologists, marriage and family therapists, and social workers who had increasingly succeeded in persuading the courts and third-party payers that they were equally qualified to practice psychotherapy, particularly cognitive and behavioural therapy, and at lower costs (Buchanan 2003).² After DSM-III, psychotherapy turned into the primary domain of clinical psychologists (whose payment now also depended on the use of DSM codes), while drug therapy became the “turf” of medically trained psychiatrists. To insurance companies and managed care organisations focused on cost-containment, the

¹Reanalysing the data gathered in the DSM-III field trials (including data on the newly introduced child psychiatric disorders), Kirk & Kutchins (1994) found no credible evidence of increased reliability, although this was an explicit aim of the DSM-III Task Force (see also Bemporad & Schwab 1986). Further, they note, the modest agreement that has been achieved in existing studies may not reflect the actual use of the DSM in normal, uncontrolled clinical settings, where external bureaucratic demands, reimbursement probabilities and potential stigma influence the judgement of clinicians.

²By 1980, a national survey reported that there were 28,000 psychiatrists, 50,000 psychologists and 300,000 social workers, with the latter two groups having increased their ranks by 700% since 1950 (Mayes & Horwitz 2005, p. 257).

manual represented a great improvement, introducing accountability and greater clarity into the reimbursement process. Before 1980, and even in the years immediately following the publication of DSM-III, front-line practitioners barely gave DSM a nod ([Diller 1998](#), p. 56). But that changed vastly, as diagnosis took on even greater practical consequence in the US, due to the rise of third party insurers and managed health care. Now all mental health professionals had to use DSM codes for reimbursement and insurance purposes, which meant that DSM-III became a veritable money-spinner for the APA. In addition, clinical researchers and pharmaceutical companies wishing to obtain an FDA product license also had to buy any new revision of the DSM ([Kendell 1991](#); [Kutchins & Kirk 1999](#)). Within the first six months of its publication, more orders were received for DSM-III than all the previous DSM editions combined.

DSM-III first and foremost emphasised reliability and thus differentiated distinct disease entities in terms of their symptoms, not their causes. Since the research psychiatrists who developed it also decided to encompass the full range of disorders encountered by clinicians – a range that dynamic psychiatry with its focus on the continuity between normal and abnormal behaviour had done much to foster – the result was the incorporation of a very broad range of disorders: while DSM started out very small in 1952, DSM-III included 265 disorders ([Horwitz 2002](#), pp. 67-72).³ In the years around its release, the manual received much attention on both sides of the Atlantic, both in terms of praise and criticism. Most of the critical reports focused on the validity of the diagnostic criteria and the many new syndromes, including ADD. The largest diagnostic expansion had occurred in the childhood section, which contained four times as many as disorders as the more dynamically inspired DSM-II ([Spitzer & Cantwell 1979](#)). In the US, DSM-III was subjected to a variety of critiques, especially from clinical

³In its latest version, DSM-V ([1994](#)) runs to 900 pages and nearly 400 disorders. Controversially, this trend looks set to continue with the much delayed and debated DSM-V (due to be approved in 2013), as a draft has suggested that the number of listed disorders will increase even further, including among other things various “risk syndromes”, which identify a particular disposition in a patient ([Aldhous 2009](#)). Significantly, it will introduce a dimensional component that allows for a description of degrees of illness, this in order to enable a more detailed and accurate evaluation of symptom development and prognosis.

psychologists who wondered whether it would be good for their profession (Schacht & Nathan 1977), and for science (Zubin 1977) more generally. Others reflected on its significance in terms of the medicalisation of distress in children. Thus, psychologist Norman Garnezy – who at in the late 1970s worked closely with Michael Rutter at the Maudsley and then at Stanford doing pioneering research on stress and coping mechanisms – scoffed at the inclusion of such poorly validated entities as “specific reading disorder”, “oppositional disorder”, “identity disorder”, “avoidant disorder of childhood” and “attention deficit disorder” on the grounds that they could hardly be regarded as mental disorders (Garnezy 1978, p. 4). He emphasised that the “overextensions into the psychiatric domain of so many problems of childhood” was not so flagrant in Rutter et al.’s 1975 draft of the ICD-9 childhood section, where many problems were specified as “delays” rather than disorders.

Indeed, the psychological profession seems to have felt particularly threatened, as demonstrated by the angry articles and letters to the Editor in the *American Psychologist*.⁴ One of the early drafts of the DSM-III stated that “mental disorders are a subset of medical disorders” – a notion which caused a storm of protests from the American Psychological Association. When DSM-III was released in 1980, the disputed phrase had been dropped. Further, from 1976 until the final approval of the manual, an acrimonious conflict flared between this the psychodynamically oriented members of the American Psychiatric Association and members of the DSM-III Task Forces, especially over the proposal to banish the term of neurosis from the manual because it was felt to be too theoretically loaded (Kutchins & Kirk 1999, p. 44).

In Europe, DSM-III was generally resisted, especially on the Continent, where reactions were particularly hostile. While the categorical approach and the multi-

⁴During the 1980s, the early resistance of American psychologists to DSM-III lessened. In fact, the American Psychological Association elected not to go through with their plans to construct a competing document, partly because psychologists were involved in the construction of DSM-IV. Three or four psychologists were on the Task Force and a greater number were on the several Work Groups and advisory groups. That is not to say that psychologists in the US are now largely supportive of syndromal diagnosis; some, like Tom Widiger and David Watson have in fact been leaders in the effort to reintroduce a dimensional approach (Nathan int. 2007).

axial format were on the whole easily accepted, objections were directed towards the terminology and the specific contents and limits of categories. The more permanent criticisms, however, were according to the French psychiatrist Pierre Pichot more “irrational” and had deeper roots, linked to basic approaches to psychiatry as well as systems of national values (Pichot 1997).

Essentially, DSM-III was seen as a “parochial, American formulation” that did not reflect the psychiatric views or histories of other countries, even if non-American consultants were used in its development (see also Maser et al. 1991, p. 271). In view of the multiple demands faced by American psychiatry, the developers of DSM-III had made a decision to revert to the descriptive approach; they were looking to make a bold move and felt a compromise solution as the one embodied in ICD-8 and proposed for ICD-9 to be inadequate. To many European psychiatrists, however, the atheoretical syndromic model represented a historical regression and expressed an American preference for superficial facts (Pichot 1997, p. 51). Furthermore, the introduction of quantitative procedures, such as the use of behaviour rating scales, was rejected by some who advocated a more “artistic” approach allowing for a deep understanding the individual case.⁵

Thus, under the surface of the more technical debates about the manual’s shortcoming lay a more profound and diffuse feeling related to its character. The constitutive factors of DSM-III were almost all of British-European origin, but the blend was American, as were the values that had influenced its realisation. Among those, Pichot notes, were pragmatism, the tendency to solve problems by the addition of new structures, and the veneration of change. After World War II, American science and medicine were objects of ambivalence in Western Europe. The large sums of money allocated to psychiatric research and teaching was considered with awe in European countries impoverished by war, and European psychiatrists looked with envy upon the enormous growth and public prominence of the profession across the Atlantic (Freyhan 1956). But the growing American

⁵The reactions to the introduction of quantification were not uniform. Even though reservations were expressed by many European psychiatrists, the use of rating scales had been accepted in most countries, first by clinical pharmacologists.

influence was also felt as a threat in many quarters. Significantly, the spread of English as the preferred vehicle for scientific communication was identified with the dominance of American culture and represented as a loss of national identity, especially in countries such as France and Germany, whose scientific roles had been important in the past.

The most negative reactions came from France and Italy, where psychoanalytical theory and practice had profoundly reshaped the training and the professional identity of psychiatrists ([Sergeant & Steinhausen 1992](#)). Ironically, at the very moment when psychoanalysis was on the defensive in the US and the Britain, in these countries it was in fact gaining rather than losing ground. In France in particular, parts of the psychiatric community objected strongly to the spread of quantitative descriptive measures which had followed in the wake of the triumph of randomised controlled trials and the rise of psychiatric epidemiology ([Diatkine 1968](#); [Lebovici 1964](#)). Moreover, even in the 1980s, biological explanations for mental illness were regularly identified with the Nazi and Vichy expulsions and persecutions of psychoanalysts, almost all of whom were of Jewish or émigré origins or both, including leading Parisian psychiatrist Serge Lebovici, a specialist in convulsive tic disorder, whose psychiatrist father was sent to die in Auschwitz. ([Kushner 2004](#), p. 84).

Lebovici was among the many French psychiatric commentators who criticised the reductionism and perceived conformism of American and British psychiatry. For example, as claims continued to mount from America during the 1970s that the major tranquiliser, haloperidol, was more effective than psychotherapy in treating the involuntary tics of Tourette syndrome, he and his colleagues reacted. Although admitting that neurotransmission doubtlessly played a role in the presentation of the symptoms, they remained persuaded that this did not rule out psychogenic and social factors. At a 1982 conference, Lebovici thus acknowledged the growing importance attached to drug treatments, but yet observed that Americans were ready to accept “excessive therapeutic risks” because they would not tolerate “anything that interferes with the school and social life of the ticker” (cited in [Kushner 2004](#), p. 86). His paper signalled that the main threat to psychoanalytic

approaches would no longer be seen to be psychopharmacological; rather, fitting the more general French national attitude of the 1980s and 1990s, the issue was transformed into a wider defence of French cultural institutions from American medical and cultural imperialism. The prime target was DSM-III, which converted complex, multidimensional disorders into a cut-off point on a behavioural scale, and in this way – it was felt – expressed the small-minded and literal view that American psychiatrists had of mental processes (Lefèvre et al. 1983).

Similarly, in an article comparing the ‘Anglo-Saxon’ concept of hyperactivity to the French concept of child psycho-motor instability (*‘instabilité psychomotrice de l’enfant’*), psychoanalyst Christian Flavigny reproached Anglo-American authors for ignoring the contributions of French-speaking authors on the subject, and their reservations towards DSM-III (Flavigny 1988). Noting that the area of hyperactivity research had become thoroughly colonised by statistical and psychophysiological perspectives, he criticised the field for focusing solely on manifest behaviour and the effects of drug treatment, while disregarding more dynamic explanations that address underlying mechanisms related to patterns of interaction in families. In a manner quite far-removed from present-day mainstream theorising about ADHD, the article offered a Freudian interpretation of ‘child instability’, focusing on underlying conflicts and sexual dynamics within individual parent-child relationships (mother-son) as the possible origin such behaviour. In the case stories presented here, the mother’s perceived, almost “incestuous” overprotectiveness was interpreted as masking a deep rejection of the child, whereas the ‘effaced’ fathers were avoidant and absent. Moreover, Flavigny rejected the notion of a paradoxical stimulant response in hyperactive children, emphasising that such an effect instead demonstrates the presence of an underlying depression.

Indeed, even the British and American psychoanalytical schools seemed to have completely neglected hyperactivity. To French psychiatrists and analysts, it was especially surprising that American and British works offered so little in the way of explaining the vast preponderance of boys among hyperactive children: that hardly any attempts were made to tie this fact to family and psychosexual

dynamics. They held that the real is not necessarily quantifiable, and that many phenomena cannot be fruitfully studied within comparative, quantitative research designs involving samples or cohorts. Flavigny argued that a theoretical approach which declines to consider connections between the manifest and the latent – and at least implicitly confines itself to a neurological framework – prevents an understanding of events that can only be fully explained with reference to the subjective. Speaking of the prevalent ‘passion for generalisation’ and obsession with categories, he accused American and British hyperactivity/ADD researchers of applying the same form of circular reasoning that characterised the MBD field, and concluded that the status of hyperactivity and inattention as forming a discrete pathological entity – a syndrome – with a common objective cause remained a postulate.

British psychiatrists were generally not as sceptical of DSM-III as their colleagues in France. In the UK, where psychometrics had a long history, quantification was completely accepted in many clinical fields and various rating scales were already employed in child psychology and psychiatry. Furthermore, even if it differed in the number of diagnoses included and adopted a more conservative, hierarchical approach, ICD-9 like DSM-III emphasised description and strived for greater reliability. Michael Rutter had as mentioned previously led the efforts to develop the WHO multi-axial scheme which kept theoretical concepts of causation separate from patterns of symptomatology, and included information on psycho-social stressors and level of functioning. Indeed, the decision of the makers of DSM-III to adopt a multi-axial system was in no small part influenced by one of Rutter’s students, American child psychiatrist Dennis Cantwell, who had studied at the Maudsley in the early 1970s and on his return became a member of the Task Force ([First 2012](#), p. 135).⁶

But even if British psychiatry did not always fit easily with what Pichot

⁶According to Robert Spitzer, Chair of the DSM-III Task Force, the multi-axial scheme was not adopted primarily due to its perceived value in clinical work and research. Rather, given that the format allowed DSM-III to be presented as within a broad psycho-social model, the main impetus was the perceived need to address the concerns of those who feared a narrow diagnostic focus. Thus, the decision was as much about reacting to criticism as it was about innovation.

describes as “the European view”, Rutter and Shaffer’s 1980 appraisal of the child section demonstrated that many aspects of the classification did not agree well with the position taken at the Institute of Psychiatry at the Maudsley Hospital. Rutter and Shaffer rejected the view of DSM-III as an inevitable source of medicalisation and discriminatory labelling, and conceded that the DSM-III represented a landmark in terms of its descriptive, phenomenological approach and the development of precise operational criteria (it was in this aspect that DSM-III differed the most from ICD-9). However, they remained critical of the fact that many diagnostic categories, including ADD, had imprecise and ambiguous criteria (“often doesn’t seem to listen” or “needs a lot of supervision”), making it difficult for the clinician to make an informed decision. Further, for ADD, the criteria specified the required number, but not the pervasiveness, of overactive behaviours.

Rutter and Shaffer also acknowledged the systematic attempt to provide an exhaustive classification of child psychiatric disorders, but nevertheless objected to the proliferation of unvalidated diagnostic categories with low inter-rater reliability. While ICD-9 had introduced more diagnostic differentiations than could be adequately justified on the basis of research findings, DSM-III had produced even finer subdivisions (Rutter et al. 1975). A child presenting with socially disruptive behaviour could thus be placed under three attention deficit disorder categories, under one of five varieties of conduct disorder, oppositional disorder, identity disorder, adjustment disorder or under the code for childhood anti-social behaviour. As regards the description of the behaviours listed under “oppositional disorder” (violations of minor rules, argumentativeness, stubbornness etc.), they thought it sounded “like the behaviour of a lot of children one meets socially and not at all like a psychiatric disorder” (Rutter & Shaffer 1980, p. 384).

Overall, the appraisal was quite harsh and reflected the general irritation the new manual provoked within British psychiatry.⁷ The APA was at the time widely

⁷Based at Columbia University, New York, since the late 1980s, David Shaffer (2001) expresses some regret regarding its “arrogance”, noting that he has since come to appreciate the enormous difficulties in producing a classification that considers many different requirements and needs. Like

criticised for breaking ranks with the WHO and creating its own private classification system.⁸ Thus, Rutter and Shaffer observed that it seemed curious to commence the manual introduction with an explicit statement about the need for a common language in psychiatry “and then go on to argue that the US must speak a different language from the rest of the world!” (ibid, p. 379). The claim that no other classifications had been subjected to thorough clinical trials before adoption caused particular annoyance: “... it is wrong to assert that DSM-III has blazed the research trail when it has clearly followed in the wake of the WHO and has adopted some of the research strategies in the WHO programme” (ibid, p. 386). The overall effect of DSM-III was described as “educationally unsound”, not least because of the “dogmatic style which sometimes leaves little room for doubt” – a style that is “a function of the failure to make any adequate differentiation between those statements which represent the summary of decades of research and those which are no more than spitting in the wind.” All too often, Rutter and Shaffer concluded, it provided “a vivid illustration of the old saying, ‘It ain’t ignorance that does the harm, it’s knowing so many things that ain’t so!’” (ibid, p. 392). Elsewhere, in a brief acerbic review, prominent Maudsley epidemiologist Michael Shepherd (1981) had called DSM-III a “hodgepodge”, noting that “serious students will continue to use the ICD” and that “well-wishers will hope that DSM-IV will conform more closely to international usage.”

4.3 Testing the validity of the hyperactivity syndrome

Though influential, the reconceptualisation in DSM-III of the hyperkinetic syndrome as a disorder defined primarily by attention deficits was controversial on

many of his colleagues, he now considers DSM-III as a stepping stone that was open to revision and lead to a sharpening of concepts (Shaffer *int.* 2005).

⁸It is worth noting that the WHO would probably never have introduced such radical changes itself (Kendell 1991, p. 299). Whereas the ICD represents a conservative compromise – a comprehensive classification of diseases for use by a wide range of health professionals and researchers in different countries and cultures – the DSM is only designed to meet the needs of psychiatrists and clinical psychologists in a single country, and can therefore be transformed more radically.

both sides of the Atlantic. [Rutter \(1982\)](#) argued that this suggestion still lacked empirical support and emphasised that just like hyperactivity, problems of attention were often situational in nature and common in many different types of psychiatric disorders. Also, there was the same problem of distinguishing between “normal” and “abnormal” levels. In fact, at this point there was disagreement in academic child psychiatry surrounding the usefulness of *any* definition of a hyperactivity syndrome. Even when narrowly defined, its validity was still considered controversial; in spite of “suggestive evidence”, some British psychiatrists felt “still some way from that point” where it could be said to “constitute a meaningful distinct condition” ([Rutter 1978](#), p. 16 see also; [Shaffer & Greenhill 1978](#)). Thus, inspired partly by the empirical work of Douglas and colleagues, both British and American research on hyperactivity in the 1980s was characterised by attempts to improve diagnostic criteria. Throughout the decade, central figures in the discipline called for studies to determine whether the symptoms of hyperkinetic disorder or ADD/ADHD⁹ could be distinguished from those of other childhood psychiatric disorders, rather than simply to continue demonstrating differences from non-disordered populations ([Quay 1979](#); [Rutter 1989](#)). In this way, just as it had been elemental in the foundation of the field of paediatric psychopharmacology, the hyperactivity syndrome became a major impetus to taxonomy in child psychiatry, prompting some psychiatrists to argue that this made it a useful concept, whether or not it met the acknowledged criteria of reliability and validity ([Werry 1992](#), p. 473).

Researchers at the Maudsley in London took leading roles in the attempts to meet the classification challenge. From being a topic of marginal interest in British child psychiatry, the question of hyperactivity, its subtypes, and its relation to conduct disorder in particular, now became an area of extensive empirical study.¹⁰

⁹With the publication of DSM-III(R) in [1987](#), ADD (+/- H) was renamed ADHD. The three separate symptom categories in DSM-III were now replaced by one single list of 14 behavioural items, such as “often fidgets with hands or feet or squirms in seat”. A diagnosis required the presence of at least eight items.

¹⁰The diagnostic category of conduct disorder appears both in the DSM and ICD manuals. Although not as openly controversial as ADHD, conduct disorder is also a contested category which covers a wide range of problematical behaviours which are widely distributed in the population

Prominent among these researchers were Seija Sandberg, Russell Schachar, and not least Eric Taylor who was to become one of the world's leading experts on ADHD and in 1999 replaced Michael Rutter as director of child psychiatry at the Institute of Psychiatry. Having researched psychological aspects of attention and memory as an undergraduate Cambridge, Taylor was keen to find a department that was applying neuropsychological ideas to clinical problems. In 1971/72 he therefore went on a travelling fellowship to Harvard University to work with Keith Conners (of the Conners rating scale), in Leon Eisenberg's department, leaving several senior UK colleagues puzzled at his keen interest in what they saw as a rather obscure subject characterised by conflict over treatment and difficulties of delineation ([Taylor int. 2005](#)). Upon returning to the UK, he found there was a marked contrast between the "shoe string" research operation in England compared with the abundant facilities and financing that he had experienced in the US. He had been particularly impressed with the competitive environment, the teamwork organisation of research, and the way in which new scientific advances would rapidly be applied to the analysis of clinical questions. Apart from having more financial resources, the researchers had a "positive and energetic spirit" and were willing to try new things. Though alerting him to the downsides of the "consumer ethos" which characterised American clinical practice, the trip only served to reinforce Taylor's impression of having found his niche, and over the next two decades he worked to turn hyperactivity into an area of priority in Britain, among other things by opening an NHS hyperactivity research clinic at the Maudsley in 1980 (*ibid*).

Early investigations by Sandberg and colleagues ([1978](#); [1980](#)) concluded that no evidence existed for the validity of a broad hyperactivity syndrome as hyperactivity was highly correlated with problems of conduct (aggression, disobedience), also in term of the presence of a strong link with social disadvantage and maternal mental distress. However, a re-analysis of data from

([Coppock 2005](#)). Clinical features include stealing, lying, disobedience, verbal or physical aggressiveness, truanting and substance abuse.

the original Isle of Wight study highlighted the usefulness of a narrow concept of “pervasive” as opposed to “situational” hyperactivity, the former being determined by overactivity both at home and at school, and associated with greater aggression, peer relationship problems, cognitive impairments, and generally a poor diagnosis. This view was reflected in the monograph *The Overactive Child* from 1986, edited by Taylor. Rejecting a reductionist medical model of common behaviour problems, the contributors concluded that much hyperactive behaviour is situationally specific but aetiologically non-specific, and that only a restricted concept of hyperkinetic disorder was valid.

Another strand of clinical research focused on treatment and the important question of whether stimulant drug response could be used as a tool for making diagnostic distinctions within the large heterogeneous group of children with behaviour and attention problems. [Taylor \(1987\)](#) dismissed the theory promoted by Wender and others that stimulants specifically treat or reverse hyperactivity but nevertheless made the case that drugs were underused in British clinical practice, as very few children were diagnosed and doctors worried about long-term drug effects and potential harmful outcomes. In a group of children referred with various behaviour problems, most responded to methylphenidate, but particularly those with high levels of inattention and restlessness. Not only did this point to the validity of a separate hyperactivity construct and the usefulness of stimulant treatment in some children; it also made it all the more plausible that behaviours predominantly diagnosed as anti-social disorders of conduct in the UK and disorders of hyperactivity and inattention in the US were overlapping. According to Schachar, they were more impressed with the treatment response than they thought they would be; Taylor helped “the fog lift from our collective eyes”, and “we realised that we may have been overstating the counter-argument to the American position” ([Schachar int. 2005](#)).

Interestingly, this situation was quite reminiscent of the conditions which in the 1960s led researchers to initiate the famous US-UK Diagnostic Project on schizophrenia ([Kendell et al. 1971](#); [Cooper et al. 1972](#)), an Anglo-American comparative study undertaken on behalf of the WHO as part of their post-war

efforts to standardise psychiatric diagnosis by examining national variations in psychiatric practice. Since the 1930s, comments had been made on the diverging diagnostic statistics generated by mental hospitals in Britain and the US. Psychiatrists who had worked in both countries in the 1950s and early 1960s quickly formed a strong impression that most American psychiatrists had, by British and European standards, a remarkable propensity to give almost all seriously ill patients a diagnosis of schizophrenia. Biometrician Morton Kramer of the NIMH ([Kramer 1961](#)) was the first to systematically investigate this puzzling national discrepancy. In a statistical study, he demonstrated that the hospital first-admission rate for schizophrenia in the US was about 33% higher than in England and Wales, while the rate for manic-depression was nine times lower. The purpose of the US-UK Diagnostic Project was to examine whether these differences in rates were real, whether they originated in the referral process, or whether they stemmed from different training and diagnostic fashions. In an exercise where panels of American and British psychiatrists examined a common set of patients via videotape, it was clearly shown that many patients diagnosed as schizophrenic by American clinicians were diagnosed as depressed or manic-depressive by the British. However, when standardised criteria were employed by an independent research team, the differences largely evaporated.

The discrepancy revealed in the study shed much light on the different historical trajectories psychiatry had taken in Europe and in the US during the inter-war period. Mostly due to the greater influence of psychoanalytic principles in the US at this time, the American concept of schizophrenia had expanded greatly, while no corresponding enlargement had occurred in the British concept ([Kendell et al. 1971](#), p. 129).¹¹ The growing disregard for diagnosis meant that many ignored Kraepelin's fundamental distinction between manic depression and schizophrenia, favouring instead a dimensional, unifying definition of mental

¹¹The research team suggested that the diagnostic habits of the staff of a psychiatric hospital are principally determined by the models and opinions of half a dozen of its senior psychiatrists, who often fail to adapt to change demanded by new research findings.

illness.¹² With time, the concept of schizophrenia held by New York psychiatrists evolved to a point where it meant being out of touch with reality, severely maladjusted or simply psychotic; it embraced not only part of what in Britain would be regarded as depressive illness but also substantial parts of other diagnoses such as mania, neurosis and personality disorder (Klein & Healy 2000, p. 328).¹³

The US-UK Diagnostic Project gave momentum to the radical process of change culminating in the publication of the DSM-III in 1980. When the results came out in the early 1970s, they were considered quite scandalous. Forming part of a series of embarrassments, the findings left American psychiatrists exposed to the disdain of their European colleagues and the rising tide of criticism from the “Mid-Atlantics”, while also supporting the anti-psychiatry movement’s criticism of the profession’s scientific pretensions and the poor reliability of psychiatric diagnosis. Another source of humiliation was a much talked about study published in *Science* (Rosenhan 1973) which revealed that a healthy group of volunteers feigning hallucinations had managed to get admitted to American hospitals, where they were diagnosed as schizophrenic. The only people who recognised the fraud were the other patients. However, the question of which conceptualisation was superior essentially persisted until a drug seemed to demonstrate that the British position was correct. Towards the end of the 60s, lithium was introduced as a specific and fairly effective treatment for manic-depression and soon produced a dramatic resurgence of interest in the diagnosis in the US; in fact, in a few decades, American psychiatrists went from using only two

¹²Karl Menninger, a leading psychiatrist at the time, viewed all mental disorders as reducible to one basic psychosocial process, namely the failure to adapt: “Adaptive failure can range from minor (neurotic) to major (psychotic) severity, but the process is not discontinuous and the illnesses, therefore, are not discrete” (Menninger in Wilson 1993, p. 400).

¹³To some extent, the US-UK Diagnostic Project gave too alarming a picture of the overall national difference (Kendell 1975, p. 80). The majority of the American raters worked in or near New York, and subsequent studies made clear that the New York concept of the schizophrenic patient was unusually comprehensive even by North American standards. Not surprisingly, it turned out that one US centre was in line with European diagnoses, namely Washington University in St. Louis, one of the so-called “mid-Atlantics” (Andreasen 2007). Within the relatively homogenous area of the British Isles, little evidence was found of significant regional variation.

diagnoses, neurosis and schizophrenia, to using hundreds.

The idea that drugs can function as catalysts of diagnosis is also reflected in the case of hyperactivity and Ritalin, although it is now commonly acknowledged that stimulant drug treatment cannot provide the same sort of diagnostic distinction, or “pharmacological dissection”, as lithium did for manic depression.¹⁴ Child psychiatrist Rachel Klein argues that the history of hyperactivity/ADHD presents an interesting parallel in the sense that the disorder became more widely recognised in the US because the great majority of the stimulant drug studies were done there (Klein *int.* 2005); having an effective treatment meant that it made sense to recognise the disorder. In the UK, where few drug studies were done, and the drug treatment itself was not widely accepted, the diagnosis was ignored. On the other hand, Klein notes, one has to remember that even today “Americans are extremely ethnocentric and pay little attention to, or even devalue, what comes from abroad; this is so not only in psychiatry but also in politics” (Klein *int.* 2005). Indeed, according to Klein, “territorial attitudes” played a significant role in the ADHD area, as things only started to change when Eric Taylor and his group became interested and began to publish on the topic.

We have an expression in America, I don't know if it exists in England, which is NIH, Not Invented Here. As long as the English had not done the studies on ADHD, they didn't accept the finding from US investigators and viewed the disorder as an American invention. Here, it is relevant to point out that the ICD-8 included “Hyperkinetic Reaction of Childhood”, but for exclusive use in the US. Once Eric Taylor and his group conducted studies on hyperactivity and ADHD, published books on it, the diagnosis became much more acceptable and listened to. So I'm afraid there's a bit of social history involved in the science of this process. If the research had never taken place in England, I'm not so sure that attitudes toward ADHD would have changed so much in the

¹⁴Lithium and the one-drug/one-disease model had an enormous influence, making it look as if drugs would be “splitters” – definers of illness. However, most subsequent medications have been “lumpers”, and none more so than Prozac, the wonder anti-depressant drug of the 1990s (Kramer 1993). The popular idea that stimulant drug response could be used as a diagnostic test took a serious blow in the mid-70s when Rapoport *et al.* (1978) demonstrated that stimulant drug also have an immediate performance-enhancing effect on children with normal learning abilities and behaviour. However, the theory still popped up in many of my interviews with parents as well as doctors. See the comments of Whalen & Henker (1980, pp. 37-38) on the tendency of clinicians to label a child hyperactive when his/her behaviour and school performance improved on drug treatment.

UK, notwithstanding the parents' demand for appropriate treatment for their children (ibid).

ADHD and stimulant treatment, from this perspective, had "USA stamped all over it". Whereas the rivalry between American and British psychiatry is much less obvious today, it was still at play to some extent in the late 1970s when the US was attaining a leading position – particularly in psychopharmacology and other neurobiological fields – following a period during which the British were at the forefront of developments in social and epidemiological psychiatry as well as clinical trial methodology, and were far ahead of anyone else in child psychiatric research.

By the mid-1980s, the difference between the US and the UK in the area of hyperactivity had become so glaring that a handful of prominent researchers decided to do a comparative study with the aim to determine whether the discrepancy in national figures reflected genuine epidemiological differences – which would suggest that hyperactivity is a culture-bound syndrome – or differences in diagnostic practices.¹⁵ In the study, forty cases of boys between the ages of 6 and 11 – 20 from American clinics and 20 from English clinics – were diagnosed by a panel of US clinicians, a panel of UK clinicians, and by specially trained research teams from both countries who all made both DSM-III and ICD-9 diagnoses on every case. Whereas the research teams showed a "reasonably" degree of agreement, the panels of clinicians were much less reliable. When a single diagnosis was required, the British child psychiatrists tended to put most emphasis on anti-social features and aggression, and to select a diagnosis of conduct disorder. Their American colleagues, on the other hand, paid most attention to signs of restlessness and identified ADHD more readily. Further, more American than British cases were on the whole diagnosed as hyperactive, perhaps

¹⁵See [Luk et al. \(2002\)](#) for a comprehensive review focusing on comparative hyperactivity studies, e.g. a 1993 Hong Kong-UK study which found some evidence for the theory that aspects of Asian culture are likely to suppress hyperactive child behaviour, whereas in Western countries, the development of disruptive behaviour may be facilitated. Further, it suggested that while Hong Kong teachers had a lower threshold for the recognition of problems of hyperactivity/conduct, they had a higher threshold for making a referral for help (ibid, pp. 85-86).

as a result of referral bias; while in the US hyperactivity was a commonly diagnosed condition likely to be treated specifically with stimulants, in the UK, where stimulants were not used, hyperactivity and inattention alone was rarely a reason for referral. When British children were sent to a specialised service, it was probably because their problems were severe and included other disabilities. The paper concluded that the diagnostic schemes used, as well as physician training and beliefs, both contributed to the difference in reported rates; disappointingly, even among the research teams using identical criteria, diagnostic agreement was not quite satisfactory.

While the research done by Taylor and colleagues during the early 1980s had already begun the process of putting hyperactivity and stimulant treatment on the map in the UK, the comparative study is seen by many as an important turning point which drew serious attention to the possibility that the British conceptions of hyperactivity might be too narrow. As one of the study participants recalls:

I mean, I can remember the US/UK study, I was one of the participants, and we were, I think it's fair to say, bemused by it... I sort of sifted through it, thinking my God, it's like the kid I saw last week, good God, is that what they call them? I remember sitting in a room with at least a dozen people, looking at these Americans in the videos interviewing children and going on about activity levels and attention, which we didn't... I think it's fair to say people like Philip Graham suddenly perked up and said, 'This is actually quite interesting.' You know, these badly behaved children, where we're taught that it's down to poor family functioning or neglect or high levels of family discord, depending on which centre you're working in... we didn't know what to do with them, Christ... I think that study for some academics was a turning point, it certainly was for me ([P. Hill int. 2005](#)).

The study not only affected the British participants; the Americans recognised that the low reliability of diagnostic ratings pointed to weaknesses in the DSM, such as a lack of explicit definitions and cut-off points for various problem behaviours ([Prendergast et al. 1988](#)). The study highlighted a number of inadequacies in both classification schemes, and the need for them to be brought closer together. As regards the question of hyperactivity management, the result was mainly a heightening of awareness among the British of the areas where the

UK needed to catch up ([P. Hill int. 2005](#)). Significantly, the shift in British outlooks was also stimulated by new American follow-up studies which underlined that problems of restlessness, inattention, and impulsivity persist into adolescence and adulthood and put sufferers at risk for a range of developmental abnormalities, including delinquency and other anti-social behaviour, mental health problems, substance abuse, and academic underachievement ([Gittelman et al. 1985](#); [Manuzza et al. 1993](#); [Weiss & Hechtman 1986](#)). Similarly, a number of British studies indicated that the presence of severe hyperactivity in middle childhood predicted poor social adjustment in adolescence ([Thorley 1984](#)). Not least due to this growing body of evidence about risks to individuals as well as society, concern started to grow among British psychiatrists and paediatricians that the treatment of hyperactivity should be given greater priority ([Lancet 1986](#)).¹⁶

4.4 ADHD displaces hyperkinetic syndrome

By 1990, the rising profile of hyperactivity in the UK was marked by the publication in 1990 of a Maudsley monograph on the epidemiology of childhood hyperactivity, based on an East London population sample of 3215 boys of primary school age ([Taylor et al. 1991](#), p. 132). Here, Taylor and colleagues demonstrated that the large heterogeneous group of children with anti-social conduct disorders contained a subgroup of children with marked hyperactivity and inattention characterised by early onset and frequent associations with cognitive impairment, clumsiness, language delay and perinatal risk. Hyperactive behaviour patterns were found to be continuously distributed in the population, but the authors maintained their support for a restricted diagnosis of hyperkinetic disorder with a prevalence of 1.7% of 7-8 year-old boys (excluding those with known severe

¹⁶Recently, a series of UK policy reports has framed ADHD as a direct threat to national prosperity, and provided exact calculations of the cost to society of an ADHD individual: “[ADHD] produces an estimated lifetime earnings cost of £43,000, suggesting that substantial benefits would accrue to the individual (and to the economy) from interventions that would reduce these problems” ([Foresight Mental Capital and Wellbeing Project 2008](#), p. 101).

learning disability).¹⁷ This was about only one tenth of the rate of ADHD diagnosis, but much higher than that suggested in the original Isle of Wight study (Rutter et al. 1970a), the results of which were arguably shaped by the rural, “small town” character of the island.¹⁸ Although the East London study did not confirm previous suggestions of a clear link between pervasive hyperactivity and low socio-economic status (Schachar et al. 1981), it did show that the children were often living in families with high levels of expressed criticism, family discord, and depressed mothers. In conclusion, it was recommended that hyperactivity should be more widely recognised and stimulant therapy used more often in specialist child psychiatric and paediatric centres.

A few years later, this opinion was becoming widespread among British child psychiatrists. In 1984, CIBA withdrew methylphenidate from the UK market due to a mixture of reputational concerns and poor sales, but after a period of restricted named-patient-only prescription, methylphenidate had now been made generally available in Britain again (Taylor int. 2005; Taylor & Hemsley 1995). At the same time, the ICD-10 (1992) included a new and more explicit definition of hyperkinetic disorder, which was more closely aligned with its American counterpart. With the publication of DSM-V (1994) two years later, the DSM and ICD manuals recognised the same problem behaviours as the basis for a diagnosis of HKD and ADHD respectively. There were still important differences, however. In North America, ADHD was seen as a common but heterogeneous developmental disorder, as reflected by the delineation of subtypes and by the preoccupation with the significance of comorbid psychopathology (Tannock 1998,

¹⁷Bearing in mind that several studies have suggested a 4:1 male to female ratio, the authors emphasised that their prevalence rate of 1.7% should be approximately halved in order to apply to all children, including girls. They also pointed out that their urban study population was likely to have a particularly high rate under all circumstances, especially compared to rural environments.

¹⁸The fact that the Isle of Wight does not fully reflect the general population of Britain – and certainly not the situation in major cities – was indicated by a 1975 study of an inner London borough where the prevalence of general behaviour disturbance was twice that found on the Isle of Wight in the late 1960s (Rutter et al. 1975a). The authors concluded that the high prevalence was due in part to the fact that a relatively high proportion of the London families were discordant and disrupted, often large and living in overcrowded homes, and that the schools were more often characterised by a high rate of turnover in staff and pupils.

p. 66). ICD-10, on the other hand, was more demanding as regards the number of required symptoms, the pervasiveness of the behaviour in question, and the need to identify a single overriding diagnosis (Swanson et al. 1998).¹⁹

The introduction of new criteria did not immediately lead to a marked change in clinical practice. A 1994 survey of paediatricians and child psychiatrists found that the treatment and diagnosis of hyperactivity and ADHD was anything but uniform, and that many in fact placed little emphasis on DSM and ICD diagnostic criteria (Kewley et al. 1994). Nevertheless, it was clear that the majority wished to receive further training in the area of neurodevelopmental disorders and psychopharmacology. The same was true of child psychiatrists. In 1997, a survey demonstrated that over half of 100 respondents used methylphenidate, and that many of the non-prescribers indicated a willingness to gain more experience in the area of paediatric psychopharmacology (Bramble 1997).²⁰ Like many other investigators, the author emphasised the pressing need to develop a more standardised consistent approach in the light of the growing, and increasingly uncomfortable, consumer pressures upon the specialty and other health providers to provide comprehensive services for hyperactive children: “Despite the significant resource implications of such a development, particularly within a

¹⁹In the symptom domain groups (inattention, hyperactivity, and impulsivity), an ICD-10 diagnosis of HKD requires some symptoms in all three groups, whereas DSM-IV (ADHD) does not. Instead it defines partial subtypes: predominantly inattentive, predominantly hyperactive-impulsive, and a combined type roughly corresponding with the ICD category of Hyperkinetic Disorder. Further, ICD-10 aims at a single diagnosis and uses other comorbid conditions such as anxiety and depression as exclusion criteria. DSM-IV on the other hand aims to recognise as many diagnoses as there are symptom patterns.

²⁰In the early 1990s, British child psychiatrists and general practitioners were prescribing psychotropic medication for children, albeit very infrequently and somewhat idiosyncratically, and most often sedatives for common sleep problems (Bramble 1997, p. 169). The most important governmental child mental health commissioning document to be published in that decade, *Together We Stand* (HAS 1995) which has shaped the current prevailing model of service delivery in the UK, made no specific reference to the subject of drug treatment. As recently as 1997, a forum of British experts and a few invited American “consultants” concluded that paediatric psychopharmacology represented an underdeveloped field of clinical activity in the UK which merited wider evaluation (BAP 1997). However, over the next few years, the cultural position of paediatric psychopharmacology shifted markedly, as illustrated by prominent textbooks such as Rutter and Taylor’s *Child and Adolescent Psychiatry: Modern Approaches* (2002), in which the chapter on physical treatments merited the largest text space allocated to specific interventions, together with behavioural therapies.

national context of already severely over-stretched and under-resourced child mental health services, the long-term individual, family, and societal costs of not doing so are potentially enormous” (ibid, p. 162).

A key concern in medical debates at this point was clearly the increasing number of parents informed by media reports on the subject who were pressing for assessment and treatment, and the question to which extent the NHS should give in and provide specialist services in the form of hyperactivity or ADHD clinics. Many were worried that the UK would end up with enormous numbers of children being diagnosed and treated, like in the US, if the “floodgates were opened” (BAP 1997). In order to avoid American conditions, there was a recurring emphasis on the need for proper comprehensive assessment before initiation of drug treatment, as only a minority would be severely affected and thus likely to benefit fully from drug treatment.

Still, by the turn of the century, doctors increasingly found themselves going beyond the ICD definition and diagnosing children in the milder, heterogeneous group of ADHD, including those who were simply inattentive. At this point, the disorder had ceased to be the domain of child psychiatry alone, despite the profession’s misgivings about sharing prescribing responsibilities with other medical specialties (Bramble 1997). Partly because referrals for ADHD assessment were making huge demands on child mental health services, several professions became involved in the identification and treatment of hyperactivity in the late 1990s, including community paediatricians, clinical psychologists, psychiatric nurses, and even general practitioners collaborating with specialists via “shared care protocols”. Throughout the UK, funding was provided to set up so-called ADHD clinics, and more often than not they were led by a new breed of “developmental-behavioural” paediatricians (Salmon & Kemp 2002).

In terms of spreading awareness of ADHD, one should not overlook the advocacy efforts of individual practitioners who collaborated closely with parents and set up private clinics in order to diagnose the disorder American-style (Taylor & Hemsley 1995, p. 161). Prominent among these was Australian paediatrician Geoff Kewley who repeatedly complained publicly about the poor level of services

for hyperactive children, mother-blaming and arrogance, and the perceived ignorance of medical and educational professionals on matters relating to ADHD (Kewley 1998; Kewley int. 2005).²¹ In particular, Kewley criticised British doctors for focusing solely on social causes of bad behaviour, and on the presence of pervasive hyperactivity when deciding on a diagnosis, thus excluding children with inattention as the main symptom from receiving proper assessment and care.

Indeed, although sceptical and reluctant to contribute to self-fulfilling prophecies, more and more GPs and specialists started to acknowledge that withholding diagnosis, and discrediting parents' experience of inborn difficulties, could have undesirable consequences (Klasen 2000). Given that raising hyperactive children is often associated with a sense of anger and guilt, surely some doctors felt that the label – via its ability to circumvent the issue of blame – allowed them to collaborate better with parents in developing new ways of coping with illness. Despite causing ambivalent feelings and grief, it was clear that the diagnosis empowered many parents by acting as a gateway towards a multitude of support groups, voluntary agencies, and self-help literature. Further, it could provide them with sense of control that might ultimately improve the parent-child relationship, as seeing their child as ill rather than bad led to increased sympathy.

New research also had a substantial impact. First, findings from longitudinal and epidemiological studies continued to stimulate consensus that hyperactivity in itself carries a risk for later development, even if it decreases with age (Tannock 1998, p. 66). Second, in terms of treatment, a great deal of attention was given to the first large-scale multimodal treatment study of children with ADHD in the US (MTA Cooperative Group 1999). Considered a landmark in the evolution of child mental health into an evidence-based discipline, the MTA trial concluded that a carefully executed regimen of medication management was superior to other

²¹ Another Australian doctor whose publications and talks had considerable influence is Christopher Green, one of a group of prominent drug company-sponsored paediatricians who have played a major role in promoting the diagnosis and the drug treatment in their home country in the early 1990s (Kean 2009, pp. 179-183). Subsequently, he also made frequent visit to the UK where he liaised with various parent organisations and held public meetings to raise awareness, thus inspiring many parents to seek medical attention for their children's difficulties.

treatments and nearly as good as combined treatment with drugs and behavioural therapy.²² This surprising result put the restricted use of methylphenidate in Britain and other European countries in stark relief and clearly influenced British psychiatrists and paediatricians to revise their diagnostic and prescription habits (Hill & Taylor 2001).²³

The MTA trial provides a good example of how single studies can become the basis on which practice develops; certainly, in the years following its publication and popularisation, there was a sharp rise in the use of stimulants in the UK and many other European countries. Due to uncertainty about drug effects and diagnostic boundaries, the first UK and European clinical guidelines on ADHD and HKD had recommended that medication should only be the first choice of treatment in severe cases (Overmeyer & Taylor 1999; Taylor et al. 1998). In 2000, however, stimulant treatment was officially sanctioned by the British government's National Institute of Clinical Excellence in its guidance paper on methylphenidate for ADHD which stated that drugs "should be used as part of a comprehensive treatment programme", adding that therapy "could, but does not need to, include specific psychological treatments" (NICE 2000). At this point, prescription levels were already increasing dramatically. While the total number of stimulant prescriptions for England was 6000 in 1994 and roughly doubled every year to reach 126,500 in 1998, the number had risen to 450,000 in 2004 (Timimi & Leo 2009, p. 6).

Yet, when follow-up studies were published in 2007 and 2009, it became clear that all the advantages in terms of symptom reduction for the medication-only and "combined" groups had been lost, whereas the improvements in the behavioural-therapy-only ("therapy-only") group had remained stable. Furthermore, children

²²The study compared four groups of children who were given medication only; intensive behavioural therapy only; combined behavioural therapy and medication; and standard community care. The authors concluded that the medication-only and combined behavioural therapy and medication groups had the best outcome, with the "combined" group having only a marginally better outcome than the medication-only group.

²³Child psychiatrist Sami Timimi recounts hearing an eminent British professor of child psychiatry state at a large conference attended by child psychiatrists and paediatricians that the implication of the newly published results was that they should be treating hyperactive children with stimulant medication as the first line and possibly only treatment (Timimi 2008).

exposed to medication for the longest periods were found to be somewhat lighter and shorter than their peers ([Molina et al. 2009](#)). Due partly to this new body of evidence and the growing concern about “over-reliance on medication” among physicians, new official British guidelines on ADHD published in 2008.

Illustrating that British notions of hyperactivity remained less rigid, more multifaceted, and certainly less confident than those in the US (see for example [Barkley et al. 2004](#)), the guideline stipulated that the diagnosis did not imply a neurological cause, and that parent training and educational programmes should be offered as a first-line treatment for the majority of ADHD children. Drug treatment was recommended for children over five and young people with *severe* ADHD, but only in combination with psychological and behavioural interventions ([NICE 2008](#)).²⁴

4.5 From description to aetiology

In contrast to the 1970s and 1980s, when much work focused on describing and validating ADHD or Hyperkinetic Disorder, research in the 1990s saw an increased focus on aetiology and pathogenesis. Further, though the interaction of nature and nurture has been well-accepted and stressed for decades, there was a shift back toward viewing hyperactive, inattentive behaviour traits as more influenced by biological factors than by social and environmental ones. Commenting on the results of the US-UK hyperactivity study, [Taylor \(1986, p. 15\)](#) suggested that American treatment programmes could usefully take more account of research on the psycho-social origins of disruptive, anti-social child behaviour. But subsequent developments actually went in a somewhat different direction, as studies on

²⁴Other notable aspects to the new guidance included a call for multidisciplinary specialist ADHD teams or clinics to be established; a recommendation that teachers should provide behavioural interventions in the classroom; a statement that the efficacy of dietary fatty acids is not proven; and a recommendation that GPs do not initiate drug treatments for ADHD. Critics noted that by providing an escape route for practitioners to continue misapplying medication to patients by simply re-categorising them as “severe” cases, the guideline development group was apparently unable to address the challenge posed by new evidence on long term outcomes. In addition, although the guideline recognised the lack of robust evidence supporting the idea that ADHD as caused by brain dysfunction, it still referred to ADHD as a “neurodevelopmental disorder”.

cognitive processing, neuro-anatomical localisation, and heritability came to dominate mainstream hyperactivity research ([Tannock 1998](#)). By the turn of the century, ADHD/HKD was in both the US and the UK predominantly viewed as a developmentally disabling condition with a generally chronic nature²⁵, a strong biological or hereditary predisposition, and a significant negative impact on academic and social outcomes for many children, although its severity and outcome was seen to be affected by environmental, and particularly familial, factors. Still, a 1998 National Institutes of Health Consensus Development Conference statement concluded that “after years of clinical research and experience with ADHD, our knowledge about the cause or causes of ADHD remains largely speculative” ([NIH 1998](#)).

As described here and in chapter 2, British psychiatrists have made important contributions to nosology, and to the understanding of the natural history and epidemiology of child psychiatric disorders, including the social distribution and determinants of child mental health. Generally, research in the UK has focused not on samples but on populations, and it has had stronger social orientation than American research ([Taylor int. 2005](#)). The approach taken at the Maudsley Child Psychiatry Unit, established in 1984 and led by Michael Rutter, was wide-ranging from the beginning, bringing together a variety of overlapping fields, including early psycho-social development, longitudinal studies of the general population and high-risk samples, genetics, and statistics. Thus, it is not the case that interest in organic factors was lacking, but due to Britain’s strong social medicine tradition, an interest in environmental factors such as parenting styles, schools, housing, diet and toxins has gone alongside the focus on individual deficits like genes and brain damage. All this in turn means that approaches to treatment have been multifaceted, combining a number of different things. According to Rutter, “the

²⁵During the 1990s, ADHD in adults became increasingly recognised as a legitimate disorder in the US, partly as a result of repeated publications of follow-up studies documenting the persistence of symptoms in about two thirds of hyperactive children, but also because of pressure from the general public. In the UK, this development is now also well underway, as reflected by the publication of a series of articles on the subject in leading British medical journals and the opening of an adult ADHD-clinic at the Maudsley ([Asherton et al. 2007](#)).

good side of that is that there has been much more concern with people as people and not just treating a symptom with a drug. The down side is that, at its worst, it was sort of a muddled bit of everything, with no proper look at anything. So it's not that things were entirely right either side of the Atlantic" ([Rutter int. 2005](#)). Certainly, few drug studies were conducted in Britain up until the 1990s, least of all in the child area, leading some American professionals to claim that treatment research had been under-prioritised in the UK ([Klein int. 2005](#)).

In comparison, the US has dominated the field of psychopharmacology as well as genetics and neuroscience – areas which have attracted generous funding from the NIMH and the pharmaceutical industry. This is especially true of the ADHD area. Recent research into the disorder can be divided into two different types: the development of cognitive models that highlight faulty information processing, and research into the neurobiological correlates of hyperactivity, in terms of genetic influences as well as structural and biochemical brain abnormalities. These different streams have tended to remain separate from one another, but an overarching thesis eventually emerged, implicating a dysfunction of the fronto-striatal networks linked to attention and response organisation ([Tannock 1998](#), pp. 65-66).

Rather than focusing on hyperactivity and inattention, current cognitive models emphasise the construct of impulsiveness (poor behavioural inhibition), postulating that the failure to inhibit a behavioural response is the central deficit in ADHD. This theory is first and foremost associated with neuropsychologist Russell Barkley, the modern champion of ADHD diagnosis and one of the strongest advocates for a brain dysfunction model and the use of drug treatment. Barkley defines the concept of impulsivity as the relative inability to utilise one's knowledge of delayed consequences. He thus suggests that ADHD arises principally from genetic and neurodevelopmental origins, and represents a failure in the brain circuitry that underlies inhibition and self-control, leading to the disruption a set of abilities known as "executive functions", which are critical for planning and self-regulation ([Barkley 1997; 2006](#)).

While the account of ADHD as a disorder of self-regulation associated with

deficient executive functions and impulse control represents the majority view, alternative explanations have been proposed by researchers who describe ADHD children as being predominantly averse to reward-related delay. Evidence for this “motivational” model comes primarily from choice studies where such children display a greater sensitivity to delay of gratification than their peers. One of the leading proponents of the motivational account is British neuropsychologist Edmund Sonuga-Barke who – together with his American colleague Xavier Castellanos – has recently focused on the default brain network activated during [wakeful](#) rest and engagement in internal tasks as an alternative site for dysfunction in ADHD ([Sonuga-Barke & Castellanos 2007](#)). Furthermore, [Sonuga-Barke \(2002\)](#) is renowned for proposing a reconciliatory “dual pathway” hypothesis of ADHD, which proposes the existence of distinct cognitive (inhibitory and more general executive dysfunction) and motivational (delay aversion) developmental routes to ADHD. The contention is that these two forms of difficulties can occur independently of each other, but when they act together to influence behaviour, the level of impairment is increased.

In addition to using standardised neuropsychological tests, researchers have sought confirmatory evidence for the purported brain function deficits in neuroimaging studies, using CT and MRI scanning as well as new functional imaging techniques that have attracted much attention from the popular media. In the large number of studies conducted since the early 1990s, abnormal volumes have been associated with structures such as the prefrontal cortex, basal ganglia and corpus callosum, with most studies implicating the prefrontal-striatal network as being smaller in children with ADHD ([Castellanos et al. 2002](#)). Functional imaging has also found differences between ADHD patients and controls, among other things in patterns of neurotransmission, but the reported differences have varied, and the studies say little about whether the observed anomalies were present at birth or whether they may have resulted from trauma, chronic stress or other early-childhood experiences ([Leo & Cohen 2003](#)).²⁶ Leading investigators

²⁶An early much publicised NIMH study ([Zametkin et al. 1990](#)) reported that ADHD subjects

acknowledge the limitations of existing brain scan research, but yet emphasise that constant advances are made in the area, and argue that the field of neuroimaging has placed on a considerable firmer foundation the view that ADHD involves impairments in the development of the brain at the embryological stage.

Research on the familial nature of ADHD already started appearing in the 1970s, but it became a subject of increasing attention in the 1990s, reflecting technological advances the fields of behavioural and molecular genetics and the burgeoning interest in the separate and interactive effects of genetic and environmental factors in child psychiatric disorders. Numerous family-genetic studies over the past 30 years have found a higher prevalence of psychopathology, particularly ADHD, in the parents and other relatives of children diagnosed with the disorder, and recently several twin studies have implied a strong genetic basis of ADHD and its behavioural manifestations. However, genetic studies of have also suffered from methodological limitations and biases ([Tannock 1998](#), p. 85). One complicating factor involves the high rate of co-occurrence of conduct, mood and anxiety disorders, as well as learning difficulties. Also important to genetic researchers is the question of whether differences in DNA should be conceptualised simply as representing variation or as genetic defects which identify a behavioural disorder. Lastly, one should note that the familial nature of ADHD does not straightforwardly indicate the involvement of genetic factors as familial aggregation could just as likely be due to a shared family environment as it is to biological inheritance.

Apart from neuroimaging and genetic techniques, the introduction of psychopharmacological agents has been crucial for the understanding and validation of ADHD as a neurobiological disorder. In the 1960s and 1970s, a fast growing number of well-controlled studies demonstrated that stimulants

had reduced glucose metabolism in regions of the brain associated with attention and motor activity. However, there was a considerable overlap between normal and ADHD brains, and follow-up studies by Zametkin himself and other researchers failed to replicate the original findings. Furthermore, excepting one widely touted study by [Castellanos et al. \(2002\)](#), all brain imaging research has been conducted on individuals who have already been exposed to stimulant treatment, thus making it feasible that any abnormalities detected may be due to drug effects ([Leo & Cohen 2003](#)).

immediately improved children's performance on repetitive tasks requiring concentration and diligence. This spurred an increase in drug treatment and led many to conclude that the "brain deficit" hypothesis had been confirmed. Indeed, doctors today still routinely use stimulant drug response to confirm a positive diagnosis of ADHD (NIH 1998; Sroufe 2012). However, it has proven highly unreliable to use drug effects as a guide for specific aetiological factors, and to see drug efficacy as an indicator of pathophysiology (Furman 2009, p. 23). Firstly, research has been unable to conclusively pin-point the precise method of action of stimulants in terms of neurotransmission. Secondly, there is now much to indicate that stimulants generally affect all children and adults in the same way, and that the effects of stimulants on children with attention problems seem to fade after prolonged use (Molina et al. 2009), in spite of expert claims that children with ADHD would not develop such tolerance because their brains were somehow different. Finally, clinical drug trials showing a positive treatment response have tended to be rather short, leading experts in Britain and elsewhere (including the US) to question the evidence for long-term benefits: "So – I slightly caricature, but only slightly – whereas the American approach was, 'OK, it works for six weeks, let's assume it works for six years and let's go for it', the British questioning approach would be to say, 'Well that's all very well, but actually we're dealing with a chronic disorder, so what works over a very brief period of time isn't necessarily a good guide to what happens in the longer term'" (Rutter int. 2005).

Whereas the biological models described above currently dominate expert views of hyperactivity/ADHD, one does not need to look far beyond the scientific mainstream to find alternative and influential environmental discourses with roots back to the hyperactivity critiques of the early 1970s (Gallagher 1970; Conrad 1976; Schrag & Divoky 1975). Some of the theories put forward at this time stressed the effects of poor child rearing techniques, while others promoted the notion of hyperactivity as a cultural product, highlighting society's increasing intolerance of diversity in children, and the effects of growing environmental excitation caused by rapid technological change (Block 1977). Much the same argument was recently rehearsed in DeGrandpre's *Ritalin Nation* (1999) which

criticises America's reliance on performance-enhancing drugs and cautions that Western society's "rapid-fire culture" leaves children especially vulnerable to "sensory addictions". According to this view, the symptoms of ADHD – hyperactivity and an inability to pay attention in class – reflect a kind of escape behaviour used by the child to maintain sensory stimulation. Taking a somewhat different angle, critics like [Timimi \(2005\)](#) has linked the dramatic increase in behaviour and learning disability diagnoses to a fundamental ambivalence in Western culture toward children and boys in particular, emphasising cultural preconditions such as a breakdown in the moral authority of adults, the loss of extended family support, pressure on schools, and a market economy value system that emphasises individuality, competitiveness and independence.²⁷ To these factors he adds a profit-dependent pharmaceutical industry and a high-status profession looking for new roles. Like other bio-psychiatry critics, DeGrandpre and Timimi argue that the great number of neuroscience studies aimed at elucidating the biochemistry and genetic components of ADHD reflect the immense power, resources, and momentum of the pro-ADHD medical establishment, whereas long term studies focusing on more complex causes of behaviour disorders stand little chance of being funded, as government research bodies like the NIMH have largely adopted the "brain-based" agenda.

However, it must be emphasised that neuroscientific research – especially in the UK – is increasingly being combined with the study of psycho-social and other environmental influences and interventions. Leading UK researchers have for example collaborated on the longitudinal English-Romanian Adoptees study of the developmental impact of early institution-based deprivation, exploring among other things the extent to which links between deprivation and long-term outcome are mediated by specific alterations in brain structure and function.²⁸ Moreover, in

²⁷[Diller \(1998\)](#) proposes a more moderate version of this argument, leaving more space for the possibility of biological origins and beneficial effects of drug treatment.

²⁸Led by Michael Rutter and Edmund Sonuga-Barke, the Romanian adoptees study investigates the development of children adopted into the UK from Romania in the early 1990s. So far, assessments have revealed considerable catch-up but significant residual problems, especially amongst those children who experienced the most extended period of institutional care. Problems most characteristic of this group were hyperactivity, difficult attachment, quasi-autistic features

units like the Institute for Disorders of Impulse and Attention, University of Southampton, there is a strong interest in how (grand)parenting style, and the quality of mother-child interaction may moderate developmental risk, as well as a focus on the need to develop effective non-pharmacological treatments, given that the long-term efficacy of medication is unclear, and that many families do not wish to use drug treatments. Alternative interventions currently explored through controlled trials include parent training, delay and executive skills training, and last but not least the removal of artificial food preservatives and colourings from children's diet.

Finally, this brings us to the popular theory of hyperactivity which stresses the effects of diet on child behaviour. Interestingly, like in the current medical model of ADHD, focus here is almost entirely on biological factors, but more on the trigger potential of sugar and various food additives than genes and faulty neurotransmission. The idea of a link between diet and hyperactivity was originally developed in the 1970s by the charismatic American paediatrician and allergist Ben Feingold who posited that hyperactive behaviour could be caused by allergic or toxic reactions to preservatives and synthetic dyes, perhaps in as much as half of all cases ([Feingold 1974](#)). Effective treatment would thus consist in eliminating foods that contained offending substances. In the context of growing public concern with the large amounts of chemicals in the food supply, and the broader climate of suspicion of government and industry within American society during the early 1970s, the Feingold diet generated enormous public interest ([Smith 2011a](#)). As the various American medical associations and top medical journalists were ultimately unwilling to provide Feingold with a venue to disseminate his theory, he increasingly came to disseminate his message via the mainstream media directly to the public, and particularly to parents who were dissatisfied with conventional drug therapies. Soon, parent groups, or "Feingold Associations", were established in nearly every US state, lobbying legislators for stricter controls on food production and advocating diet as a treatment for

and some degree of cognitive impairment.

behavioural and allergic problems in children. Many studies followed which searched for a link between additives and hyperactivity, but they were often poorly designed and the results were contradictory. Nonetheless, the overwhelming opinion which emerged from these trials was that the diet was too cumbersome and moreover ineffective. Following Feingold's death in 1982, medical and media interest in the Feingold diet regime – although not effectively disproven – thus died away.

Like their American colleagues, most British psychiatrists and paediatricians were highly sceptical as to whether diet had any effect. Researchers in the UK were relatively slow to investigate the Feingold diet, partly because the concept of hyperactivity as a discrete childhood behaviour disorder was not prevalent at the time. But from the mid-1980s, a number of studies were done at Great Ormond Street Hospital and elsewhere which clearly showed that some children responded adversely to certain diet items, although the response was not only related to additives as such. In particular, researchers found evidence for the efficacy of a so-called elimination diet in a selective group of children ([Egger et al. 1985](#); [Carter et al. 1993](#); [Hill & Taylor 2001](#)). In the end, these results did not have a big effect on physician attitudes, however; it was among the general British public that the idea of a diet-behaviour link gained the strongest hold, resonating among other things with long-standing middle class concerns about environmental toxins and food safety, as well as a tradition of state-sponsored intervention in the feeding of children. The notion that additives and high-sugar foods can make children overactive, aggressive, or even criminal was taken up regularly by the British press and television during the 1980s and 1990s (see for example [BBC 1992](#); [Cannon 1987](#); [Gibney 1985](#)).²⁹ But public interest grew even further in the early 2000s in the context of new medical research, growing public distrust of drug companies and the food industry, and wider panics over child obesity and behavioural

²⁹Picking up on the wave of interest in the adverse effects of food additives on behaviour, the BBC documentary "Little Monsters" ([1992](#)) covered the research at Great Ormond Street Hospital, and the work of diet-based hyperactivity parent support, HACSG, founded in 1977. It also reported on various projects focusing on the rehabilitation of criminals through nutrition.

problems in school children (Bee 2000; Hansard 2003; Lawrence 2005; Mack 2000; Smithers 2007a; Tracy 2000).

These elements were all present in the influential Channel 4 TV show *Jamie's School Dinners* from 2005, which appeared in the wake of several highly publicised studies showing beneficial effects of fish oils and certain vitamins and minerals on learning and behaviour (Gesch et al. 2002; Richardson & Puri 2002; Richardson & Montgomery 2005). Moreover, bowing to public pressure, the British Food Standards Agency (FSA) issued a call for proposals to test whether the behaviour of children in the general population was affected by food additives. The results of this research, led by Professor Jim Stevenson at the University of Southampton, eventually vindicated Feingold by demonstrating significant adverse effects of artificial colours and preservatives on children's behaviour and concentration (Bateman et al. 2004; McCann et al. 2007). The 2007 trial was published in the *Lancet* and generated a flood of reports in the electronic and print media, indicating how the centre for research and debate regarding Feingold's hypothesis had shifted from one side of the Atlantic to the other (Smith 2011a, p. 158). Nonetheless, the results were also widely reported in the US, where it inspired renewed interest in food additives and hyperactivity in the paediatric profession.

4.6 Towards a globalised child psychiatry

In the mid-1950s, American psychiatrist Fritz Freyhan (1956) complained that American psychiatry residents, unlike their European research-minded counterparts, prepared almost exclusively for psychotherapy. By the 1970s, however, the tables were turning; once they gave up their long flirtation with psychoanalysis and got interested in differential diagnosis and psychopharmacology, the Americans swamped the area with budgets that outranked the British several-fold (Healy 2002, p. 478). In 1981, Michael Shepherd had dismissed the DSM-III, arguing that "serious students will continue to use the ICD", but an empire was already slipping from British hands. The DSM-III was

met with remarkable world-wide interest, and during the 1980s and 1990s intensive international collaborative efforts were undertaken to enhance the compatibility of the two classifications ([Schwab-Stone & Hart 1996](#)). As a result, despite considerable historical rivalry and criticism, the two systems converge considerably in their current editions, DSM-V ([1994](#)) and ICD-10 ([1992](#)). There are still some differences in the child section, among other things in the conceptualisation of hyperactivity as described above, which reflect the traditionally more narrow and conservative British conception of the disorder. But the dissimilarities are slight. As an illustration of the status of the diagnosis in British psychiatry today, it is worth noticing that ADHD (not Hyperkinetic Disorder) is currently listed as a top research priority on the website of the child psychiatry unit at the Maudsley, even if children diagnosed with ADHD in the UK still belong to the more severely affected hyperactive sub-group, and children with purely inattentive behaviour will not usually get a medical diagnosis.

Russell Barkley, one of the world's leading ADHD experts, argues that due to the growth of the internet and the global spread of biomedical models of mental illness, it is actually no longer possible to speak meaningfully about national or regional cultures of hyperactivity management or national cultures of child psychiatry in general:

There was a time when each country had its own view of mental disorders, their causes, and their management... Such walls between different countries' understandings of ADHD are now figuratively crashing down, with the democratizing spread of the internet and the scientific (and non-scientific!) information it can bring to any user. This means that there is no longer going to be an Italian view of ADHD or a U.S. view, but an international view, founded on the most recent advances as they become available... Italian professors, many of whom still practice a psychoanalytic view of childhood disorders as arising from early upbringing, can no longer count on this view going unchallenged by parents... ([Barkley 2006](#), p. 38).

The medical world of hyperactivity/ADHD is now global and full of evidence-based protocols and consensus statements that claim international validity (see for example [Barkley et al. 2002](#)). In many countries, the government and the professional communities have produced guidelines in order to standardise

practice ([Hill & Taylor 2001](#); [NICE 2000](#); [2008](#); [Taylor et al. 1998](#)). In Britain and other European countries, these guidelines refer to both the ICD-10 and DSM-IV criteria, and most of them emphasise that the disorder is generally under-recognised and under-treated. Yet, both estimated and actual rates of hyperactivity diagnosis remain considerably lower in the UK than in the US, and debates in British medical journals and mass media demonstrate that there is still professional as well as public resistance to treating large numbers of children with psychotropic drugs. Even if the scepticism has lessened considerably among doctors in the past decade, theories about the adverse effects of sugar, additives and preservatives on behaviour have a particularly strong resonance in the general population, and the idea of dietary management as an alternative to pharmacological treatments of hyperactivity has attracted much attention in the media. Despite powerful globalising tendencies and all the information now flowing between sites and nations, hyperactivity conceptualisations and treatments clearly continue to differ between places, not just because of the different local historical trajectories of child psychiatry, psychology and paediatrics, but also due to structural variations in health care provision (market-based versus publicly funded), educational policies and practices, and broader public attitudes to children's disruptive behaviour and various forms of therapeutic intervention.

In this connection, it is important to emphasise that developments in Britain are not representative of Europe as a whole. Although the great reluctance to prescribe medication to young people has been a general feature, one finds great variation in attitudes between countries, with the UK veering the most towards the US. In Iceland, children are ten times more likely to be prescribed stimulant drugs than their counterparts in Finland, where hyperactivity is seen as an "everyday educational challenge" rather than a pathology (Zoëga cited in [Smith 2012](#), p. 174-175). In Sweden, ADHD was for a number of years associated with a controversy over a similar, but narrower diagnosis, DAMP (Deficits in Attention, Motor Control and Perception) ([Kärfve 2000](#)), and in Denmark clinicians are now mostly following the British line, meaning that ADHD and Ritalin have become established there, too. However, in Italy and France, where analytical perspectives

are still prevalent in child psychiatry, ADHD was by the start of the 21st century only recognised by a handful of child psychiatrists, methylphenidate not licensed as a treatment, and small groups of parents were fighting to educate the public and teachers about the disorder (Frazetto et al. 2007).³⁰

Also, one cannot overlook the fact that the widespread diagnosis of ADHD continues to engender much public controversy in the US, where Ritalin has been a topic of constant debate since 1970, when a national furore erupted over claims of overmedication in schools (Maynard 1970). In the late 1980s, the debate was reignited when the Church of Scientology-backed organisation, the Citizens Commission on Human Rights, fuelled a massive anti-Ritalin campaign which put doctors on the defensive and called into question the judgement of school administrators. A large number of legal suits were initiated or threatened, resulting in a great deal of national and local negative media publicity, spearheaded by major television talk show hosts like Oprah Winfrey. The media blitz had clear effects; following a well-publicised threatened local lawsuit, a survey showed that the medication rate among public school students declined by 39% in Baltimore County, Maryland, most likely due to parent apprehension about side effects and school staff's fear of potential litigation, as well as increased physician concern (Safer & Krager 1992). Five years later, the media in general exhibited a more positive perspective on the subject, inspired in part by optimism of the major US federal mental health programmes promoting the 1990s as "the decade of the brain", and by successful awareness campaigns organised by advocacy groups like Children and Adults with Attention Deficit Disorder (CHADD) (Safer et al. 1996). In the late 1990s and early 2000s, public suspicion and concern regarding safety were yet again aroused by media and scientific reports of increasing

³⁰See also Kushner (2004) for an interesting account of the differences between French psychogenic views and Anglo-American organic interpretations of Tourette syndrome. The general points made here also apply to other so-called neurodevelopmental diagnoses which are viewed with suspicion in France. This was illustrated very recently by the heated public controversy sparked by Sophie Robert's documentary *Le Mur: la psychoanalyse à l'épreuve de l'autisme* from 2011, which featured interviews with a series of leading French child psychiatrists who still maintained that autism primarily has psychological origins in a dysfunctional mother-child relationship.

“polypharmacy” (the practice of prescribing multiple drugs to children); growing rates of psychotropic drug use in preschoolers (Zito et al. 2000); drug coercion in schools (Burton 2002); and serious adverse effects linked to several popular prescription drugs, including various antidepressants and stimulants.³¹ Since then, commentators have regularly argued that stimulants are over-prescribed, harmful, and ineffective in the long term, while surveys have showed that a large number of people in the US believe that ADHD is often the result of insufficient parenting rather than a biological dysfunction (Dell’Antonia 2012).

Thus, in conclusion, it would be mistaken to simply portray developments since the 1970s as the replacement of local “hyperactivity cultures” with a global, uniform perception of ADHD as a legitimate and fairly common hereditary medical disorder that can be effectively and relatively safely treated with medication, as Barkley and other American top researchers indicate. Such claims are problematised not only by the enduring international differences in outlooks but also by the persistence of considerable *intra*-national differences in attitudes to diagnosis and treatment, particularly in the US, where stimulant use has varied greatly both between and within individual states over time (Griggins 2005; Singh 2006). It is arguably more correct to speak of a general shift in balance between the environmental and biomedical viewpoints, both of which remain influential in varying degrees on each side of the Atlantic.

In addition, it is highly doubtful whether one could ever speak of separate American and British cultures of child psychiatry and psychology, as there has

³¹In the early 2000s, the FDA had to withdraw several popular prescription drugs from the market, as they had been shown to cause serious adverse effects such as heart attacks and muscle damage. This was a public relations disaster for the drug regulation authority, especially since it was revealed that some drug safety reviewers and agency heads were on the payroll of drug companies as consultants and clinical researchers (Mayes et al. 2009, p. 156). As regards the stimulants used in ADHD, controversy has centred on British Shire’s drug Adderall XR, which the Canadian health authorities temporarily suspended in 2005 due to strong concerns that it contributed to heart failure deaths in children. In the US, the FDA allowed sales to continue, but following a long debate during which different advisory panels made contradictory recommendations, the FDA in 2006 ended up ordering all stimulant manufacturers to add black box warnings of possible heart risks to their products. This decision was fought by the major psychiatric professional associations and by parent groups like CHADD, who felt that it would unnecessarily alarm clinicians and patients, thus increasing the risk of non-compliance and future social failure.

been a continuous exchange of people, concepts, and practices across the Atlantic, with influences going both ways. One could list many examples which illustrate this point. In the post-war period, John Bowlby's work on maternal deprivation for instance inspired North American researchers like Mary Ainsworth, who in the 1960s expanded and developed the concepts of attachment theory and enabled empirical testing of its tenets. This attracted many scholars to the field in the US and challenged the dominance of behaviourism there (J. Hill *int.* 2006).³² More famously, from the late 1960s, Michael Rutter and figures such as Lorna Wing, Beate Hermelin, Neil O'Connor and Victor Lotter at the MRC Social Psychiatry Unit had a huge impact on the emerging field of autism research based on epidemiological and statistical methods, notably in transforming the meaning of autism from a psychodynamically informed concept of psychotic withdrawal into fantasy to a developmental disorder associated with various cognitive deficits and language abnormalities. In the mid-1970s, Rutter would also conduct the first-ever genetic study of autism, based on twins.

Compared to autism, British researchers have had much less influence on the hyperactivity field, especially in the period before hyperkinetic disorder became a research priority at the Maudsley under Eric Taylor – and they had no impact on the creation of the ADD/ADHD categories. Indeed, as this thesis shows, many opposed the concept and expressed their views through published opinion pieces. However, in the late 1970s, considerable attention was paid internationally to Rutter's attacks on the "brain damage mythologies" that were taking over from psychological models in the guidance of clinical practice in the US especially (Rutter 1982). The MBD diagnosis was criticised by American authors as well (Rie & Rie 1980), but Rutter's contributions played an important role in bringing down Minimal Brain Dysfunction as a viable scientific concept in child psychiatry as well

³²In fact, British psychiatrist Jonathan Hill argues that Bowlby's work had to go to America in order to be translated into an empirical framework, due to the British empiricist tradition of mistrust in theory and the associated tendency to research small questions in a highly focused, tight manner. In America, they were more comfortable with theory and had a stronger tradition of combining psychoanalytic and biological perspectives. In Hill's reading, this partly explains why research into attachment and the impact of early experience on development took off in the US in a much bigger way (J. Hill *int.* 2006).

as in paediatrics ([P. Hill int. 2005](#); [Schachar int. 2005](#)).

More generally, it is safe to say that British psychiatry has been influential in terms of its early leading role in empirical research, be it epidemiological, clinical, or longitudinal. According to psychiatrist Peter Hill, Rutter and other prominent British researchers effectively exported a way of thinking about child psychiatric conditions as they exist and develop in the real world, rather than as they present in the consulting room ([P. Hill int. 2005](#)).³³ They were much respected by key figures like Leon Eisenberg, especially for the Isle of Wight study. However, in American child psychiatry, it was only in the 1980s after the publication of DSM-III that the scientific influence was truly felt; before that time, the discipline on the whole demonstrated little interest in research and therefore, on the whole, little attention was paid to the body of British work, in spite of its importance and often ground-breaking character ([Klein int. 2005](#)). Furthermore, in the US, the development of child psychiatry as an academic discipline was first and foremost inextricably linked to what was happening in adult psychiatry, where methodology was already a major interest in the 1970s.

It is important to emphasise that Rutter himself had originally been deeply inspired by a number of American researchers who played important roles in the critique of psychoanalysis in the US. Having spent part of his childhood there during the war, he already had strong ties to the US when, in 1961/62 at the urging of Aubrey Lewis, he obtained a fellowship to receive training in child development in New York with psychologist Herbert Birch and psychiatrists Stella Chess and Alexander Thomas, of the famous New York Longitudinal Study on the influence of temperament. This experience constituted a pivotal turning point in Rutter's career, as he was introduced to many international leaders in child psychiatry, including sociologist Lee Robins who later came to shape the development of

³³The epidemiological approaches originating in the Social Psychiatry Unit at the Maudsley and in the work of "biometricians" such as Morton Kramer in Washington built on an interest in developing valid diagnostic criteria. Interestingly, this had unintended consequences in the area of treatment; thus, there is an argument that by delineating psycho-syndromes clearly and establishing their prevalence in the community, epidemiological psychiatrists indirectly did more than anybody else to create larger markets for psychotropic medicines ([Healy 2002](#), p. 138).

diagnostic criteria for DSM-III significantly. Together with psychiatric epidemiologists Ben Pasamanick and Ernest Gruenberg in New York, Robins was instrumental in teaching him about the value of, and methods required for, epidemiological and longitudinal research ([Witness Seminar 2009](#), pp. 24-25).

As regards the creation of the hugely important DSM-III, the British input was negligible. As noted above, the manual was above all an American product of private clinical practice, rather than an official comprehensive classification system like the ICD system, which was designed to improve international comparability in statistics and epidemiological research; DSM-III was a creation of a profession looking for ways to meet health insurance requirements, while also responding to the needs of the burgeoning field of psychopharmacology, and bolstering its scientific credentials by improving reliability. However, its architects – led by “Mid-Atlantics” such as Washington University at St. Louis – were indeed informed by the epidemiological, phenomenological and nosological modalities that characterised Anglo-European psychiatry and would have been familiar with, and inspired by, work done in the UK. Rutter provided an important early contribution in outlining the first a-theoretical classification of child mental health disorders ([Rutter 1965](#)), and during in the 1970s in developing the WHO multi-axial model of diagnosis, which to a certain extent influenced the design of the DSM-III multi-axial scheme.³⁴

With the ICD-10 ([1992](#)), the WHO and American classification systems have become more closely aligned, including the categories of Hyperkinetic Disorder/ADHD. But even though there are still important differences in terms of guidelines on comorbidity and the severity of symptoms required for diagnosis, British diagnostic and treatment modalities have approached those of the US considerably. The question is to which extent this development simply reflects a logical movement towards global consensus on the topic, when one takes into account the dominance of the US in terms of research resources, as well as the drug

³⁴Specifically, the WHO framework led to the decision to put personality disorders and mental disorders on axis II. However, it had no influence on the concept or definition of ADD.

industry's support and promotion of DSM constructs.³⁵ Thus, some argue that the growing prominence of the broader ADHD diagnosis in British psychiatry does not reflect its conceptual superiority so much as its practical usefulness for both clinicians and patients. Further, for researchers around the world, acknowledging and operating with the ADHD concept is a precondition for obtaining research grants and securing publication in high-impact journals.

Ironically, in large measure because of the overwhelming success of DSM, observers of contemporary American psychiatry claim that the study of phenomenology and nosology, which was so important to the Mid-Atlantics, is no longer seen as relevant in the US ([Andreasen 2007](#)). The diagnostic criteria were never meant to form a comprehensive description of the patient's condition, but nonetheless the manual has been given total authority in training programs and health care delivery systems, resulting in a steady decline in the teaching of careful clinical evaluation. According to critics, this has had a dehumanising impact on the practice of psychiatry, with history taking frequently being reduced to the use of DSM checklists. The perceived decline has now become so severe that there is talk of "the death of phenomenology" in the US; a good general knowledge of psychopathology is yet again devalued, but for different reasons than in the era of psychoanalysis. For some, this situation calls for a return to the old values of European psychiatry:

The word is out – if you want to succeed as a serious scientist, you need to do something relatively basic. Fortunately, the Europeans still have a proud tradition of clinical research and descriptive psychopathology. Someday, in the 21st century, after the human genome and the human brain have been mapped, someone may need to organize a reverse Marshall plan so that the Europeans can save American science by helping us figure out who really has schizophrenia or what schizophrenia really is ([Andreasen 2007](#), p. 112).

However, some British specialists claim that by making the mindset of clinicians

³⁵The links between the DSM and the drug industry are exemplified by the finding that 56 out of 170 panel members who contributed to the diagnostic criteria produced for the DSM-IV had one or more financial associations with pharmaceutical companies. All of the members of the panels on mood disorders and schizophrenia and other psychotic disorders had financial ties to drug companies ([Cosgrove et al. 2006](#)).

more rigid and less creative, the DSM has already had a destructive impact on diagnosis and service provision in the UK, too ([Keen int. 2006](#)). Others have compared the strong presence of DSM in Britain to that of McDonalds and other major brands ([Rowe 1999](#); [Timimi 2010](#)), thus echoing the globalisation and Americanisation critiques of the likes of Naomi Klein and her British counterpart, George [Monbiot](#), who in *Captive State* (2000) described how the UK has become increasingly dominated by multinational corporations, to an extent not seen elsewhere in Europe.

Being among the largest and most profitable businesses in the world, drug companies are major drivers of the globalisation process. By consolidating into huge concerns, they have accumulated increasing levels of power and managed to influence not only clinical medicine and research but also patients, regulators, the media, civil servants and politicians. In Britain, a highly critical survey by a cross-party group of MPs concluded that links between the pharmaceutical industry and the UK Department of Health have become so intertwined that the public's health is being put at risk ([House of Commons 2005](#)).³⁶ The report cited multiple failings by the British drug regulatory body (the Medicines and Healthcare products Regulatory Agency) for not scrutinising the data from companies seeking licences for new drugs and for not monitoring side-effects adequately. It also blamed lax controls at the Department of Health for allowing pharmaceutical corporations to expand their influence over the public and the medical profession. These observations mirror those of other British critics who claim that changing prescribing habits are being strongly influenced by the industry's marketing strategies, among other things through the promotion of new diagnoses and a discourse which states that these are under-diagnosed and under-treated ([Healy 1997](#); 2004).³⁷ Some suggest that child psychiatry may be especially vulnerable to

³⁶The Health Committee concluded that evidence received from the Department of Health was remarkable for its denial that any significant conflict between commercial and health objectives might arise that was not properly addressed through existing process and systems. However, their inquiry left them "in no doubt that the scope for conflict between trade and health is huge".

³⁷Child psychiatrist Sami Timimi, for example, reports how he and his colleagues were increasingly invited to conferences to discuss a new treatment, asked to fill in questionnaires about their practice, and to find patients for drug trials, all with financial inducements, while drug

manipulation because of its fragile professional identity, sitting as it does at the intersection of many different systems of knowledge, including the fields of medicine, psychology, sociology, and paediatrics. Seen from this perspective, the move towards biological models and physical treatments has been attractive to sections of the profession that wish to carve out a clearer territory and bolster their claims of authority in managing mental health problems ([Goodman 1997](#); [Timimi 2008](#)).

Nonetheless, within the EU, the influence of the drug industry is still relatively restricted compared to the US, where government intervention in the market has been low. Over the past decade, drug company lobbyists and industry-funded patient groups have made a concerted effort to lower the barriers to direct-to-consumer (DTC) advertising in Europe, but any such hopes have repeatedly been dashed as the European Parliament has voted overwhelmingly against European Commission proposals for new pharmaceutical legislation permitting companies to disseminate product “information” to patients, this despite the fact that the allowed media would have been limited to the internet and specialist health publications ([Humphreys 2009](#)). So far, the culture and market conditions (including drug pricing systems) in Europe remain very different to those in the US, so even though adjustments to current regulations are likely to occur with time, it is difficult to see DTC evolving into the advertising style typified by the US market, also because the European pharmaceutical industry itself has been careful to be seen to distance itself from such an approach ([Yan 2008](#)).

4.7 Conclusion

Picking up the thread from chapter 3, this chapter has examined conceptual developments in the hyperactivity area since 1980 on both sides of the Atlantic,

company representatives send them free samples of screening questionnaires and “educational” material for parents ([Timimi 2008](#)). Moreover, pharmaceutical companies facilitate meetings at plush hotels at which they offer to help local professionals develop “care pathways” for a particular disorder such as ADHD.

culminating in the emergence of a globally dominant biomedical concept of ADHD originating in the US. I have focused particularly on the making of the DSM-III, its initial cool reception in Europe, and the ways in which the DSM and its categories – including ADHD – have gradually gained a foothold in the UK. Compared to the US, British research on hyperactivity during the 1970s and 1980s was based on a more discriminating approach to diagnosis, asking what the differences were between children with hyperactivity and those with anti-social behavioural problems. The real point of contention in that era was the American assumption that hyperactivity was a relatively common *disease*. This was disputed in the UK, where statistical epidemiological studies were central to the efforts to establish the validity of hyperactivity construct, especially in relation to conduct disorder. Initially, key figures like Eric Taylor at the Institute of Psychiatry supported the traditional position that only a narrow concept of hyperactivity was supported by the evidence, but gradually this view changed, and from the early 1990s onwards, the diagnosis was applied to a wider category of difficulties.

The process by which it became clear that American and British medical perceptions of hyperactivity had become seriously disconnected bears much resemblance to the discussions which took place in the 1960s on the transatlantic differences in the conceptualisation and treatment of schizophrenia. The famous US-UK Diagnostic Project on schizophrenia in fact reached almost the same conclusions as the similar but much smaller study on hyperactivity three decades later – namely that the crucial explanation for the observed discrepancies lay primarily in diverging diagnostic systems and physician training. Such studies contributed significantly to the emerging consensus in the UK that doctors were under-diagnosing hyperactivity, with potentially grave consequences for afflicted individuals as well as society.

As I emphasise, American and British/European (child) psychiatry must be seen as an ongoing system of mutual influence through various channels of exchange of people, methods and ideas, rather than as separate entities. Despite the considerable differences, it would be wrong to exaggerate cross-Atlantic contrasts in concepts and practices. Existing historically informed comparisons of

the “psy sectors” in the US and the UK, and the place of hyperactivity within them, have tended to associate British mainstream child psychiatry with psycho-social explanatory models, and the US with a focus on biological research combined with an emphasis on behavioural psychology, psychometric testing, and pharmacological solutions (Ford 1996; Kewley 1998; Ideus 1995; Malacrida 2003). Such accounts are too simplistic, as one finds all these elements in both places, although the balance between them has varied. As regards research on the neurobiology of child mental health disorders, including ADHD, investigators on both sides of the Atlantic have been involved in genetics research, and in brain imaging and neuropsychological studies. The biggest difference concerns work on drugs, of which there has been far more in the US. Another important dissimilarity between the two countries lies in the context in which research has taken place. The influence of drug companies is strong globally, but in the US it is more obvious than elsewhere and has driven the agenda to a greater extent over the past half century. In the UK, with its strong public health tradition, a broader array of possible environmental causes continue to be considered alongside genetic and neurological factors, which in turn means that approaches to treatment remain more eclectic. Further, a difference can be observed in perceptions of what constitutes sufficient evidence, for example in terms of treatment efficacy, where a more sceptical attitude has prevailed in Britain. Once a clinical trial is complete, the British physician will typically draw less sweeping conclusions from it than will his American counterpart, and there is a greater tendency to emphasise potentially troubling side effects, or simply that less medical care may prove to be better.

Since the publication of the DSM-III, international collaboration in child psychiatry has grown immensely. Up until the 1980s, doctors in one Western country often did not even read the medical literature of any country but their own, and as indicated by some interviewees, territorial issues may have been a factor, making it more difficult for a theory or a treatment developed in one country to be accepted in another. But today in the age of evidence-based medicine, anybody working seriously with hyperactivity cannot be unaware of

what is happening elsewhere. Ideas about hyperactivity are now widely circulating within global networks involving news features, high impact scientific journals, international conferences, networks of collaboration, and clinical trials. In addition, practices are becoming homogenised through international classification systems, standardised measuring tools, clinical guidelines, the development of gold standards in drug research, and drug company influence. This has led commentators to claim that while different national traditions or schools may lead to certain issues coming to a head in one place before another, persisting differences between the US and Europe are disappearing, as evidenced for example by the striking similarity between the Texas Medication Algorithm Project (TMAP) and the British NICE guidelines ([Healy 2010](#), p. 207).

Nonetheless, it still seems important to question the claim that national cultures of hyperactivity have in fact ceased to exist and become replaced by one global “science-based” perception, which emphasises neurobiology and drug treatment. ADHD diagnosis and stimulant treatment have not spread in a uniform fashion, and not without sparking resistance and intense debate. Even if psychiatric diagnosis has become increasingly standardised, Western mental health ideologies and practices are still heterogeneous, not only from a cross-Atlantic perspective, but also within the US, which is characterised by vast internal cultural differences, and within Europe, where one finds varying degrees of resistance to the ADHD concept and drug treatment. In the UK, both parents and clinicians have been very reluctant to use medication for emotional and behaviour disorders in children, and today those attitudes have not gone completely. American and European consumers still differ significantly. Thus, in the US the market for psychotropic drugs like antidepressants and stimulants is still an enhancement market to a much higher degree than in Europe where the greatest usage tends to be in poorer areas. Lastly, when considering the claim that near-consensus now prevails internationally on the main features and causes of ADHD, one must not overlook the fact that the playing field is uneven in terms of research resources.

Whereas chapters 3 and 4 have mainly focused on mapping medical debates and practices surrounding HKD/ADHD, the last three chapters of the thesis will

illustrate that one cannot simply explain the long-standing differences between the US and the UK in hyperactivity diagnosis and treatment – and the recent reduction of those differences – as a product of varying physician outlooks and levels of disagreement about classification. To gain a full understanding of historical developments in hyperactivity diagnosis, it is clearly not sufficient to look at the medical sphere in isolation, nor merely to emphasise the pharmaceutical industry's ever-expanding colonisation of new markets. We must also examine how the uptake of psychiatric concepts and diagnoses is shaped by various social and political forces. Indeed, I would argue that recent transformations in approaches to hyperactivity are inextricably linked to a number of social and educational trends, notably the rise of patient/parent power, changing labour markets, and growing concerns about boys' academic underperformance and disruptive behaviour in school.

CHAPTER 5

The school as a site of mental and behavioural health intervention: education and the birth of hyperactivity diagnosis, c. 1900-1980

5.1 Introduction

Throughout the 1970s, Ciba-Geigy adverts for Ritalin appeared in various American medical journals, the majority of which showed the “MBD child” in a school setting and concentrated on the drug’s ability to enhance academic performance. One particularly suggestive example featured a teacher attempting to control a hyperactive boy in a classroom full of otherwise well-behaved and attentive children. The headline “Is MBD why Johnny can’t read?” implicitly referred to Rudolph Flesch’s popular Cold War polemic “Why Johnny Can’t Read” from 1955 which criticised American teaching methods and even characterised them as a threat to democracy (see Fig. [A1](#)). Around that time, numerous books were published on the alleged decline of American education, spurred on by the shock of the Soviet launch of Sputnik and the resulting fears of Soviet intellectual and technological superiority. These geopolitical anxieties were subtly exploited in the advert text:

He can’t sit still for a moment. Doesn’t take direction well. He’s easily frustrated, excitable, often aggressive. He’s got a very short attention span. The

problem seems to be more than the mischief and hyperactivity that occur as a normal phase of growth. All of which makes Johnny a very disruptive influence in the classroom. But the real tragedy is that he is simply not developing basic learning skills. And the failure to learn in these formative years could mean that he'll never catch up. Johnny could become a school dropout. Yet this tragic waste of human potential can be averted. For Johnny is a victim of Minimal Brain Dysfunction, a diagnosable disease entity that generally responds to treatment programs (Ciba-Geigy 1971a).

Several points can be gleaned from the above, the first of which is that paediatric stimulant drug treatment was inextricably linked with issues of schooling and learning from the outset. As described in chapter 3, Ritalin first became the focus of public scrutiny in the US in 1970 when a series of congressional hearings were held following reports that 5-10% of school children in Omaha, Nebraska, were being treated with stimulants (Gallagher 1970). Among other things, the hearing demonstrated a widespread preoccupation with the use of drugs as disciplining tools and as performance enhancers. There was clearly a strong belief in the power of psycho-pharmaceuticals to transform both the individual and the environment, including the learning environment, as well as concern about the use of public schools as sites of various forms of behaviour modification, be it psycho-pharmacological or psychological. The involvement of government in the issue was not just restricted to the federal level; in Michigan, for example, a House Committee was formed in 1974 to investigate "the use and abuse of drugs such as Ritalin in schools to induce behaviour conformity" (Robin & Bosco 1976, p. 142). On a slightly more positive note, an article from *Today's Education* predicted that kindergartens and public schools would soon be turned into high-tech "learning clinics" in which "learning clinicians", supported by biochemical therapists/pharmacists, would work to produce highly skilled graduates with improved personalities, concentration and memory (Shane & Shane 1969, p. 170). In many places across the US, legislators and child development experts worried that the turn to stimulant treatment heralded the coming of a Brave New World in which children were being transformed into obedient robots during their most creative, exploratory years in order to meet the increasing demands of the classroom. In particular, commentators argued over the extent to which teachers

pushed the new treatment – a question which is still central in current hyperactivity debates.

Secondly, the Ritalin advert highlights the proposition that the emergence of childhood hyperactivity as a medical and social problem in the 1960s reflected the Cold War crisis in American education and the effects of the Space Race on the tolerance of troublesome, inattentive behaviour in schools. According to this argument, the true roots of the disorder are to be found not in human genetics, but in a specific, political and ideological place, namely, the United States during the late 1950s and early 1960s. Thus, [Smith \(2010\)](#) suggest that the persistent perception that America was in danger of losing the “brain race” contributed to the growth of hyperactivity diagnoses by problematising behaviours seen to interfere with high educational achievement; by demanding that all children stay in school as long as possible; and by urging that school counsellors be hired to identify difficult children, label their deficiencies, and refer them to physicians for treatment.

No matter how one views the question of the origins of the disorder, it is clear that schools are a key “surface of emergence” of the phenomenon of hyperactivity and other mental health problems, as well as a powerful mediating context for diagnosis and treatment strategies ([Singh 2006](#), p. 451). As children’s disruptive behaviour will typically first become a noticeable and significant problem in the classroom, schools and teachers have always played a crucial role in identifying children with challenging behaviour. Indeed, the medicalisation of child unruliness was initially encouraged in the late 19th century by the introduction of compulsory schooling, which highlighted problems with children who were unable, or unwilling, to conform to the academic or behavioural demands of the universal education system. Today, in the age of ADHD, a common critique is that schools require too much of children at a very young age: they are cutting down on unstructured time, adding to school and homework, and initiating more standardised testing regimes designed to track intellectual progress – demands which are all thought to be particularly difficult to handle for young boys, who therefore tend to dominate this diagnostic category ([Sax 2000](#)).

The current power of examination and remediation practices, including the medication of children for schooling purposes, has a deep and complex history. Originally designed to teach reading, writing and arithmetic, schools in most Western contexts were soon mandated to care not just for children's minds but also for their bodies and their souls, through exercise, meals, basic health screening and moral education. Since the Progressive era, education also became integrated with a medical agenda for the care and prevention of mental illness in children. This is especially true of the US. From the mental hygienists of the 1920s and 1930s to the recent Bush administration's New Freedom Commission, which suggested comprehensive mental health screening of all young school children and adolescents, American child experts and politicians have often concurred in emphasising schools as being uniquely positioned for preventive work and case finding. Thus, [Singh \(2006, p. 444\)](#) has argued that the relatively high level of historical integration in the US amongst school, clinic, government policy and psychiatric theories of child development may have resulted in a uniquely fertile ground for the acceptance of paediatric psychopharmacology.

Conversely – and in keeping with the general observation that inter-professional collaboration has an effect on the degree of medicalisation likely to be implemented ([Conrad & Schneider 1992](#)) – I would suggest that the absence of such an integrated agenda was a key factor in the relatively late turn to ADHD diagnosis and drug treatment in the UK, where the history of special education since 1945 has been characterised by rivalries and mistrust between the educational and medical professions, and where the pressure for ADHD evaluation eventually came from parents, mostly. While school personnel in the US have generally supported, instigated and negotiated the pathway towards medical assessment and treatment, British educators typically resisted the importation of the diagnosis, which was seen as fad with American values and norms attached to it. These negative attitudes toward ADHD have softened markedly over the past 15 years, but considerable scepticism remains. Certainly, the idea of the school as a site for psychiatric intervention in the shape of mental health screening and psychotropic drug dispensing still sits uncomfortably with the teaching profession

as well as the wider UK public.

Examining schools as a key mediating context in relation to ADHD illuminates important questions about cultural variation in the perception and tolerance of young children's disruptive behaviour, educational and developmental goals for children, as well as cultural styles of achieving those goals and treating problem behaviours. Just like clinical understanding of children's behaviours is not necessarily consistent or coherent within a given national context, neither is educational or political opinion on what constitutes a disorder, and how best to manage it. There are clearly inherent problems in making crude generalisations about the culture of schools and schooling in relation to ADHD diagnosis and Ritalin treatment, as regional and local variations can be vast. Nonetheless, it is possible to identify a number of relevant factors that have led to substantial differences in the perception and management of overactive children in American and British schools. In the two following two chapters, I will suggest that these factors include 1) the degree of overlap between medical, educational, and parental understandings of children's behaviour; 2) divergent policies and attitudes surrounding disability "rights" and the use of medical labels in education; 3) varying emphases on individual competitiveness and performance in terms of measurable scholastic achievement; and 4) the relative reliance on medicine and technology to solve human problems and improve performance. At the same time, the increasing similarities between the two countries' educational policies, for example in the importance placed on market-oriented reforms, will also be explored.

Spanning the period between the turn of the 19th century and the release of the British 1981 Education Act, the present chapter starts by providing a general account of the historical emergence of various categories of mental and behavioural deficiency following the introduction of compulsory schooling. Next, it examines the development of mental hygiene and progressive educational approaches in the interwar period, as well as the growing focus on the problem of maladjusted children on both sides of the Atlantic in the context of World War II. Having thus set the stage for the rise of hyperactivity in the US in the post-war

period, I explore how school personnel were established as the primary instigators of the diagnostic process. Focus is on the impact of the National Defense Education Act of 1958, which called for higher academic excellence, and flooded schools with psychologists and guidance counsellors armed with normative tests.

Moving on to the tumultuous years of the 1960s and 1970s, I will look at the centrality of the issue of race in the early American public debates about hyperactivity/Ritalin, and the corresponding debates about social class inequalities and the unfair treatment of Afro-Caribbean youth in the British education system. For the US, I also examine the rise of the influential learning disabilities movement, which significantly influenced legislation on disabled children's federally mandated right to special services and accommodations in the normal classroom – an achievement that helped pave the way for ADHD to be officially recognised as a separate educational disability in the early 1990s. Here, it is interesting to compare with the UK, where parent and community involvement in the legislative process was much less marked. While the 1981 Education Act similarly aimed to increase inclusion, it remained more open to the option of segregation or expulsion, and local authorities were given considerable freedom in determining eligibility and the level of services provided. Furthermore, it sanctioned a process of de-medicalisation of special education, which located the assessment and management of difficult pupils primarily within the educational context. Eventually, in the 1990s, these developments would have important implications for the identification of ADHD children in British schools.

5.2 The emergence of the deficient child in the context of compulsory schooling

During the last decades of the 19th century and the early years of the 20th century, children's mental deficiencies and disruptive behaviours became the objects of increasing public, educational, and medical concern in the US and Europe. The social and political context of this development was the rapid urbanisation and industrialisation which had taken place over the course of the century, and, most

importantly, the recent introduction of compulsory popular education and the formalisation of teacher training. Through the application of a pedagogical regime with restrictive rules for learning, speech, competence and behaviour, school brought into focus all kinds of learning difficulties and deviant behaviour in children. On the other hand, schools also provided the conditions that allowed for the generalisation of clinical observations to encompass large numbers of individuals. In the years following the implementation of nationwide systems of compulsory elementary education in Western nations¹, new child pathologies were discovered by paediatricians and psychiatrists who, across terminological and theoretical differences, presented similar accounts: some children, though apparently endowed with normal or near-normal intellectual capacities, were found to be unstable and unable to control their behaviour and pay attention for any length of time. As described in chapter 2, one such physician was George Frederic Still, professor of children's diseases at King's College Hospital in London. In three lectures delivered to the Royal College of Physicians (Still 1902), Still explicitly distinguished "defects of moral control" from contemporary popular categories like idiocy, imbecility or insanity, finding that the symptoms became more pronounced in the school setting, where these children appeared to be unresponsive to punishment.

The advocates of mass education came primarily from the ascending metropolitan elites who were concerned about the widespread illiteracy in the

¹Until the 1840s, education in the US was highly localised and available only to people with means. Prominent among reformers advocating universal public schooling was Horace Mann, secretary of education in Massachusetts, who worked to create a state-wide training programme for professional teachers, based on the model of "common schools", referring to the belief that everyone was entitled to the same content in education. Massachusetts passed the first compulsory school attendance laws in 1852, followed by New York in 1853 (Osgood 2008, p. 6). Arguing that universal public education was the best way to turn the nation's children into disciplined, judicious citizens, Mann won widespread approval from modernisers. However, it was still very difficult to translate the concept into practice because of political upheavals, vast immigration, and economic transformations. In 1900, 34 states had compulsory schooling laws, 30 of which required attendance until age 14 or higher, but not until 1918 did every state required students to complete at least elementary school. Across the Atlantic, England and Wales were among the last areas in Europe to adopt a compulsory system, after the Elementary Education Act of 1870 paved the way by establishing school boards to set up schools in any places that did not have adequate provision. Attendance was made compulsory until age 10 in 1880.

population and about the public disorder accompanying the industrialisation and urbanisation process. In the context of the social crises and ideological ferment of the time, schools began to be seen as institutions that could moralise the poor masses, provide a substitute for a home environment presumed to be deficient, and instil a sense of belonging to the newly formed national communities (Brancaccio 2000, p. 167). In other words, mass education was primarily intended as a means for propagating civic virtues, and instilling appropriate work habits. In the US especially, because of the diversification on the country's population and the mass concentration of immigrants in the cities, the nation's schoolhouses were increasingly charged to assume a role as social service and acculturation agencies, the argument being that they would naturally take lead in guiding children from all kinds of backgrounds down paths that ensured public safety, economic stability and cultural integrity (Osgood 2008, pp. 6-7).

By the end of the 19th century, most American states and European countries had managed to place the majority of their child population in some form of classroom. Schools were spatially organised in a way that allowed for the education of the greatest number at the minimal cost; every child was assigned a place in a row, to allow total visibility to the teacher in charge of each group, and the individual method, where every child was taught in turn by the teacher, was abandoned in favour of the simultaneous method, in which children were all taught at the same time (Brancaccio 2000, p. 169). This method required that virtually all pupils would be able and willing to understand and comply with their teachers' instructions at the same pace, and that they would sit still at their designated place during the lesson. However, in reality, this structure meant that hearing, sight and speech defects that would have previously passed unnoticed, or considered simply a misfortune, became problems in need of evaluation and management, as did children considered an impairment to effectiveness and a drain on teachers' time and energies, namely those categorised as "mentally deficient", "feeble-minded", "dull" or "backward".²

²The term "feeble-minded" was used from the late 19th century in Britain, Europe and the US to

Pupils' lack of discipline attracted increasing attention as it generated immediate problems for teachers who had difficulties imposing behavioural standards and a rigid time schedule on children accustomed to different lifestyles, conceptions of time, and forms of conduct. Pupils who were difficult to manage, even more so than slow learners, were both an impediment to classroom activities and a dangerous example for others to follow, and hence a threat to the teacher's authority and the school's civilising mission. However, there was no easy solution to the problem of disruptive children, if they were not manifestly mentally ill, mentally retarded, or obviously delinquent. They needed to be managed in a way that reflected consideration for the intrinsic objectives of the education service, which was to civilise as many as possible, but the issue of unfit pupils also had an important economic dimension, as school administrators had to be careful not to exceed their budgets (Ford et al. 1982, p. 40). A viable solution appeared to be the creation of a parallel system of education within the public schooling system for difficult and slow pupils, along the lines of the already existing model of special provisions for blind, deaf and dumb children – a notion which subsequently led to the creation of specialised medico-pedagogical surveys and commissions on feeble-mindedness and other mental deficiencies, and also to the establishment of various special educational provisions for this category of children on both sides of the Atlantic.

In the UK, it was made obligatory for local authorities to provide educational classes for the feeble-minded with the 1914 Elementary Education (Defective and Epileptic Children) Act, but at this point classes and schools for the mentally defective had already existed in the cities and larger towns for quite some time

refer to a mild form of "mental deficiency". Within the umbrella concept of mental deficiency, doctors established a hierarchy, ranging from "idiocy" through "imbecility" to "feeble-mindedness" at the highest end of functioning. During the 1890s, doctors, teachers, politicians, and social reformers focused increasingly on the feeble-minded, who were thought to be the root cause of much social disease: they were criminal, negligent parents of hordes of illegitimate children, bearers of disease, and the primary source of poverty and racial degeneration (Jackson 2000). The perceived threat of the feeble-minded stemmed not only from their combined mental, physical, and social pathologies but also from their ability to evade recognition and to transmit their disabilities to the next generation.

(Hendrick 2003a, pp. 52-55).³ In the US, apart from classes for the deaf and partially-sighted, so-called “ungraded” classes for low achievers, truants, and recalcitrant children started appearing from the 1870s in cities like New Haven, Boston, Baltimore, Philadelphia, Detroit, Chicago and Los Angeles. Functioning as de-facto dumping grounds for poor, unkempt and disorderly pupils who were struggling academically or behaviourally, these arrangements allowed unruly elements to be removed from the regular classroom (Winzer 1993, pp. 320-321). The system in this way acted as a safety valve for an increasingly stratified and rigid school system, one that was designed for uniform performance but concurrently faced with the harsh realities of widely divergent cultures, backgrounds, needs and abilities among its students. Around the turn of the century, as administrators began to use more complex and sophisticated methods of identification, the classes became increasingly subdivided, for example into those for the merely “backward”, the “feeble-minded”, the chronically ill, and for immigrant children who did not speak English (often immigrants ended up with the backward, however). Thus, over the next twenty years, segregated “special classes” for a variety of conditions became a standard feature of public education in most large school systems and in some smaller cities in the US (Osgood 2008, pp. 11-12).

Both in the US and the UK, the importance of segregating feeble-minded children from normal education was emphasised, along with the need to distinguish the “educable” from the “ineducable”, so that children who might eventually benefit from pedagogical intervention could be separated from the unredeemable who required an alternative form of reformatory intervention (Hayes 2008, p. 98; Richardson 1989, p. 55). As regards the necessary task of detecting and classifying the heterogeneous group of “defective” children attending school, it is not surprising that doctors and psychiatrists were consulted as the main experts in the field. Physicians had already made inroads into the

³By 1897, London had 24 special schools for mentally defective children, and other schools and classes were to be found in other cities, providing for a grand total of 1300 pupils (Hendrick 2003a, p. 52).

educational system through campaigns for the sanitation of the school environment in the context of the hygienist movement, and since the early days of public schooling, they had debated deleterious effects of overcrowded classrooms upon the physical and mental development of children, while emphasising the dangers of poor health and malnutrition among working class children especially (Ford et al. 1982, p. 42). Further, some active members of the medical and psychiatric professions had started to advocate that large surveys be conducted in order to ascertain the number of defective children attending school and to plan special educational facilities (Brancaccio 2000, pp. 172-173). At this point, doctors and psychiatrists were also the only professional groups in a position to demand new provisions. Psychologists, who became active in the same field in the 1890s, were still organising themselves as a profession, and only gained significant power and official recognition as experts in the area following the introduction of the Simon-Binet Scale in 1905, which became a crucial tool for identifying and classifying problem children in the classroom setting in both Europe and America (Hayes 2008, p. 96).

In terms of causation, theories of degeneration and evolution, as well as the pathologies observed in young people in asylums, played a prominent role in the emerging medical literature on child behavioural pathology. Often, doctors interpreted persistent and excessive overactivity, distractibility, and impulsiveness as more tenuous manifestations of convulsive pathologies such as epilepsy, chorea, and hysteria, which at the time elicited great psychiatric interest for their apparent similarity to forms of conducts considered deviant (Brancaccio 2000, p. 176). While the presumed aetiology was similar – a hidden degenerative process – the most remarkable change was that severely disruptive behaviour in children was increasingly described with reference to school disciplinary norms of conduct. Medical discussions of the issue also mentioned environmental and social conditions such as poverty and alcoholism as possible aetiological factors, but they were mostly perceived as further evidence of the weight of a morbid heredity factor. Hereditary, evolutionist and environmental arguments therefore mutually reinforced each other in viewing pathological lack of discipline among “morally

deficient” children as a disorder that predominantly concerned the lower social strata. These children were in other words seen to reproduce on a small scale the behaviour and the psychological make-up considered distinctive of the lower orders and dangerous classes: morbid excitability, impulsivity, unpredictability and inability to concentrate.

5.3 Mental hygiene, progressive education, and the maladjusted child

During the second decade of the 20th century, biological explanations gradually became less central and medical interest in relational and social approaches that might account for disruptive child behaviour grew. Although severe manifestations of unruliness still evoked the spectre of tainted constitutions, physicians increasingly linked the most common forms of child behavioural problems to family- and emotional dynamics, especially following the successful treatment of shell shocked soldiers with psychological therapies during World War I. In the interwar period, the discourse of psychiatry moved ever closer to the arguments of social medicine in terms of its focus on prevention. Thus, psychiatrists extended their observation to minor forms of mental distress and sensitised parents and teachers to the long-term impact that minor disorders could have on children’s lives ([Brancaccio 2001](#), p. 106).

The new trend first emerged in the US in the early years of the 20th century with the formation of the mental hygiene movement, which would go on to have a big impact on mental health care and public perceptions of mental illness in America and Europe. By the mid 1920s, committees for mental hygiene were active in many Western countries, where they were instrumental in setting up a new type of community-based institution for the prevention and diagnosis of child mental disorders – the child guidance clinic – which from the outset had strong ties to schools. In this context, new categories of problematic children emerged, including the “anxious”, the “maladjusted”, and the “difficult” child ([Hayes 2008](#), pp. 109-110). The clinics were important in spreading the vision of the child as a

person with a mental and emotional interiority, requiring careful and sensitive management if it were to grow into a mature and healthy adult. The message of the “new psychology” was that besides the regulation of habits and morals, sympathetic consideration should be given to anxieties, fears, wishes and aspirations. If any of these were ignored, the result might be either troubled or troublesome children (Hendrick 2003b, p. 216).

Mental hygiene greatly overlapped with the new progressive education movement, which similarly stressed the importance of understanding the child’s individual context, the need for freedom from intimidation, and the idea of learning as a social process in which teachers would ideally adopt the role of facilitator or guide, and students would be allowed to experience and interact with the curriculum. At a time when many were fearful of what appeared to be growing political and personal violence, both perspectives promised to enhance social cohesion and individual harmony. Particularly in the US, the mental hygiene movement was highly influential in the area of schooling. Combining psychoanalytic premises with a biomedical understanding of disease prevention, the National Committee of Mental Hygiene (NCMH)⁴ thus became the driving force behind what Sol Cohen (1983) has called the “medicalisation of American education”, meaning the enduring “infiltration of psychiatric norms, concepts, and categories of discourse [...] into virtually all aspects of American education in this century, epitomized in the idea of the school’s responsibility for children’s personality development” (p. 124). The NCMH sought to achieve this aim not only by increasing the number of psychiatrists, psychologists, social workers, and counsellors in the schools, but first and foremost by reshaping attitudes in the teaching profession and the wider public toward learning and education. According to Cohen, the hygienists formulated a lasting medical model of schooling, including the view of “the school as child psychiatric clinic; every child

⁴The NCMH was founded in 1909 by a number of leading psychiatrists and Clifford Beers, a former asylum patient, with the initial aim of improving conditions in asylums. The NCMH later merged with several other organisations to become the National Association for Mental Health in 1950.

a “problem”; the teacher as clinician-therapist; the general ambience of the class period as that of a therapeutic hour; and the goal – the adjustment of children’s personality” (p. 131).⁵ Fundamentally, this required a change in teachers’ perception of what constituted problem behaviour in the classroom, from the aggressive child who overtly misbehaved to the quiet, timid, or shy child who showed symptoms of emotional maladjustment but was easily overlooked and neglected.

In the UK, educator and psychologist Susan Isaacs was a major force in the movements for mental hygiene and progressive education. In numerous books and papers, Isaacs integrated the new psychoanalytic ideas with the child-centred trends in the schooling of young children that had been in progress since the end of the 19th century.⁶ Further, through popular advice columns on child rearing, she advised parents and teachers to be tolerant and accepting of children and their unique perspectives (Hendrick 2003b, p. 217). With her fellow European and American progressive thinkers, she shared a commitment to the psychodynamic vision of education and child guidance as a humanising force for the development of the psychologically integrated personality and thus for the health of society. However, although the same trends were present on the two sides of the Atlantic, there were significant “differences of quantity and tempo” (Lewis 1953). The mental hygiene movement had much greater status and popular reach in the US, where it quickly entered the fabric of everyday life – including the schools – in a way unparalleled elsewhere. Although the clinical effectiveness of child guidance

⁵While Cohen’s account focused on the 1920s and 1930s, Petrina (2006) has recently argued that the medicalisation of American education was already extensive and diversified when the first child guidance clinics were established. He thus describes various practices through which schools were medicalised during the 1890s and early 1900s: intelligence tests, medical inspections, vaccinations, physical education and instruction in hygiene, school meals, hygiene of instruction (deriving from concerns with study-induced fatigue), school sanitation modelled on the clinic and hospital, clinical psychology, and the investigation and medical management of “nervous children” with patent medicines. Indeed, by 1917, education was already sufficiently subjugated to allopathic medicine that Life Magazine in a cartoon depicted the public school as a clinic charged with the mandate of “medical moralization” (Fig. A10, taken from Petrina 2006, p. 509).

⁶Apart from the educational theories of American philosopher and psychologist John Dewey, these included the German Froebelian kindergarten movement, the nursery school campaigns of Margaret McMillan, and the ideas of the Italian educationist and psychiatrist, Maria Montessori.

would eventually be questioned, the general ideas behind it were widely disseminated throughout society via various media ([Horn 1989](#), p. 177). In Britain, one did not find quite the same therapeutic zeal, although the new pedagogy had considerable impact on the schooling of young children, through figures like Isaacs and Montessori ([Thomson 2006](#), pp. 121-122).

Indeed, the most prominent examples of “therapeutic education” in the UK could be observed in the independent special schools which sprang up during the interwar period and were generally characterised by a radical philosophy that conflicted with the mental hygiene approach in important ways ([Thomson 2006](#), pp. 122-123). As psychiatric-led child guidance was becoming firmly established in the US in the early 1920s, an alternative perspective developed in Britain amongst a number of lay educationalists who argued that maladjusted behaviour was a normal and understandable reaction to hostile and abusive environments. Primary amongst these unconventional individuals were Alexander S. Neill and Otto Shaw whose residential “therapeutic communities”, Summerhill and Redhill⁷, provided seminal models for those seeking new educational methods for dealing with those severely maladjusted children others had not been able to help or manage. Such schools developed before and alongside child guidance in the UK, serving to both complement and challenge the clinic-based techniques imported from the US ([Hayes 2008](#), pp. 219-220). Common factors included Freudian and Kleinian psychodynamic theories and the belief in the significance of the child’s domestic environment. In other ways, however, the approaches of the so-called “pioneer workers with maladjusted children” were quite different since they provided a model which did not engage with the mental hygiene view of maladjustment as a symptom of existing or potential mental abnormality, but saw such children as individuals who had been failed by the adults in their lives, and whose challenging behaviour was a reflection of a lack of love, affection and

⁷Neill founded Summerhill School outside Lyme Regis, Dorset, in 1923. In 1927, it moved to its present site in Leiston, Suffolk, where it remains open and continues to follow Neill’s educational philosophy to this day. Redhill School in Kent was opened by Shaw in 1934. However, it closed in 1992.

respect in their upbringing.⁸ The primary aim was to help children build self-respect, personal independence, and self-worth, while channelling negative and destructive energy into worthwhile activities which could ensure their positions as valuable adult members of society. Among the key strategies developed were the concept of self-governance; a rejection of formal physical punishment; the establishment of therapeutic groups; and a focus on the importance of affection. Considered by contemporaries as radical and controversial, these ideas originated through the work of US-born but British-based teacher Homer Lane, who was A. S. Neill's mentor.

Like Bertrand Russell and his wife Dora at Beacon Hill School, Neill was viewed as an eccentric, and Summerhill was to become quite notorious for supposedly letting children do anything they pleased. His vision had a deeply romantic dimension, both in the goal of liberating individual development, and in the idea of a self-realisation that transcended the materialist, atomised individualism of industrial civilisation (Thomson 2006, pp. 121-122).⁹ Neill was deeply influenced by the "new psychology" but advocated an eclectic approach which was not tied to any particular dogma. In contrast to the interpretations developing in the US at that time, which emphasised medical models of maladjustment as a pre-psychotic and pre-neurotic condition, he stated that "the only curing that should be practiced is the curing of unhappiness" (Hayes 2008, p. 202). Happiness, he felt, grew from a sense of personal freedom, and it was the

⁸The history of the development of progressive education for maladjusted children has been explored extensively in Maurice Bridgeland's important study, *Pioneer Work with Maladjusted Children*, published in 1971. First and foremost, he documented how the work was largely dependent upon the individual personalities and visions of the key pioneers.

⁹Thomson (2006, p. 138) argues that the acute loss the UK experienced in World War I may have fostered a particular psychological culture as a result, that helps explain the contrast to the behaviourist emphasis in the US, where the war was a less traumatic experience for most of the population. In Britain, the war shattered optimism about human nature. Out of it therefore came an interest in the psychological origins in the child of both love and hate, and it directed a generation of psychologists to explore the psychology of loss and attachment. Whereas the "new psychology", with its focus on man's hidden drives, catered to such interests, behaviourism did not. The behaviourism of American psychologist J. B. Watson was generally not well received in the UK. Being essentially a psychology of control, it was, according to Thomson, too markedly out of line with the British attraction to a psychological subjectivity of self-realisation, and its determinism and materialism resonated poorly with the interest in the spiritual and moral dimensions of psychological development that was so strong in Britain during this period.

deprivation of this sense of freedom during childhood which in his view was responsible for many of the psychological disorders of adulthood.

Following the models set by Neill and Lane, Shaw based Redhill School around systems of self-government and social discipline decided by student committee, but in contrast to Summerhill, entry was limited to disturbed children with high intelligence. Psychotherapy was also a primary feature of the school, with Shaw carrying out formal psychoanalysis of pupils. The belief was that successful therapy would release the children's full potential, so that they could go on to live balanced and contented lives.¹⁰ Similar experimental schools were established in the 1920s and 1930s, including Dartington Hall School in Devon and Dunnow Hall School in Yorkshire. Yet, it would eventually prove difficult to replicate the good results of these unique institutions in the larger state-funded special schools that were established throughout the UK after World War II, in response to the demand for placements for the fast increasing number of children categorised as maladjusted following the inclusion of the condition as a statutory handicap in 1945 (*ibid*, 297-298).

In the immediate post-war years, the issue of child maladjustment attracted a great deal of attention on both sides of the Atlantic. Among the central themes in the professional and popular literature were the psychological effects of separation on personality development, the importance of democratic child rearing, and the propriety of the mother-child relationship. During the 1940s, American psychiatrists like Rene Spitz and William Goldfarb were the first to draw attention to the lasting damaging effects of "maternal deprivation" in institutionalised children. Significantly, this body of work would be further publicised by British psychoanalyst John Bowlby who was propelled into international fame by the WHO monograph *Maternal Care and Mental Health* (1951).¹¹ The other American

¹⁰Famously, Shaw once stated that the only way to really judge the success and effectiveness of the school would be to find out what kind of parents the former students eventually made – a parameter which would not sit well with present governmental inspection systems ([Cooper int. 2005](#)).

¹¹Later reprinted in an abridged form as *Child Care and the Growth of Love*, the monograph eventually sold over 400,000 copies in the English edition alone and was translated into fourteen languages ([Neve & Turner 2002](#), p. 389).

major influence on the prevailing emotional standard was the permissive theories being advocated in the childrearing literature, in reaction to the strict behaviourist approach of developmentalists such as American psychologist J. B. Watson. Prompted by war and fear of the consequences of authoritarian regimes such as fascism and communism, this new philosophy promoted liberal parent-child relations and, in doing so, added to the significance attached to the family environment.

In the US, the swing against Watsonian behaviourism began in the late 1930s and culminated in Benjamin Spock's influential *The Common Sense Book of Baby and Child Care*, published in 1946. Belonging to a generation which was deeply affected by the Depression and the rise of totalitarian regimes, Spock felt that it was necessary to create a more cooperative and consensus-orientated society. He therefore developed a "democratic" model of child-rearing based on the writings of American social psychologist Kurt Lewin, whose ideas would also figure in John Bowlby's political thinking (Hendrick 2003b, pp. 218-219). As Director of the Department of Children and Parents at the Tavistock Clinic in London, Bowlby was closely associated with the medical and political objectives of the "Tavistock Programme" and the growing international interest in mental health in the post-war period. Put briefly, the "Tavistock Programme" propounded that the psychological sciences, working in common with sociology, should attend not only to mental illness, but also help structure human relationships to promote health, harmony, productivity, and stability – all through the development of an individual's emotional maturity.

In the UK, a particularly important context for the growing awareness of, and interest in, child emotional disturbance was provided by the various wartime evacuation schemes which offered educationalists and mental health professionals unique opportunities to observe several hundred thousand children. The *Cambridge Evacuation Survey*, under the editorship of Susan Isaacs, stressed the theme of much of the research, namely the significance of family ties and of feelings of parents and children towards one another. As Nikolas Rose (1990, pp. 163-164) has noted, the distinguishing feature of such studies was that they

showed how fragile was the life of “normal”, non-institutionalised children. An important consequence of the war and the evacuation experience was the political centring of the nuclear family, and particularly the mother, as the anchor of psycho-social adjustment. In its pursuit of this stabilising outcome, the government made great use of the theory of maternal deprivation, which appeared in reports and surveys and informed child welfare policies throughout the 1950s and 1960s (ibid, pp. 179-180).

The increasing focus on maladjustment and its long-term implications for an individual’s social, occupational and economic future was also reflected in British educational legislation. In 1944, the education system in England and Wales was revolutionised by the introduction of a new Education Act which introduced a tripartite system consisting of primary, secondary and further education.¹² Secondary level education would be provided through grammar schools, technical schools and secondary modern schools, the selection for which was to depend on the ability and aptitude of individual students, rather than wealth and social status. Further, the new Act promised to change official approaches to children with learning, emotional, and behavioural problems by imposing new legal obligations on local education authorities to make provision for disabled and handicapped pupils. Significant changes were thus introduced in the 1945 handicap regulations, which extended the previous list of recognised disability categories from five to eleven, and included maladjustment as a statutory handicap.¹³ Apart from reflecting interest in the effects of evacuation, the formal recognition of maladjustment as a disabling condition requiring remediation was consistent with wider social and political developments, namely the progressive equal opportunity aims of post-war Labour politicians, but also the expressed, and less charitable, concern for the production of socially valuable, industrious future “citizens” (Hendrick 2003b, p. 224).

¹²Similar Acts were passed for Scotland and Northern Ireland in 1945 and 1947, respectively.

¹³Partially sighted and partially hearing children were separated from the blind and deaf; delicate, diabetic, epileptic, and physically handicapped formed four separate categories; educationally defective or “feeble-minded” children became educationally subnormal; and two new categories – speech defect and maladjustment – were created (Tomlinson 1982, p. 50).

Significantly, the fact that the category appeared within educational legislation, rather than within any medical diagnostic listing, signalled the beginning of a process in which dominance of the professional field was increasingly claimed by educational psychologists, and emphasis in terms of management strategies shifted from psychiatric intervention towards “special education treatment” (Hayes 2008, p. 282).¹⁴ This development was based on the growing belief that adjustments made to a child’s educational environment, alongside the pre-war emphasis on improving the domestic situation, would solve a range of social, emotional and behavioural problems.

5.4 Sputnik and the origins of hyperactivity disorder in the US

As described above, focus among child mental health professionals throughout the 1940s was on emotionally immature or unstable children – particularly boys – and the threat they posed to the future of the democratic society. Often, this concern was closely associated with a trenchant political and moral critique of mothers and their relationship with their sons (Singh 2002a). However, with the escalation of the Cold War, a shift occurred in the US with respect to the behavioural characteristics deemed to be most pernicious by physicians, politicians, and educators; as the premium on intellectual achievement increased, the most acute anxiety swung from withdrawn and neurotic children to excessively active, undisciplined children. By the end of the 1950s, both professional and popular child rearing advice had moved away from talk about maternal instincts and permissiveness and had embraced a different agenda, focusing on two interrelated

¹⁴The profession of psychology was noticeably strengthened by the expansion of special education and the introduction of the tripartite system under the 1944 Education Act. This was demonstrated by the increased presence of psychologists within the Child Guidance Service, the growth of the School Psychological Service, and the increasing numbers of educational psychologists employed by local education authorities to interpret the psychometric tests used to classify pupils into the three ability groups. In the inter-war period, educational psychology had made only limited inroads into the education system. By the start of the World War II, ten educational psychologists had been appointed in different areas, but by 1955 the number had risen to 140 (Hayes 2008, pp. 300-301).

topics: normalcy and discipline (ibid, p. 584). In this context, American school personnel arguably became instrumental in identifying and constructing overactive, inattentive and impulsive children as a discrete category of problem children, who, due to the concurrent revival of biological psychiatry, would increasingly be referred to physicians for medical treatment with stimulants.

The post-war period brought momentous social and economical changes to American life and society, including education. The most apparent development was the great expansion of the middle class, fuelled by the burgeoning wartime industries and the increased socioeconomic mobility they promoted. Further, it is difficult to overestimate the impact of the so-called “baby boom”, which had serious implications for American public schools. Due to the associated relocation of predominantly white, well-to-do professionals to the suburbs, many new schools were built here during the 1950s, while inner-city schools, with their predominantly black, disadvantaged pupils, began to deteriorate ([Gutek 1986](#), pp. 257-259). American higher education also experienced an unprecedented expansion in enrolment, facilities and faculty following the war. While higher education in most Western countries remained highly selective and admitted only an elite minority of their college-age population, American state colleges and universities in the post-war decades became increasingly popular mass institutions, so that, by 1970, 60% of youth aged 18 to 21 were enrolled in college-degree programmes (ibid, p. 282). To a large extent, this development reflected the transformation of the nation’s industries into large, sophisticated corporations that required a sizeable educated workforce of technicians, planners, marketing experts, engineers and managers.

However, while American society enjoyed a new affluence and optimism, the first years of peace soon gave way to the international and national conflicts generated by the Cold War, which came to exert a growing influence on domestic US schooling policy. Education was the battleground on which the Cold War would be won or lost, and following the shock of the launch of space satellite Sputnik in 1957, the fear was that the Soviets were winning. Broadening the already existing debate over the quality and conditions of American public education, Sputnik

stimulated widespread demands for more ambitious academic goals and programmes; in discussions over priorities, it became accepted that if the US were to meet the Soviet challenge, then it had to improve its scientific, engineering and technological capabilities, and this required a curricular shift to basic sciences and mathematics ([Smith 2011b](#)).

During the mid-1950s, a number of educational critics appeared, calling for reforms and asserting that academic and moral standards had been eroded in American public schools. Occupying various ideological standpoints, they all agreed that American education had suffered under the influence of the experimentalist educational philosophy of John Dewey and the permissive “fun and games” approach of child-centred progressive education, with its focus on concepts such as socialisation and “life adjustment”. The suggested solution was to institute a more rigorous, standardised system in which firm, federally-established objectives would be set out for students to achieve, especially in core subjects such as English, mathematics, foreign languages and science. One of the leading critics was Admiral Hyman G. Rickover, father of the nuclear submarine. In testimonies before congressional committees and in articles, books, and speeches, he unfavourably compared the academic abilities of American students to those of their European and Russian counterparts, and proposed a general reform programme. In order to train a technologically sophisticated workforce, Rickover argued, more high school graduates and more hours of classes and homework were needed ([Rickover 1963](#), p. 71). Dropping out of school to find unskilled work was also no longer considered an option, not just because this represented a waste of human potential, but mainly because premature school failure was simply considered a matter of national security in an increasingly competitive world.

Prompted eventually by the mood of national crisis brought on by the launch of Sputnik, federal commitment to improve and finance public education expanded significantly when Congress passed the National Defense Education Act (NDEA) of 1958, and later the Elementary and Secondary Education Act of 1965. In these two landmark statutes, Congress addressed for the first time the expansion of educational opportunity for poor children and the improvement of

instruction programmes in science, mathematics, and foreign languages, with federal assistance (Gutek 1986, p. 280). The NDEA was meant to strengthen community and citizenship by uncovering not only intellectual gifts, but also deviance and trouble. Thus, schools witnessed an influx of newly trained guidance personnel – school psychologists, guidance counsellors, social workers and nurses – armed with normative tests and a remit to identify not only talented students through testing programmes but also the socially and mentally deviant (Jansz & van Drunen 2004, p. 78). In the latter group, the aim was to identify the early stages of mental illness and behavioural pathology in order to prevent later problems of delinquency and educational failure (Singh 2006, p. 443).

Focusing on the NDEA, a number of historians and sociologists have suggested that American schooling with this legislation became truly integrated with a medical agenda for the treatment of mental illness, since it established a framework in which schoolchildren were more likely to be referred and identified as disordered (Kiger 1985; Singh 2002a; Smith 2011b).¹⁵ More than simply reflecting the growing medical interest in the disorder and its drug treatment, they contend that the rise of hyperactivity in the 1960s reflected the contemporary emergence of a high-technology labour market demanding a science and mathematics-based curriculum, which, in turn, required higher levels of attention from a diverse student body. In the context of looming national failure following the launch of Sputnik, Smith goes so far as to argue that “the hyperactive child became symbolic of perceived American intellectual inferiority and the target of politicians, physicians and educators who saw improvement in academic achievement as essential to national security” (Smith 2011b).

However, it seems important to emphasise that other profound changes to American society in this period undoubtedly also contributed to the “discovery” of hyperactivity disorder and Ritalin treatment. These include the transformations in

¹⁵The NDEA was enacted in part in order to help identify intellectually gifted leaders who could support and grow the nation’s democratic ideals during the Cold War, but in the background lurked a story of mental failure and weakness. 12% of World War II recruits being diagnosed with a predisposition to mental breakdown during pre-screening tests, and over one million US soldiers suffered from some form of neurosis during the war (Singh 2006, p. 443).

the structure of American family life represented by rising divorce rates and the growing numbers of single parents and working mothers; the expansion of access to medical care; and – as I will shortly discuss in more detail – the changes brought on by civil rights legislation and the new politics of school integration. Moreover, it must be said that although there was much talk about an impending revolution in the content and delivery of education, in real terms the effects of the reforms were relatively modest. After the introduction of the NDEA, teams of maths and science professors revised elementary and secondary school curricula, replacing the conventional stress on description and factual information with an emphasis on key concepts and the inquiry method (Guttek 1986, pp. 308-309). Meanwhile, in some areas of the country, school architects designed new schools that abandoned four-walled, self-contained classrooms in favour of large open spaces and interest centres that radiated outward from a central “learning and resource centre”.¹⁶ Further, there were incentives to introduce programmes of compensatory education designed to equalise the educational opportunities of minority groups.

But as the 1960s drew to a close, it became apparent that the decentralisation of the American educational system made sweeping national reorganisations difficult if not virtually impossible to implement, and many school districts were virtually untouched by the innovations of the 1960s (ibid, p. 311). Several of the new science and maths curricula had not been tested adequately in the field before being introduced in the schools, causing confusion and often ultimate rejection by teachers and parents. In other cases, the new curriculum and design innovation quickly became formalised and soon resembled the arrangements they were meant to replace. For the large urban school systems especially, the proposed modernisations remained low priority, as they faced more pressing issues of pronounced racial and social change and declining fiscal resources. Partly due to the closure or relocation of industries in the Northeastern and Midwestern states, many whites and middle class blacks had moved out of the central cities by the

¹⁶Due to its lack of structure, this kind of open learning environment has in fact often been blamed by experts and parents for worsening symptoms of hyperactivity and inattention in ADHD children (Diller 1998).

1970s, leaving poor blacks and rising populations of Hispanic Americans to attend urban schools facing deteriorating educational facilities and services.¹⁷

Although the US essentially ended the space race in 1969 by placing men on the moon – a triumph which was ironically paralleled by a tightening of federal education expenditure as resources were instead allocated to fight the Vietnam War – concern about hyperactivity increased during the early 1970s, as America's burgeoning psychotropic drug industry, physicians and parent advocacy groups took the lead in pathologising difficult behaviour and promoting drug solutions, while critics of psychiatry described hyperactivity and Ritalin as tools of discrimination and child control. At this point, the congressional hearings following the Omaha drug controversy ([Gallagher 1970](#)) demonstrated the presence of a strong cultural opposition to the paediatric use of psychotropic drugs, as well as the prominent role of schools as sites of psychiatric intervention.

On one level, the resistance expressed at the hearings resonated with a revival of interest in child-centred learning approaches. Running somewhat counter to the recommendations put forward by 1950s critics like Rickover, by the mid-1960s a new breed of progressive critics argued that schools were overly bureaucratic, formalised, routine, and stifling of children's freedom and teachers' creativity. Their main point was that schools lacked the flexibility that would allow teachers and learners to shape their own educational environments along more humanistic contours. Interestingly, an important source of inspiration for US advocates of informal learning was the British primary school, which quickly gained a following among enthusiastic educators who began to implement open-space learning in various areas of the country ([Gutek 1986](#), p. 312). Reflecting a longstanding tradition of humanism and individualism, child-centred approaches were clearly

¹⁷The case of Baltimore – home to the famous Johns Hopkins Hospital and the site of a major longitudinal survey of stimulant treatment in the entire school-age population, starting in 1971 ([Safer & Krager 1984](#)) – offers a good example of this trend. Historically a working class port town, with an economic base focused on steel processing, shipping, auto manufacturing, and transportation, the city went through a deindustrialisation process which cost residents tens of thousands of low-skill, high-wage jobs. Baltimore city's predominantly black population has been decreasing considerably since the 1970s, and in 2000, the US Census reported income levels below the poverty line for more than 45% of residents in some of the district's most deprived neighborhoods.

expressed in the aims and values of British elementary education throughout the inter-war and post-war periods, culminating in the optimistic Plowden Report of 1967 which emphasised flexibility in the curriculum, learning by discovery, care for children's diverse needs, and individualisation of the teaching/learning process. The premise was that children learned most effectively through a direct involvement with their immediate environment in which they were free to pursue their own interests with the guidance of teachers. A key aim was to help children develop naturally at their own pace, meaning that they were not required to sit still in their seats all the time (Ford 1996). Even the more extreme ideas of A. S. Neill and his supporters had somewhat of a renaissance on both sides of the Atlantic in the permissive climate of the 1960s. In fact, Neill's book, *Summerhill: A Radical Approach to Child Rearing* (1960), caused quite a stir in American educational circles after it was published in the US. Reinforcing the growing education reform movement there, it helped spark the creation of independent alternative schools, at first mainly for those disruptive and delinquent students who would have otherwise dropped out of school all together.

The child-centred philosophy remained central in British primary education up until the late 1970s, when politicians on both sides of the spectrum began to call for teachers to become more accountable, and for methods of assessing and monitoring the achievement of children at school. Conservatives in particular attacked comprehensive education, egalitarianism and progressive teaching methods, claiming that "formal" methods (whole class teaching, regular testing and competition) were far superior in terms of producing academic results (Gillard 1997). In the US, however, the reputation and influence of progressive education in American education had already been significantly harmed by the 1950s critics, who claimed that the progressive movement led by John Dewey had weakened the curriculum and was to blame for the shortcomings of American students (Smith 2011b). The so-called accountability movement, which took off in the 1970s, pursued this critique even further, and from this point onwards, teachers would increasingly teach to the test – an educational program that neglected Dewey's ideas of relying on children's natural curiosity and interests. For Dewey, the

purpose of education was the realisation of one's full potential, and the ability to use those skills for the greater good, rather than the acquisition of a pre-determined set of skills. But his thinking on active learning bears only limited resemblance to the way schooling in the US has developed during the past half century. In fact, being hugely labour-intensive, truly child-centred active learning was always difficult to implement in the majority of American public schools, with their overcrowded classrooms and large numbers of immigrant children. Within the context of this "melting pot", the question of how to bring about the best learning experience, or help children find their unique potential, was easily subordinated to the need for classroom management ([Bilton int. 2006](#)).

5.5 The issue of race in early American debates on Ritalin and schooling

Alongside the political tension generated by the Cold War, American society also experienced increasing domestic social conflict and polarisation in the post-war period. Signalling a pervasive shift in cultural mores and values, the late 1960s witnessed widespread student protests over the Vietnam War and the rise of the counterculture among young people (mostly white middle class) who rejected the work ethic and traditional family, social and religious values of their parents' generation. Furthermore, the struggle to gain civil rights for black Americans accelerated as activists made a concerted effort to put an end to racial segregation and achieve equality in employment and education. In the debates over hyperactivity and Ritalin – including the congressional hearings on the subject – the racial theme was pervasive, with frequent allegations that black youth in inner-city schools were being chemically straitjacketed ([Gallagher 1970](#)). Thus, members of the Omaha black community had voiced suspicion that the local programme for the treatment of learning disabled children was intended to "reduce Negro children to a state of passive submission" ([Newsweek 1970](#)). Similarly, in Minneapolis, though there was an established policy constraining faculty from advising parents on medication, segments of the minority community complained

at public meetings of school officials “drugging” students and asserted that 80% of those medicated were black. Newspaper articles, television coverage, and various other forms of public comment continued for months ([Johnson et al. 1976](#), p. 91).

These reactions must be seen on the background of the heated controversies surrounding the growth from the mid-1950s to the mid-1970s of special programmes for the mildly “retarded” or “emotionally disturbed” – labels that were often attached to black children. This expansion occurred concurrently with the abolishment of racial segregation in schools and with the development of an extensive “tracking” system. While the development of education in the US has been characterised by appeals to the American ideal of equality of opportunity – represented by the aim to allow children with “ability” from all social backgrounds to be educated to the full potential – the system has implicitly recognised a need to differentiate between children, and thus came to rely heavily on intelligence and attainment testing as a criterion of selection ([Galloway & Goodwin 1987](#), pp. 78-79). However, deep disagreements emerged among educators and the general public about this practice. Black groups in particular protested against these tests which they felt discriminated consistently against members of ethnic minority groups, leading to an overrepresentation of black children in the lowest streams of education.

When examining how schools in the US have come to play a central and controversial role in the management of children’s mental and behavioural health, it is worth considering the country’s history of mass immigration and the cultural and disciplinary challenges this has presented in the classroom. One cannot ignore the fact that American public schools were charged with the task of assimilating and moulding children from highly divergent cultural backgrounds into productive and cooperating citizens who could enact the value of sustained attention ([Bilton int. 2006](#)). The mental hygiene movement arose when the era of immigration was just ending, and Cohen therefore argued that the “omnipresent problem of immigrants, though rarely spelled out, heightened hygienist sensitivity to the need for defining standards for wholesome personality building through the school” ([Cohen 1983](#), p. 141). In addition, after World War II, the education of the

large African-American population became a growing source of political struggle and concern. Up until the 1950s, segregation by race in public and private schools was common in the US, resulting in inferior education for blacks, as black schools had a lower per pupil expenditure and lower teachers' salaries than schools attended by whites ([Gutek 1986](#), p. 263). In 1954, the Supreme Court unanimously ruled in *Brown v. Board of Education of Topeka* that racial segregation in public schools was inherently unequal and unconstitutional. However, in practice, it was difficult to eliminate discrimination, and the process of desegregation was slow and uneven, especially in the South. Furthermore, the new policies of integration and the appearance of a more pluralist cultural model increased the pressure on schools and teachers, who were already experiencing declining authority in the classroom.

This may help explain not only the expansion of special programmes for retarded and the disruptive students during the 1960s, but also the turn to drug treatments in the 1970s, at least in deprived areas. Indeed, some contemporary observers argued that the most obvious cause of the rise of stimulant treatment lay in the turmoil that disrupted many inner-city schools when an effort was made to implement the civil rights legislation of the 60s :

Of all the difficulties that this effort engendered, none was mentioned more often than that of maintaining classroom discipline, and despite the plethora of hypotheses as to the causes of the difficulty, there was general agreement that the conventional middle class school depended for order and discipline on family and community sanctions that apparently were not functioning for some of the inner-city children [...] it is therefore understandable that the teacher would welcome the use of a drug that would quiet the pupil, if it did nothing else ([Broudy 1976](#), p. 45)

Although there are signs indicating that stimulants were frequently used in children from low- income families in some areas of the US ([Broudy 1976](#); [Hoffman et al. 1974](#)), it is difficult to determine the exact ratio of black to white or poor to wealthy children in the country as a whole, as little systematic epidemiological research was done on the subject of race, social class and hyperactivity up until recently. In public debates, there was certainly much focus

on inner city delinquency and some specialists controversially claimed that about 30% of “ghetto children” were candidates for a diagnosis of MBD or hyperkinesia (Witter 1971, p. 31). Conners and Eisenberg’s early trials of amphetamines for hyperactive school children (Conners & Eisenberg 1963) were in fact completed on black inner city youths in Baltimore and according to Eisenberg, the positive results were first and foremost picked up in large public clinics in the big cities, where an endless psychotherapy was not feasible (Eisenberg int. 2005). However, by the early 1970s, the issue of drug treatment was so politicised that many child psychiatrists were highly aware and quite worried that they might be seen to attempt to control black children to make them conform to white expectations. In some cases, this affected clinical practice as well as the recruitment for research trials, with the result that white children were favoured and received more treatment (Klein int. 2005; Rapoport int. 2005).

Nonetheless, most of my interviewees suggested that hyperactivity treatment was from the beginning a predominantly a white, middle class issue, as most black people had no access to proper health care (ibid), nor the inclination to seek medical assistance, due to a high level of suspicion of medical interpretations of misbehaviour and worry about drug treatments in particular.¹⁸ This view is corroborated by various regional surveys conducted during the mid-1970s which showed that hyperactive children from well-to-do backgrounds were more likely to receive medication than their less affluent peers – probably due to a higher rate of physician and specialist visits – while other studies demonstrated no significant relationship between economic factors and medication treatment patterns (Safer & Krager 1984, p. 130).¹⁹ As Schrag & Divoky (1975, pp. 77-83) argued, it may also be the case that the various learning disability labels were mostly sought by middle

¹⁸From a historical perspective, African-American families may have good reason to be sceptical of psychiatry and concerned about psychiatric drugs as powerful political instruments of social control. For example, during the US civil rights movement in the 1960s, threats against authority by black activists were sometimes interpreted as evidence of psychiatric disorder – typically schizophrenia – leading to the incarceration of some activists in mental hospitals (Metzl 2011).

¹⁹However, emphasising the significance of service availability, Safer and Krager noted that this trend had reversed in Baltimore for public school children ten years later, due largely to the sizeable degree of hyperactivity clinic services available to students in working class areas at this point.

class parents who were eager to dissociate their children from those considered simply retarded.

In any case, the social class and race correlates of hyperactivity diagnosis shifted in the late 1980s and early 1990s when the disorder (now termed Attention Deficit Disorder) was promoted from various quarters as a common, more benign disability that could, but did not necessarily, include hyperactivity as such (Diller *int.* 2006). The successful attempts to de-stigmatise the condition and to have it officially recognised as a covered educational disability meant that the label became applied to a much larger group of children, and that treatment rates increased in all population groups (Olfson *et al.* 2003). In some prosperous areas, it was in fact so widespread that critics started describing stimulant use as a worrying feature of an upper-middle class culture of competitive schools and expectations of high achievement. By this point, the debate on drug treatment as a form of social control of poor black people had faded along with the radical agenda of the 1960s and 1970s; focus had now moved to questions about general over-identification and over-treatment and the role of drug companies and parent organisations in fuelling diagnosis (Merrow 1995). When the controversy over “forced drugging” by schools flared up again in the early 2000s, the issue of racial targeting was not at the forefront of concerns. Rather, researchers pointed to the problem of poor service use and provision in minority populations following a string of community studies which showed that African-American and Hispanic children were as likely to receive an ADHD diagnosis as white children, but less likely to receive medication or other forms of help and intervention (Bussing *et al.* 1998b; Griggins 2005).

5.6 Debates on IQ-testing and discriminatory selection practices in British education

Whereas focus in the US has first and foremost been on the implications of race in relation to discriminating practices of segregation in education, the corresponding central category in the UK would be social class, although race also came to play an

increasing role from the 1960s when the children of the West Indian immigrants who had arrived in Britain during the 1950s became a significant presence in the school system. The overall difference in emphasis between the US and the UK can for example be seen when one compares the debates in the two countries over IQ-testing and special education. Whereas widespread standardised testing was unique to the US before World War II, after the war intelligence and achievement tests were also introduced on an increasing scale in Europe, as the involvement of psychologists in education increased significantly on both sides of the Atlantic. In the UK during the 1920s and 1930s, there was already considerable political interest in British psychologist Cyril Burt's research on general intelligence which backed the theory that IQ was innate and measurable. Particularly in the Labour party, many began to see psychometric testing as a useful way of dividing children into different ability groups and opening up good schools to capable working class pupils. The aim was to remove traditional class barriers in order to provide better educational and social chances to children from lower social backgrounds. Partly as a result of testimony by Burt and other psychologists on the advantages of such a system, the 1944 Education Act thus embedded IQ testing as a central element in the new statutory 11- plus exam, in addition to introducing free secondary education ([Murdoch 2007](#), p. 140). Just as the Americans were "tracking" students within the mainstream system according to their perceived abilities – with black children heavily overrepresented in remedial classes – the British would now "stream" pupils by sending them to entirely different schools, based on their performance on one exam.

In the 1960s, however, an increased scepticism about the usefulness and legitimacy of student intelligence and achievement testing resulted in numerous critical publications in the US ([Callahan 1962](#); [Hoffman 1962](#)), and separate education came under heavy attack from minority and disability rights groups who felt they were being discriminated against. Protests also grew in the UK, but here the debate about IQ-testing initially focused on social class inequalities in secondary education and in special schools. During the 1950s, it soon became clear that there was a huge gulf between grammar schools and the so-called secondary

modern schools in terms of the quality of teaching, as well as the socio-economic make-up of the student population (Murdoch 2007, p. 155). Labour therefore now came to oppose what they saw as an elitist discriminatory education system, and, when they came to power in 1964, instructed LEAs to convert to comprehensive education. Meanwhile, separate provision for the growing numbers of maladjusted and learning disabled children was becoming an increasingly controversial issue. After the war, special schools proliferated in response to the increasing demand for placements as a direct result of the legal obligation for ascertainment; between 1960 and 1978, the number of maladjusted pupils in special schools in England and Wales rose from 1742 to over 13,000 pupils, with the sharpest increase occurring between 1966 and 1976 (Ford et al. 1982, p. 24). However, the category which expanded most after the war was that of educational subnormality of the mild type (ESN (M)), which rose from 15,173 pupils in 1960 to 54,775 in 1978 – an increase of 361%. These children, who made up about 80% of the whole ESN group, were typically male and came predominantly from backgrounds characterised by social and economical deprivation, low income, overcrowding, and poor housing (ibid, p. 71).

There is little doubt that teachers and schools often took advantage of the deliberately vague definition of ESN and used the label for the purpose of removing disruptive children (Tomlinson 1982, p. 52). Indeed, by the late 1960s, critics claimed that ESN schools were increasingly being used as convenient dumping grounds for black youth, and especially for those with a Caribbean background. The disproportionate number of immigrant children, largely of West Indian origin, who were being admitted to ESN special schools was first officially documented by a 1966 Inner London Education Authority report which noted that the percentage of immigrant children in ESN day schools was 23.3% compared to 13.2% in the authority's primary and secondary schools (Tomlinson 1982, p. 74-75). By September 1967, the proportion had risen to 28.4%. A further report from 1967 noted that misplacements could be four times more likely in the case of immigrant children, and that many were referred primarily for behavioural rather than educational reasons. Much like the US civil rights protesters, who for a

number of years had complained about the placement of black children in classes for the retarded, activists in the West Indian community suggested that prejudice and low teacher expectations were to blame, and that the IQ tests used in the assessment process were inappropriate due to their built-in cultural and class bias (Coard 1971).

The ESN issue continued to be a cause of concerns throughout the 1970s, voiced in the columns of the black press and in evidence to government select committees. However, attesting to the increasing focus on educational standards and behavioural indiscipline in schools, the non-statutory category of “the disruptive child” developed on an ad hoc basis during the 1970s and rapidly became an alternative to the referral of troublesome young people as potentially ESN or maladjusted. This development was accompanied by the concurrent explosion in the number of off-site behavioural units in England and Wales, from 62 in 1973 to 439 in 1980 (Ford et al. 1982, pp. 28-29). Characteristically, these so-called “disruptive units” comprised often poorly maintained accommodation, largely informal modes of referral, restricted learning opportunities, and frequently inexperienced, if well-meaning, teachers (DES 1989). Many educators attributed the expansion in provision to general transformations in society, such as falling moral standards, the break-up of families, and the perceived growth of an anti-social youth subculture. Most also emphasised the pressures on schools during the transition phase from selective to comprehensive education and the growing restrictions on the use of corporal punishment. It seemed that schools themselves were simply less able to cope with deviant behaviour than they used to be, among other things due to the structure and impersonal nature of the newly introduced large comprehensive schools, as well as the high rates of teacher turnover. Furthermore, the new system bypassed the lengthy special education assessment procedures and long waiting lists of special schools, while giving educational psychologists and teachers a direct say in referral and placement. Disruptive units could accommodate children immediately, and studies showed that in many cases, effective decision-making had informally passed to groups of teachers (ibid, p. 52).

However, while American observers noted that the increasing difficulties of

maintaining classroom discipline was an important factor in the growth of stimulant treatment in the US, it did not ring true when British criminologist Steven Box, without presenting concrete evidence, asserted that “tens of thousands” of British schoolchildren were being put on drugs, “simply because their behaviour did not fit in with the requirement of school” (Box 1977). Acknowledging that the diagnosis of hyperactivity was as yet nowhere near as common in the UK, he instead pointed to “maladjustment” or “mental subnormality” as comparable categories and implied that teachers, psychologists and doctors were conspiring to diagnose deviant children in order to drug them into conformity, particularly in schools located in urban slum and ethnically mixed areas. These accusations provoked strong responses from various quarters, amongst others from National Union of Teachers (NUT) secretary Fred Jarvis who vehemently denied any kind of scheme on the part of educational and medical authorities to create docile classrooms in Britain: “we have no evidence of anything remotely resembling Box’s picture of how teachers cope with children who have behavioural problems or who are merely boisterous” (*New Society* 1977, p. 537). Psychologist Raj Parasuraman also disagreed, emphasising that British child psychiatrists had known about and voiced concern over “the American predilection for over-diagnosis and over-enthusiasm for drug treatment for a number of years, and generally viewed it with a mixture of amusement and alarm” (ibid.). Similarly, prominent child psychiatrist Philip Graham argued that while Box was right to suggest that educational problems were unfortunately treated as evidence of medical disease in some areas of the US, his picture of the UK seemed so improbable and alarmist as to require questioning. Emphasising that his own clinical experience involved the use of drugs only very occasionally, he concluded that “even in the most dire situations, with obvious organic determinants of behaviour making learning impossible, teachers and parents are healthily worried about the effects of drugs” (ibid, p. 589).

With the 1981 Education Act, it became more difficult to exclude a child from a mainstream school in the UK, but various practices of segregation continued to be viewed as necessary in the case of young people with severe behavioural problems. In the mid-1990s, the disruptive units were replaced by “pupil referral units”

which in many cases would amount to little more than holding pens, and socially disadvantaged boys – often of Afro-Caribbean origin – were again overrepresented (POST 1997, p. 3). But although clearly at the centre of debates about school indiscipline, exclusion, and academic underperformance, black children have been relatively absent in the UK hyperactivity and Ritalin statistics. Here, there are important parallels with the US. In the early 2000s, epidemiological surveys of the prevalence of ADHD/hyperkinetic disorder showed lower treatment rates for black children in the US (Olfson et al. 2003), and lower rates of hyperactivity diagnosis of black youth in the UK (Green et al. 2005). Despite differences in methods, both studies showed similar variations across ethnic groups. Yet while ADHD rates have risen in all socio-demographic groups in America, in step with the growing tendency there to associate the disorder predominantly with school performance-related problems, in Britain it appears that the label is still mostly applied to white boys with working class/lower middle class backgrounds, who present with challenging aggressive behaviour. At the same time, the overall rate of mental disorder in British black children was higher than in any other ethnic group, with conduct disorder making the biggest contribution to the difference. No comprehensive study has so far been conducted on the ethnic distribution of actual ADHD diagnoses in the UK, but several of my interviewees followed American critics in speculating that doctors and teachers are more likely to attribute conduct or learning difficulties to a neurological disorder in white children, and to an anti-social behavioural disturbance, or simply low intellectual capacity, in black boys: “I’m not sure if there is any conclusive research to show that mental health practitioners in the UK are more likely to typify the problems of minority ethnic/black children as mostly conduct disorder rather than ADHD, but I wouldn’t mind betting that this is actually the case based on my own, admittedly anecdotal, experience in Inner London over many years” (Prior int. 2006).

5.7 The rise of the American learning disabilities movement

While the the 1970s showed the major Western economies to be increasingly affected by recession and cuts in public spending, one important educational milestone – the formal recognition of the educational rights of children with learning difficulties – pointed in the opposite direction and was unique to the domestic American situation. In some respects, this development grew out of the larger civil rights movement, as the judicial decisions that fostered racial integration also brought public attention to the plight of the mentally and physically disabled. Indeed, as described in the above, in American schools the segregation of children on the basis of race and handicap was often interrelated. In other respects, the new awareness of children's special educational needs resulted specifically from the emerging phenomenon of "parent power". The civil rights movement taught the public that schools were vulnerable to political and legal pressures, and when parents became more concerned with the poor quality of their children's education, they protested and mobilised. In particular, it was broadly agreed that the label of retardation and the associated practices stigmatised those so labelled and that segregation into special schools or buildings compounded the problem ([Galloway & Goodwin 1987](#), p. 80).

Thus, as a result of a combination of political pressures from various parent advocates, from the black community, and from educators, the US Congress passed the Education for All Handicapped Children Act (EHA) in 1975. This piece of legislation established that the nation's handicapped children between the ages of 3 and 21 would be assured a "free appropriate public education" in the "least restrictive environment possible".²⁰ It stipulated that school personnel must

²⁰Prior to 1966, when federal funds first became available to the states to initiate or expand local programmes to meet the special educational needs of handicapped children, the federal government had done little to assist in this area. Many states even had laws that explicitly excluded children with certain types of disabilities from attending public school, including children who were blind, deaf, and children labelled "emotionally disturbed" or "mentally retarded". At the time the EHA was enacted, more than 1 million children had no access to the public school system, and many of these lived at state institutions, where they received limited or no educational or rehabilitation services. Another 3.5 million children attended school but were held in segregated facilities and received little or no effective instruction.

prepare an Individualised Education Plan (IEP) for each child and that supportive services were to be provided, including speech therapy, physical and occupational therapy, counselling and medical services needed for diagnosis and evaluative purposes. Also, parents received the right to a due process hearing if they disagreed with any aspect of the school's diagnosis or its program of treatment. With its far-reaching implications for children, schools and parents all over the country, the law brought momentous change to American public education, and it was perceived as great victory for the parent advocacy organisations which had pushed for its realisation.

Not surprisingly, however, the new legislation also led to protests and criticism. The mainstreaming provisions caused apprehension among teachers with no training in special needs education, and among school officials who felt they lacked sufficient means to provide the required services ([Gutek 1986](#), pp. 329-332). Further, after EHA took effect, the US Department of Education reported a remarkable rise in the number of children classified as disabled, resulting in widespread concerns about over-identification and the associated financial costs. Between the school years of 1976/77 and 1999/2000, the number of children who were found eligible for special education services and accommodations rose from 3.7 million 6.1 million – an increase of 65%. Much of this rise was accounted for by the exponential growth of one particular category, namely that of “specific learning disability”, which increased from 796,000 to 2,726,000 children during the same period ([Horn & Tynan 2001](#), pp. 27-28). Consequently, the cost of special education skyrocketed, often at the expense of regular education.

The history of the learning disability movement started during the 1950s and early 1960s, when groups of parents concerned about the lack of attention and provision for their low-achieving but yet intellectually normal children started forming associations for so-called “brain-injured” children in several cities all over the US, including Minneapolis, Milwaukee, Baltimore, and New York City.²¹ An

²¹ As described in chapter 3, the emphasis on neurological dysfunction in LD first and foremost grew out of the work of Alfred Strauss and Heinz Werner who in the 1940s defined the characteristics of the “brain-injured child” and gave rise to the broader concept of “minimal brain

immediate problem facing the organisations was the need to clarify precisely the difficulties their children were facing (Franklin 1994, p. 64). At a big national conference held in 1963 in Chicago, the highlight of the meeting was a keynote address by expert in mental retardation, Samuel Kirk of the University of Illinois. Pointing to the heterogeneity of the category in question, Kirk told the audience of his dissatisfaction with the use of terms such as “brain injury” to capture the learning problems of children without marked intellectual deficits, as these terms offered no guidance to those responsible for educating them. Focusing on remediation rather than aetiology, he instead introduced the descriptive concept of “learning disabilities” (LD) and so swayed the audience that within a year the attending parent groups joined together to form the Association for Children with Learning Disabilities (ACLD).²²

Kirk thus provided a banner behind which parents would march. However, during the 1960s, there were as many explanations of learning disabilities as there were researchers working in the area, and the conflicting definitions and explanations made it difficult to establish the widely shared understanding of the condition that would encourage the development of public school remedial programmes.²³ The definition put forward by Kirk was eventually incorporated into the Children with Specific Learning Disabilities Act of 1969 and thus achieved official status:

The term “specific learning disability” means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain

damage”, which allowed for the possibility of inferring damage from behavioural symptoms alone (Sandberg & Barton 2002). They also provided extensive guidelines for the education of learning disabled children, including among other things the instruction to keep distracting stimuli in the classroom to a minimum.

²²Signalling that they also cater for adults, the organisation is today called the Learning Disabilities Association of America (LDA).

²³Three years after Kirk’s speech, a US Public Health Service task force reported on the existence of at least 38 terms commonly used by both professionals and laypersons to describe children with learning disabilities, including brain injury, hyperkinetic syndrome, minimal brain dysfunction and dyslexia (Franklin 1994, p. 65).

dysfunction, dyslexia, and developmental aphasia. The term does not include children who have learning disabilities which are primarily the result of visual, hearing, or motor handicaps, or mental retardation, or emotional disturbance, or of environmental, cultural, or economic disadvantage (ibid, p. 67).

With the passage of the Children with Specific Learning Disabilities Act in 1969, LD was bestowed with official recognition as a state designated handicapping condition. The legislative language, which later reappeared in the EHA, had significant input from parent organisations, and ACLD in particular:

Through the efforts of ACLD, learning disabilities took Washington with storm. Parent volunteers were all over Congress, educating members about learning disabilities. Whenever a piece of education legislation was considered, members of Congress were reminded to address the needs of children with learning disabilities [...] 13 years after ACLD began, the 94th Congress of the United States passed its 142th piece of legislation, Public Law 94-142, The Education for All Handicapped Children Act. What a masterpiece. What a victory for our organisation. This law was unique. There was no expiry date. It is regarded as a permanent piece of civil rights legislation [...] ACDL played a significant role in the writing of the legislation as well as in getting it passed and implemented (Silver 2003, p. 12-15).

Yet, like its close relative, MBD, the LD label was still rather vague and failed to provide a clear delineation of parameters for educational classification and intervention, relying as it did mostly on diagnosis by exclusion. Because the category became a “catch-all”, minor definitional variations were subsequently introduced, most of which focused on the presence of a major discrepancy between actual achievement and ability as measured by an IQ test. But partly due to the continuing influence of the unsubstantiated concept of subtle brain damage or dysfunction, these definitions have all remained problematical, leading critics to call learning disabilities a “pseudoscience” and a “victim of its own history” (Kavale & Forness 1985, 81).

In 1990, the EHA was replaced by the more politically correct-sounding Individuals with Disabilities Education Act (IDEA). At this point, too, a diverse coalition of children’s and parent advocates, disability activists, and professionals were very active in the legislation process. Particularly influential was the newly

formed parent group, Children and Adults with Attention Deficit Hyperactivity Disorder (CHADD), which worked hard to expand services for children with behaviour and attention difficulties. While the IDEA was being drafted in 1990, a fierce debate raged behind the scenes over whether to specifically include ADHD in the list of covered disabilities, together with the categories of autism and traumatic brain injury (Mayes et al. 2009, pp. 107-111). On one side were disability advocacy groups such as CHADD, who felt that too many children fell through the cracks due to educators' inadequate knowledge of ADHD and the vagueness of the existing classifications. On the other side, one found various disability and professional organisations claiming that the needs of these children were already being met, for example under Section 504 of the 1973 Rehabilitation Act, or that including ADHD would divert scarce resources away from the general student population and those with more severe impairments.²⁴ Initially, the opponents prevailed, and the law was passed without mention of the disorder, but one year later a massive lobbying campaign mounted by CHADD resulted in a Policy Clarification Memorandum to states and local school districts, which underlined that students with ADHD diagnoses could qualify for IDEA services if they met the criteria for a "serious emotional disturbance", "specific learning disability" or "other health impairment" (a catch-all listing designed for children with chronic or acute health problems). While the separate inclusion of ADHD as a covered disability was only made absolutely clear with the 1999 regulations of the IDEA, this clarification became an important driver of the steep increase in ADHD diagnosis during the 1990s (ibid, p. 97).²⁵

²⁴Although disability groups frequently work together, the question of adding ADHD to the IDEA bitterly divided them. While CHADD pressed for a separate listing, a number of well-respected disability and education groups opposed the move, including the National Education Association, the National Association of School Psychologists, the Council for Exceptional Children, and the National Association for the Advancement of Colored People (NAACP). The latter organisation specifically worried that the explicit recognition of ADHD would encourage the over-identification of African American boys (Mayes et al. 2009, p. 109).

²⁵Between 1991 and 2001, the total special education population increased by more than 28%. The most dramatic growth occurred in the listing for "other health impairment", growing from approximately 58,700 students to more than 290,000 over the course of the 1990s. Many critics have attributed this development to the policy changes made in relation to ADHD, although the Department of Education's clarifications were not meant to automatically qualify ADHD children

Although various studies from the 1970s and 1980s pointed to the disproportionate representation of minority and poor students in special education classes ([Franklin 1994](#), p. 70), most commentators contend that middle class parents led the effort to establish public school programmes for learning disabled children, and that the clientele for the many “learning centres” which emerged throughout the 1970s were, for the most part, white underachievers. ACLD had a phenomenal growth in suburbia but, not surprisingly, negligible success in attracting poor and minority-group parents whose children had as much or more difficulty with school achievement and behaviour. Nearly all active members were college-educated, good citizens who told similar stories of doctors and psychologists who misdiagnosed, and tended to treat learning difficulties as a result of emotional problems and inadequate mothering ([Schrag & Divoky 1975](#), pp. 77-83). According to [Erchak & Rosenfeld \(1989, p. 84\)](#), it was particularly galling for affluent parents to have offspring with learning problems at a time when academic underachievement became more socially consequential than ever. In this situation, the advantages of medical labels like LD or MBD were numerous: they were preferable to the old stigmatising diagnoses of mental retardation or emotional disturbance, and they provided an explanation for the children’s school failure without allocating responsibility and blame.²⁶ Illustrating the impossibility of separating the clinical and the bureaucratic aspects of a disorder – especially in legalistic, pragmatic cultures such as the American – ADHD and Asperger Syndrome arguably perform a comparable function today: they are perceived as full-fledged neurological disorders, yet afflicted individuals can potentially be of average or even above average intelligence, and in addition gain access to various forms of help in school ([Eisenberg int. 2005](#); [Norwich int. 2006](#)).

for extra assistance or accommodations ([Mayes et al. 2009](#), p. 111).

²⁶Some historians of education argue that the post-war migration of Americans to the suburbs created the social conditions that spawned the learning disabilities movement ([Franklin 1994](#), pp. 71-72). According to this theory, the school failure which had always affected a large number of American children remained a salient feature of the supposedly excellent suburban schools, but by explaining it as neurologically-based learning disabilities, parents were able to rescue from imminent collapse the dreams that they held for their children and for their lives in the suburbs, which turned out not be as ideal as imagined.

Nonetheless, it is worth pointing out that many “stakeholders” in the special education area seemed motivated by a sincere wish to assist children experiencing difficulties in school. At the hearings prior to the introduction of the Children with Specific Learning Disabilities Act of 1969, much of the testimony thus indicated that the goal of the accommodations was to help children educationally and to save them from stigma. But clearly, as borne out by other testimony which addressed the threat which learning disabled children posed to the larger society, the child’s best interests was not the only concern of the state and the medical and educational professions. One expert for example testified that 20% of the population had learning difficulties and that ignoring this issue may have grave social consequences in the form of delinquency, crime and poverty: “There is no doubt that there is a great savings in dollars and human values in attacking this problem at its source rather than paying for the consequences” (quoted in [Franklin 1994](#), p. 75). Others pointed to the danger of these children becoming school drop outs and murderers even, emphasising that 85% of the prison population in Texas were probably learning disabled (*ibid*, p. 76). A few years later, much the same arguments were being used for the treatment of MBD and hyperactivity in physician Camilla Anderson’s book *Society Pays: The High Costs of Minimal Brain Damage in America* ([1972](#)). As such, the initiatives to promote special education in the 1960s and 1970s appeared to reflect the same contradictory purposes that propelled forwards the establishment of special classes for “backward children” in the US in the inter-war era: both movements seemed undecided about whether their goal was to protect the abler segments of the population or to help the disabled.

5.8 The 1981 Education Act versus the 1975 Education of All Handicapped Children Act

The dilemma of weighing the handicapped individual’s interests against those of pupils in mainstream education also plays a central role in the history of British special education post World War II. Despite the stated government aim in the

construction of the 1944 Education Act of a policy of inclusion and the creation of “equality of opportunity”, in reality the number of pupils in special schools trebled between 1950 and 1978, revealing a strong reliance on the option of removing troublesome pupils from mainstream education (Ford et al. 1982, p. 24). The advent of the indeterminate “disruptive units” only reinforced this impression, and by the mid-1970s, egalitarian distaste for segregating certain groups of children led to an intensified debate on “integration”.

In 1973, a committee comprising a variety of professionals was set up under the chairmanship of Mary Warnock in order to review educational provisions for handicapped children. Two years later, the Department of Education and Science released a document designed to clear up uncertainties surrounding the subject of ascertainment and the respective roles of the professions in this process. Describing a direction opposite to that taken in the American legislation, circular 2/75 was clear that an educational model of assessing children was preferable to a medical model. Dissatisfied with their inferior role in the child guidance team, educational psychologists had during the 1960s come to place more emphasis on their contact with schools, and schools in turn came to see them as a valuable resource, not least because they could provide immediate help in the form of behaviour modification techniques at a time when teachers were confronted with increased problems of classroom management (Laslett 1998, p. 11). Consequently, demand for their service increased, and now their growing influence was acknowledged in the formal recommendation that they, rather than medical officers, should assume final responsibility for conveying a recommendation to the Local Authority about the nature of the special education required in a given case. In 1978, the ground-breaking Warnock Report estimated that special education in a broad sense should be extended to one child in five. Further, it emphasised the use of purely descriptive terms such as the broad concept of “special educational needs” and the non-statutory category of “learning difficulty”. These recommendations came to form the basis of the 1981 Education Act, which entailed 1) the abolition of the 1945 statutory categories of handicap, many of which were now considered archaic and offensive, and their replacement with the

concept of Special Educational Needs (SEN); 2) the requirement that local education authorities (LEAs) ensure the meeting of special needs in mainstream schools, where possible; 3) the introduction of a new formal and legally binding system of assessment, which was to incorporate a statement of the LEA's proposals for meeting the needs; and 4) the requirement that educational psychologists take a more prominent role in the statementing process than previously, making them in effect gatekeepers to resources. Another consequence of the Act was the creation of the post of the special needs coordinator (SENCO), and a shift away from the development of specific knowledge and skills relating to particular kinds of conditions in favour of the development of common core skills among professional personnel. As social workers and psychiatrists moved back into their own fields and lines of management at the same time, emphasis clearly shifted toward education, both in terms of how children's problems in school were evaluated and in terms of the solutions proposed.

Finally, a significant change was that LEAs were now obliged to involve parents in the decision-making process. However, in general parents did not have much voice in the making of the 1981 Act. Compared to the US, where the question of inclusion and the exact definition of learning disability were subjects of lively and open debate from a variety of different viewpoints, public debate about special education was rather limited in the UK, and it was more difficult for pressure groups to exert an influence on educational policy. A few attempts were made during the 1970s to have autism included as a separate handicap category, but they were resisted. Rather, observers identified a strong emphasis on professional expert discourse in the making of reforms. Only one parent was represented on the Warnock Committee, and in the end the Warnock Report avoided all use of the term "rights", employing instead terms such as "partnership and goodwill", which tended to muffle disputes and differences of opinion (Galloway & Goodwin 1987, p. 86).

Despite differences in government and legislative contexts, there were important parallels between the British 1981 Education Act and the American Education for All Handicapped Children Act of 1975, mainly in their emphasis on

the need for the identification of disabled children, the protection of children's and parents' entitlement to non-discrimination in the evaluation and placement process, and the desirability of integration and mainstreaming. In both cases, there was a tension between the "least restrictive" and "appropriate education" environments, to use the US terms (Pumfrey & Reason 1991, p. 12). However, concentrating primarily on the needs of the child, the American legislation had a stronger integrationist philosophy where onus was on demonstrating the need for special education provided elsewhere than in the ordinary classroom. Unlike in the UK, US school authorities were, at least theoretically, not allowed to give efficient use of resources public credence as an argument for segregation.

This difference was highlighted by British educationalists, who, while appreciating the initiatives of the Warnock Report, were still quite sceptical that practice would change substantially, as the concept of SEN was kept sufficiently vague to accommodate segregation when deemed necessary. Tomlinson (1982, p. 57) thus predicted that there would be no widespread integration or inclusion, both due to economic interests and due to the continuing relevance of a system for the removal of troublesome children from normal education. She added that the integration debate had become partly confused by the conflation of normative and non-normative categories of handicap: "Crudely, while teachers in normal schools may be willing to accommodate the 'ideal' child with special needs in their classrooms – the bright, brave child in a wheelchair – they will still want to be rid of the actual 'average' child with special needs – the dull disruptive child" (ibid, p. 80). As it turned out, evidence suggested that mainstream schools were by the 1990s becoming increasingly hostile to the integration of disruptive pupils with social, emotional and behavioural problems, including the ADHD-type subgroup.

Many observers of education have also pointed out that while the Warnock Committee was strongly influenced by arguments against the negative aspects of labelling, it actually substituted a new set of labels in terms of special needs for the old set in terms of deficits (Farrell 2001; Galloway & Goodwin 1987). Specifically, stigmatising labels such as educational subnormality and maladjustment were replaced with broader, supposedly more politically correct ones, like severe and

moderate “learning difficulties” or “emotional and behavioural difficulties”, while contested and more “attractive” disorder categories such as ADHD, dyslexia and Asperger Syndrome have come in from the side. Reflecting the gathering momentum of the inclusion agenda, the revised SEN Code of Practice from 2001 attempted to move even further away from categories, but the guidance still referred to specific learning difficulties and autistic spectrum disorders, for example.²⁷ Despite long-standing dissatisfaction with category-based systems for describing various types of disabilities, it seems that classifications have been difficult to dispense with.

Compared to the British terminology, special needs language in the US has remained more medicalised and straightforward. In 1972, the mounting interest in the various dilemmas associated with the education of learning disabled children led the federal government to sponsor a major analysis on the classification of “exceptional children” (Hobbs 1975). The contributing experts generally agreed that labels were not only of little use but also potentially harmful, even if they could be beneficial in terms of service planning and provision. Over the past 30 years, however, the development of special education has followed a somewhat different path. The influence of a social model of disability could for example be seen in the argument made by supporters of the EHA that the limitations of children with disabilities were caused mainly by their exclusion from mainstream education, but the quick expansion in the number of children diagnosed with disabilities revealed a growing tendency to manage educational needs by locating problems within the individual child and attempting to remedy them on an individual basis through IEPs. In short, support services came to be driven largely by specific diagnoses, and in this important respect, the EHA/IDEA embodies a medical model of disability (Pumfrey & Elliot 1990, pp. 16-20).²⁸

²⁷ ADHD is still not mentioned, however. The Behavioural, Emotional and Social Development Section of the 2001 Code only makes specific references to “interventions for schools to support pupils who are hyperactive and lack concentration”.

²⁸ The medical model of disability explains difficulties in the disabled person’s life as the inevitable consequence of his/her physical or mental impairments and, accordingly, seeks to remedy the problem of disability through forms of rehabilitation or “cures”. In contrast, a social model of disability points to the ways in which disability is a consequence of the social environment

In terms of the number of children classified as entitled to special education, the British and American approaches have had very different effects. Compared to the 12% of US students who received services under the IDEA in 2000, only 2% of students in England and Wales had Statements, the statutory equivalent of an American Individualised Education Programme (IEP). Following the five-stage assessment model first outlined in the 1994 Code of Practice, the process to obtain a Statement is long and arduous, taking up to two years or even longer in some cases – much longer than getting an IEP ([Malacrida 2003](#), p. 94). Critics have claimed that this primarily serves the purpose of cost-containment, since LEAs are themselves responsible for paying for special needs pupils, and since the child enjoys a high level of support when a Statement is finally granted, often in maintained special schools in the case of severe emotional and behavioural problems. One important aim of the EHA was to channel federal funding to all US school districts with handicapped children, so that those with recognised disabilities could be treated the same before the law, even if the expenditure on special education would vary significantly between individual school districts. In contrast, the 1981 Act did not provide extra government funding, and local authorities have been given broad discretion to work out their own individual policies on which conditions can be recognised, and which types of provision need to be made for such children, if any at all ([Pumfrey & Elliot 1990](#), pp. 18-19). Over time, this has resulted in the development of great variation in assessment and provision practices between individual LEAs, and a growing number of appeals from parents to the SEN tribunal – among them many parents of ADHD children – prompting calls from professionals for more distinctive definitions which carry some legal force, together with a more uniform system of assessment.

– physical, organisational, or cultural – impinging on people with impairments in discriminatory and essentially arbitrary ways. By locating disability in the cultural and institutional environment, the social model calls into question the distinction between disability and non-disability, as well as the distinction among disabilities, suggesting that rigidly categorised disabilities are mere artefacts.

5.9 Conclusion

Having initially provided a brief account of how schools became prime sites for the identification of mental disturbance in children in the first half of the 20th century, this chapter has focused on the role of education and disability activism in the “discovery” of hyperactivity diagnosis in the US during the 1960s and 1970s, while drawing lines of comparison to relevant developments in the UK. Starting with the interwar mental hygiene movement and the “therapeutic” orientation to education which it encouraged, I have examined how schools and schooling in the US became closely integrated with a medical agenda for the care and prevention of mental illness – an agenda which was much strengthened with the introduction of the National Defense Education Act of 1958. In Britain, the post-war years were characterised by a similar focus on psychological disturbance, and the threat it posed to national fitness and human relations in general. This concern was expressed for example by the high priority given to the problem of child maladjustment in social and educational policy. However, the urgency of the task of creating a large educated workforce was arguably not felt to the same extent as in the US in the years following Sputnik. In addition, Britain did not experience the same growth of psychopharmacological research and industry, which to some extent propelled the diagnosis and drug treatment of hyperactivity in America. Finally, from 1945, a gradual shift occurred in the UK in favour of an educational rather than a medical approach to administering and meeting the needs of children with behavioural and learning difficulties. Culminating in 1981 with the abolishment of medical categories of handicap, and the legal ascendancy of educators in the decision-making process, this development would subsequently have important consequences in terms of the recognition of ADHD as a valid disorder in the school system.

[Smith \(2011b\)](#) contends that one cannot understand the present-day concept of ADHD without paying careful attention to the political and ideological climate of the particular place from which it emerged long before anywhere else, that is, the US during the middle years of the Cold War. Certainly, the effects of the Cold

War and the Space Race were ubiquitous and should not be underestimated. But when examining to the historical establishment of hyperactivity diagnosis, I would argue that we also need to look at other social and political changes which affected the structure and function of American schools between the 1950s and the 1970s. Here, I have drawn particular attention to the influence of the civil rights and disability rights movements, and their call for the non-discrimination and integration and of vulnerable populations. One major development in the history of ADHD was the policy changes introduced in the early 1990s following lobbying efforts by the advocacy group Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD). However, at this point, parent organisations were already important actors on the political scene, as demonstrated by the influence of the Association of Children with Learning Disabilities on the 1975 Education for All Handicapped Children Act. Although it was a well-known diagnosis by then, the new legislation helped to put more focus on hyperactivity/MBD and its drug treatment, to the extent that various critics by the late 1970s mentioned educational labelling as the most important factor in the growing tendency to medicalise the rambunctious behaviour of children.

In a society as diverse as the US, maintaining discipline in the classroom became a particularly pressing issue when public schools were faced with the demand to provide equal education to all segments of the population, while promoting the highest possible educational standards. Seen from this perspective, one may argue that medical labels and drug therapy became attractive to schools as a way of maintaining high levels of integration, especially considering the decreasing access to traditional authoritarian measures ([Conrad 1976](#); [Kiger 1985](#)). Over the years, however, the increase in disability diagnoses has come to pose serious problems due to the federally mandated costly support services, of which only a shrinking percentage is covered by federal funds.

In the UK, inclusion also became a prominent concern during the 1970s, which saw a steep increase in the number of children placed in special schools or off-site units for disruptive youth. Whereas debates in the 1950s and early 1960s had centred on the unfair treatment of white working class children in the highly

selective secondary education system, focus now moved to the growing problem of indiscipline and the removal of the troublesome children from mainstream education. Mirroring developments in the US where civil rights activists had protested against the segregation of black children in special classes for the retarded, the overrepresentation of Afro-Caribbean pupils in schools for the “educationally subnormal” was a particularly controversial issue. The inclusion debate in Britain eventually led to the introduction of the broad concept of special educational needs (SEN) in the 1981 Education Act, which also made the individual’s entitlement to mainstream educational provision a key issue. However, community involvement in the process was negligible compared to the US, and the adoption of a generic rather than a medical/individualised “rights”-based approach helped to make sure that fewer children would be identified as disabled in the UK. Further, the continuing availability of the option to exclude difficult pupils may, from the schools’ perspective, have lessened the perceived need to seek medical solutions to disruptive classroom behaviour.

CHAPTER 6

Neurological disability or behavioural difficulty: the contribution of schools and schooling to the rise of ADHD in the US and the UK, 1980-2010

6.1 Introduction

While the previous chapter concentrated mainly on the post-war period, this chapter deals with the ADHD era from 1980 to the present and investigates the role of education in the recent explosion in diagnoses on both sides of the Atlantic. In the US, we have seen that critics were already alarmed by the level of Ritalin use in 1970, but it was only from the early 1990s that the prescription of stimulants truly started to escalate, and ADHD and Ritalin assumed the iconic proportions they have today.¹ In the UK, ADHD hardly existed as medical and social problem until the mid-1990s, and here schools and educational policy have played a less obvious role as a driver of diagnosis and stimulant treatment. Viewing the label as an excuse for bad behaviour and/or as a stigma that might harm the child, British educators were generally hostile towards ADHD and the push from parents for

¹In 1970, more than 150,000 American school-age children were receiving stimulant treatment annually (Safer 1971). By 1975, this number had risen to about 300,000, prompting one of the nation's foremost developmental psychologists to warn about the potential dangers of this development in the *New England Journal of Medicine* (Stroufe & Stewart 1975). But the trends Stroufe observed during the 1970s pale in comparison with those of the last two decades.

recognition of the disorder. In other ways, however, schools were moving in a direction similar to the market-oriented route adopted by American education, with considerable implications for vulnerable and disruptive pupils.

A number of scholars have argued that the roots of ADHD are to be found in the effects of the politics of the Cold War on schooling in particular ([Kiger 1985](#); [Smith 2011b](#)). However, while staying with the notion that military, economic and ideological threats to the integrity of nations play a decisive role in expanding the number of behaviours perceived to be pathological, I find it equally relevant to move somewhat forward in time and concentrate on the effects of the damning 1983 federal report, *A Nation at Risk*. The concerns expressed here were very alike the education critiques of the 1950s, except now fears centred mainly on the competition from Asia. However, by stimulating a pervasive “high-stakes” testing culture, which significantly increased the pressure on both schools and students to succeed, the report arguably had a larger indirect impact on diagnosis and prescription than the post-Sputnik panic. At the same time, a growing number of studies confirmed already existing beliefs that many of the pathologies of childhood and adolescence were not transitional but would typically persist into adulthood and hinder the individual’s employability and work performance. Such research pointed to the neurological origins, chronic nature, and high prevalence of hyperactivity and attention deficit, and the necessity of early medical intervention in order to avoid future complications, like depression, drug abuse, failed relationships, and professional disappointment ([Weiss 1983](#)). By the mid-1980s, the field of hyperactivity research had reached such a size that the vast majority of US child psychiatrists and paediatricians would have diagnosed and treated the condition, which was re-conceptualised more broadly as Attention Deficit Disorder in DSM-III ([1980](#)). In schools, knowledge of the new expanded disorder category of pure attention deficit was rather patchy at this point, but that would change towards the end of the decade when the parent organisation CHADD emerged as a powerful driver of awareness among teachers, politicians and the wider public ([PBS 2000](#)).

During the 1970s, the UK was also increasingly affected by recession and

disenchantment, not least in the area of education. Apart from falling educational standards, unruly behaviour or even violence in schools was a major source of public disquiet (Symon et al. 1971a;b).² However, at this point, practically no one suggested that neurological disorders may be partly responsible for some children's inability to cope, nor that their problems could be dealt with pharmacologically, despite the claims put forward by British criminologist Steven Box (1977) that hyperactivity and Ritalin was spreading fast from the US to the UK. In fact, it would be another 20 years before Box's predictions came close to being realized, and ADHD and Ritalin were sufficiently established to become the subject of lengthy public and political debate. At this point, concern about behavioural problems and a growing culture of aggression in state schools was greater than ever, as demonstrated by the considerable amount of research on the topic, and by the constant flow of media stories about beleaguered teachers and "untamable" pupils (Lacey 1996).

In 2003, a discussion on ADHD in the House of Lords revealed many of the issues considered to be at stake (Hansard 2003). Apart from demonstrating the British tendency to lean towards dietary explanations of hyperactivity – that is, the belief that a diet high in sugar and artificial additives can adversely affect a child's behaviour – the Lords emphasised the need to spread more awareness of hyperactivity among teachers and social workers, noting that they were often woefully ignorant of the condition and tended to blame the parents. Furthermore, they highlighted the potential danger in neglecting treatment, due to the devastating cost to society and the individuals themselves, in the form of permanent school exclusions, future mental illness, unemployment, and anti-social behaviour. Earl Howe thus argued that

We are dealing with a condition, or rather a range of conditions that can literally lay waste to young lives. Families are pulled apart. Unspeakable

²In 1989, the influential Elton Report on discipline in schools – the largest survey to date of teachers' perceptions of school behavioural problems in England and Wales – came to the conclusion that press reports had exaggerated, but it confirmed that there was nonetheless a significant problem of persistent indiscipline of a disruptive nature, which created a challenging environment for teaching and learning (DES 1989).

disruption is caused in school classrooms. In the worst cases, of which there are many, ADD and ADHD can lead to crime and mental illness in adult life [...] Why is it that against that sort of background we in this country seem incapable of giving ADD and ADHD the attention and input that they deserve? Parents or healthcare professionals involved as advocates for the children will tell us that in many areas of the country it is like banging one's head against a brick wall to try to get schools and LEAs to acknowledge that a child who is aloof, unfocused, fidgety and who sometimes causes untold disruption in schools has something wrong with him. To suggest that that "something" not only needs treating, but requires special educational provision to be made is often the subject of huge confrontational argument, sometimes lasting years [...] At every step of the way, a LEA can make life a nightmare for families (ibid, column 314).

Certainly, British educational authorities initially resisted the importation of what they perceived as an American fad, with American norms and values attached to it. In addition to a widespread mistrust of the biomedical model which the diagnosis represents, there were grave concerns about the potential drain on already stretched special education services. However, mirroring larger trends in British society, attitudes to ADHD among UK educators have generally softened markedly over the past 15 years, even if the condition is still not officially recognised as a distinct educational disability and parents in many areas of the country continue to complain about the difficulty of obtaining appropriate assessments and services. One could speculate that the increasing pressure on schools to raise academic standards while remaining inclusive may have contributed to the increasing acceptance of the diagnosis. But clearly, as we shall see in chapter 7, wider social processes, such as the growth of parent activism and the spread of information on ADHD through the internet, have also been crucial.

Staying with the theme of national fitness pursued in the previous chapter, this chapter will first examine the context and impact of *A Nation at Risk* and its standards- and accountability raising agenda. Subsequently, I compare with the corresponding shift towards a market model in British education under Margaret Thatcher and the ways in which this development might relate to the boom in ADHD diagnoses in the late 1990s. In analysing the initial hostile reception of ADHD among British educators, I look at the values that have underpinned special

educational policy in the UK over the past 30 years, and then attempt to provide some possible explanations for the growing acceptance of the label in recent years. Among other things, this involves an examination of the growing dissatisfaction with Warnock's SEN framework, which has struggled to cope with the increasing number of pupils identified as having social, emotional, and behavioural problems. Finally, I compare with recent debates about disability labelling and special education in the US.

6.2 A Nation at Risk

During the post-war period, in parallel with the decreasing influence of stabilising social institutions such as the church and the family, the American public school had increasingly come to be perceived as the main arena for turning children into good, productive and moral citizens, as well as a "one stop shop" where school personnel could make sure that children were tuned for the future, both in terms of health and intellect. The 1960s and 1970s brought new federal and state programmes which aimed to improve education in general, and to enhance the social and cognitive development of previously under-served children from low-income families through the provision of comprehensive educational, health, nutritional, social and other services. However, such efforts where schools were on the front lines to remedy race, class, and gender inequities were by the early 1980s regarded as having all but failed. Several studies showed that the competencies of American students had declined considerably in spite of numerous reforms, and teacher competency now became a prime target of taxpayers and politicians (Erchak & Rosenfeld 1989, p. 85). At this point, it was generally accepted that America's position as the world's leading economic power was under threat, both from the recession which had originally been sparked by the energy crisis, and from the growing competition from Asia and Western Europe. American society was troubled by huge government budget deficits, unemployment and profound political disagreement about whether the country was moving in the right

direction. Incessant inflation and the rising cost of energy had slowed the rate of economic growth over the course of the preceding decade, and big American corporations were losing their supremacy in world trade.

Coinciding with close to zero population growth, these hard fiscal realities deeply affected US social welfare and educational structures, which suffered serious cutbacks as Congress cut \$35 million from federal programmes in 1981 ([Gutek 1986](#), pp. 319-325). Further, the emergence of the “information age”, with its emphasis on high technology, computers, and electronics, signalled momentous change for education and raised concerns that the curricula of American schools were suffering from an obsolescence similar to that which beset many traditional older industries, like the steel and mining industries. As the number of unskilled labour jobs dwindled and schools became increasingly result-oriented, there was no longer much space for academically weak individuals. At the same time, the demands for integration and inclusion persisted, creating contradictory pressures on schools to embrace as many as possible, while maintaining academic standards ([Schrag 1997](#)).

Throughout the 1970s, a concerted movement had grown among conservative politicians, citizen’s groups and other non-professionals at the state-level for “accountability” and a return to “basic education”. In their view, the emphasis in previous decades on educational experimentation and the use of “social promotion” to advance students to the next higher grade had caused a deterioration in the quality of education, which mirrored the decline in fundamental moral, ethical and civic values (*ibid*, pp. 336-338). Indeed, there was a pervasive feeling that schools were in part responsible for the economic problems plaguing the US, partly because the school had come to assume responsibility for a whole range of areas, instead of focusing on the primary task of teaching. Critics from the military and the business community thus charged that many graduates lacked the fundamental skills, sense of discipline, and creativity needed in the 1980s, while the success of foreign competitors, especially the West Germans and the Japanese, was yet again attributed to the superiority of their educational systems.

The back-to-basics theme eventually found national expression in the educational politics of the conservative Reagan administration. In 1983, three major federal reports were published, all calling for more rigorous academic standards, an expansion of basic skills beyond minimal competency in reading, writing, mathematics, and science, and the use of computers to meet the demands of the technologically sophisticated workplace of the future. The two most important were *Action for Excellence* by the Taskforce on Education and Economic Growth, which argued for the introduction of a market model in education and alliances with the business community; and *A Nation at Risk: The Imperative for Educational Reform* from the National Commission on Excellence in Education, personally supervised by Education Secretary Terrence Bell. Its dramatic and direct prose attracted a great deal of national attention and stirred widespread debate over the state of American public schools:

The educational foundations of our society are presently being eroded by the rising tide of mediocrity that threatens our very future as a nation and a people. If an unfriendly foreign power had attempted to impose on America the mediocre educational performance that exists today, we might well have viewed it as an act of war. As it stands, we have allowed this to happen to ourselves. We have even squandered the gains in student achievement made in the wake of the *Sputnik* challenge. More over, we have dismantled essential support systems which helped make those gains possible. We have, in effect, been committing an act of unthinking, unilateral disarmament (ibid, p. 5).

Among the risks identified by the commission were a high rate of illiteracy among young people and adults; an unbroken decline in performance of American students from 1963 to 1980 on the College Board's Scholastic Aptitude Tests (SATs); and consistent declines in fields vital to US national and economic security, namely English, mathematics, and science. Thus, they issued a series of recommendations on reform, including longer school days and a lengthened school year, more homework, competency testing for teachers, and the restoration of an orderly learning environment. Further, it was stipulated that standardised achievement tests should be administered regularly in order to identify the need for remedial intervention, and the opportunity for accelerated work.

Obviously, *A Nation at Risk* in many ways echoed the NDEA and the education critiques of the 1950s, only now focus was on America's place in the hi-tech explosion led by Japan. It also had similar effects in terms of drawing attention to children with difficulties and underlining the need for their (medical) identification:

By the 1980s, the Japanese threat to our economy was a wake-up call. The publication of *A Nation At Risk* in 1983, this was a real watershed moment in American education, after we'd had this huge [movement for] inclusion in the 60s and the 70s, in terms of race and gender [...] It was the kind of seminal document, which made people look around and say: "We have to go into overdrive now, we have to re-tool our big machine to somehow continue to be competitive, economically, globally". And that's when our classrooms, our education system, became even more... what do I want to say... restrictive. Whatever humanistic tradition we had in education sort of went out the window, more or less, at that point. I would say that from the 1980s onwards, John Dewey's active learning philosophy was no longer prioritised in teacher-training programmes. It became much more scientific, managerial, and mechanistic [...] America's collective response to the realisation that the US might lose its global hegemony, was to expect everyone to pedal harder and faster. On the whole, the mainstream education agenda retained the earlier goals of inclusion highlighted by the social justice agenda of the 1960's and 1970's, but emphasis shifted towards technocratic workforce preparation for global competition. This response tended to disadvantage special needs children, because it highlighted their academic and social challenges, so that individuals with developmental disabilities and ADHD now stood out in high relief in schools, families, and the public. They had more difficulties and tended to fall even farther behind, and we [schools and teachers] had more difficulties in serving these students because we didn't really know what to do with them. At the same time, the evolving technologies of the medical sciences began to direct educators and parents towards the medical model for understanding and addressing learning difficulties (Bilton int. 2006).

The impact of the report was enormous; according to the New York Times, it "brought the issue of education to the forefront of political debate with an urgency not felt since the Soviet satellite shook American confidence in its public schools in 1957" (cited in Sacks 1999, p. 77). Many professionals disagreed strongly with the general picture drawn by the commission, but its conclusions were on the whole accepted by conservative and liberal politicians alike.³ In 1989, pledging to make

³The commission for example drew fire from teachers' organisations who believed that teachers

this country the world leader in education by the year 2000, President George Bush affirmed his commitment to the report's recommendations and called for nationwide consequential testing to allow for the ranking of every school district in the country on the same scale. This programme was continued without modification by his successor, President Bill Clinton, who in 1997 in his State of the Union address called for a "national crusade for education standards", emphasising the urgent need a set of national tests of student achievement in reading and mathematics (ibid, p. 80). Both invoked the same assumptions of crisis and failure that had fuelled every other education reform debate since WWII, as well as the idea of a bygone golden age of education which supposedly began to fall apart under a siege of grade inflation and progressive mush that left America helpless against superior competition.

However, undermining the sense of alarm, a number of studies in the late 1990s showed that things were far more complex. While recognising that American students continued to score lower than their peers in Singapore, Taiwan, Japan, Korea, and elsewhere, they showed that American high school completion and college graduation rates were the highest in history (Schrag 1997). Although SAT verbal scores declined over the years 1975 to 1990, the decline could be explained by the fact that a larger percentage of students from minority and disadvantaged backgrounds began taking the test. Clearly, it was costly to take children from an unprecedented array of ethnic and cultural backgrounds – many of them speaking little or no English – and educate them all to a relatively high level.⁴ In addition, big sums had been diverted from the regular classroom by the explosive growth in the number of students officially considered disabled, a designation that hardly existed in the immediate post-war years.

were being made scapegoats for national problems beyond their control, and that severe reductions in and the elimination of, programmes by the Reagan administration had imperilled education and especially the efforts at equality of opportunity for women, minority groups, and the handicapped (Gutek 1986, p. 344).

⁴Critics have often pointed to the high costs of the American education system, but few mention that the major Western European nations spend more on health and child care and related social services, and that theirs are for the most part still monocultural societies with less social problems (Schrag 1997).

6.3 The history and impact of high-stakes testing in the US

Despite the questionable conceptual underpinnings of *A Nation at Risk*, the report led to a substantial rewriting of federal and state laws on education, and ultimately served to usher in the current era of “high stakes” testing in American education. High stakes testing refers to the use of standardised achievement assessments that have a direct impact on a person’s life options and opportunities⁵, and furthermore involves the preferential allocation of state funding to school districts showing the greatest improvement in test scores, as well as the employment and pay of teachers and administrators on the basis of these scores. Such arrangements obviously increased the pressures faced by teachers and schools to improve the academic achievement and conduct of their students. Due to changes in disability legislation, there were now also more students with learning problems and challenging behaviour in mainstream classrooms, making teachers’ work more difficult. Moreover, perspectives on and approaches to managing students’ troublesome behaviour were changing: inexpensive and apparently effective pharmacological relief was coming into its own at this time, while an increasing amount of research was showing that untreated symptoms of hyperactivity, inattention, and impulsivity could seriously impair an individual’s long-term adjustment and prospects. Finally, following pressure from the parent organisation CHADD, hyperactivity and attention deficit were eventually accepted as covered educational disabilities under the IDEA. Together, these various developments helped to create a space within which a retooled, expanded type of hyperactivity disorder could flourish, namely ADHD, which emphasised lack of concentration and its effects on school performance.

The current emphasis on high stakes accountability in the US can be traced back to the 1965 authorisation of the Elementary and Secondary Education Act which called for greater attention to the quality of American schools and the needs

⁵For example, the consequences of low scores for students include failure to be promoted to a subsequent grade, failure to graduate high school, or denial of college scholarships (Nichols & Berliner 2007, p. 7).

of children from minority and low-income families ([Nichols & Berliner 2007](#), p. 3). In response to the launch of Sputnik, “minimum competency tests” were then implemented to ensure that all students left school with at least the ability to read and do basic math. These basic tests were soon criticised by being too easy, but despite the tough rhetoric of rigorous academic curricula, the new multiple-choice tests adopted in the mid-1980s after *A Nation at Risk* were only one step up from the previous system. During the 1990s, however, the introduction of high stakes testing in many areas of the country marked the beginning of a new regime which was eventually ratified for every state, district and school by the No Child Left Behind Act (NCLB), passed in 2001 and signed into law in January 2002 by President George W. Bush. This legislation required that states adopt a system of accountability whereby students, teachers, administrators, and schools are evaluated annually on the basis of students’ standardised test performance and that consequences follow when student scores are low. The stated aim was to motivate students and educators alike to raise academic achievement. Nonetheless, much subsequent educational research has shown that high stakes accountability in effect often limits the curriculum, constrains teachers, stresses students, and curtails access to postsecondary education, subverting both learning and equality of educational opportunity for many students ([Lemann 1999](#); [Moses & Nanna 2007](#), p. 56).⁶ Perhaps not surprisingly – though somewhat at odds with the American preference for the medical model predicated on diagnostic testing – many US educators have therefore been strongly opposed to standardised testing ([Bilton int. 2006](#)).

Several historians have examined the unique history of standardised testing in the US in the 20th century, emphasising how the ideology of individuality and the great American faith in quantitative methods and measurement devices – or “trust

⁶Interestingly, similar findings were reported about a performance-related pay for teachers program that was introduced in England as far back as the 1860s. The “payment by results” program was abandoned after 30 years because “teachers taught to the test, were confined to a narrow, boring curriculum, attempted to arrange the school intake, cheated, ignored bright children and drilled and beat the slower ones until they could satisfy the all-powerful inspector” ([Chamberlin et al. 2002](#), p. 32).

in numbers” as [Porter \(1995\)](#) puts it – created an environment particularly conducive to the expansion of testing programmes. With promises of mechanical objectivity, psychometric tests grew out of military and industrial environments and were subsequently took hold, primarily as a means of sorting students into differentiated educational paths (academic, vocational, and commercial) within the so-called “tracking system” which gained widespread acceptance within American schools in the course of the 1920s ([Jansz & van Drunen 2004](#), p. 76).⁷ The tests fitted in well with the general progressive themes of efficiency, and they were gradually introduced for other purposes, such as vocational guidance and selection for higher education. In Europe, the introduction of intelligence and related tests proceed at a slower pace, and in a less pervasive way, partly due to the fact that old class barriers continued to exist in many places, including the UK, until after World War II. Furthermore, it was hampered by theoretical doubts among psychologists themselves. A common theme was a deeply felt scepticism towards the possibility of reducing something as complex as scholastic aptitude to a simple measure such as IQ. Thus, as far as they were adopted before the war, their use was typically confined to the examination and classification of “backward” children (*ibid*, p. 78).

While widespread standardised testing was unique to the US prior to World War II, intelligence and achievement tests were also introduced on an increasing scale in Europe after the war, and the involvement of psychologists in education increased significantly on both sides of the Atlantic. In the UK during the 1920s and 1930s, there was already considerable political interest in British psychologist Cyril Burt’s research on general intelligence which backed the theory that IQ was innate and measurable. Particularly in the Labour party, many began to see psychometric testing as a useful way of dividing children into different ability

⁷Standardised testing in the United States has its origins in World War I and the Army Alpha and Beta tests developed by Robert Yerkes and colleagues, which were given to 1.7 million US recruits. Yerkes was concerned to establish psychology as a hard science and believed that promoting the use of mental testing looked a promising route to achieve this. On the basis of the Alpha and Beta test results, he ultimately concluded that recent immigrants, especially those from Southern and Eastern Europe, scored considerably lower than older waves of immigration from Northern Europe. After the war, this was used as one of the eugenic arguments for the introduction of harsh immigration restriction. Later, these findings were criticized for simply measuring acculturation, as the scores correlated nearly exactly with the number of years spent living in the US.

groups and opening up good schools to capable working class pupils. The aim was to remove traditional class barriers in order to provide better educational and social chances to children from lower social backgrounds. The 1944 Education Act thus embedded IQ testing as a central element in the new statutory 11-plus exam, in addition to introducing free secondary education (Murdoch 2007, p. 140). Just as the Americans were “tracking” students within the mainstream system according to their perceived abilities, the British would now “stream” pupils by sending them to entirely different schools, based on their performance on one exam.

At the same time in the US, growing participation in higher education created a new market for standardised testing, alongside its continuing use in elementary and high schools. Not least due to the aggressive marketing efforts of the influential publisher of the Scholastic Aptitude Test (SAT) – originally developed in 1927 as an Ivy League entrance exam – aptitude tests soon became viewed as a fair, efficient and objective way to assess students’ abilities and allot educational places based on individual merit rather than birth circumstances and social status (Lemann 1999).⁸ In addition to their meritocratic function, the idea was that they could also serve as a diagnostic tool for measuring if and how well students were learning. In the 1960s, however, an increased scepticism about the usefulness and legitimacy of student intelligence and achievement testing resulted in numerous critical publications, and separate education came under heavy attack from minority and disability rights groups who felt they were being discriminated against.⁹ Protests also grew in the UK where it soon became clear that there was a huge gulf between grammar schools and the so-called secondary modern schools in terms of the quality of teaching, as well as the socio-economic make-up of the student population (Murdoch 2007, p. 155). Labour now opposed what they saw

⁸However, in his history of how the Scholastic Aptitude Test (SAT) became enshrined in US culture, Lemann (1999) suggests that although the idealistic, patrician pioneers of testing such as James Conant Bryant may have wished to displace the entitlements of inherited privilege for what they saw as the more democratic entitlements of scholastic aptitude, at the end of the 20th century their creation looked very much like what it was intended to replace.

⁹Among these left-wing social critiques were *Education and the Cult of Efficiency* (Callahan 1962), *The Tyranny of Testing* (Hoffman 1962), and *Schooling in Capitalist America* (Bowles & Gintis 1976).

as an elitist discriminatory education system, and, when they came to power in 1964, instructed LEAs to convert to comprehensive education. Concomitantly, the political winds turned in favour of an environmentalist interpretation of IQ.¹⁰

However, in the US, the dust quickly settled after the uprising. Historian Daniel Resnick (1982, p. 191) concluded that the three major agents of the enterprise – “applied psychology, school administration, and the publishing industry” – had too firm a hold over education evaluation to let go, and moreover pointed out that whenever a crisis had been identified within American schools, politicians and the public usually called for stronger means of accountability through testing. Nonetheless, except for the graduate school entrance examinations, the various tests used up until the late 1980s rarely had dramatic consequences. Students could be denied or admitted to gifted programs on the basis of their results, and they often determined whether or not remedial programs were appropriate, but opportunities for obtaining a college degree still existed regardless (Nichols & Berliner 2007, p. 3). Similarly, administrators were only very occasionally given bonuses or fired for the performance of their students on standardised tests. With the introduction of high-stakes assessment, this all changed.

Although much of the controversy surrounding federal reports and policies on public education such as Ronald Reagan’s *A Nation at Risk*, George Bush’s *America 2000*, and George W. Bush’s No Child Left Behind Act stems from a fundamental disagreement between neo-conservative and liberal approaches, the increasing calls for consequential testing at both the state and national levels have not been limited to one political party. NCLB was originally proposed by the Bush administration, but the bill received overwhelming bipartisan support in Congress. Furthermore, the standard-based approach to education it represents has overall

¹⁰Shortly after Cyril Burt’s death in 1971, a major controversy broke out when he was accused by Princeton psychology professor Leon Kamin amongst others of having falsified research data on separated identical twins in order to “prove” the hereditarian theory of intelligence transfer. This left Burt’s reputation tarnished and today most experts agree that his later work was flawed. Kamin later went on to publish various works on the racist proclivities of the pioneers of psychometrics, such as Robert Yerkes.

enjoyed considerable public support. As basic tests of intelligence have given way to achievement tests, testing has become so commonplace in the US and frequently begins so early in a child's life that few people question its legitimacy (Moses & Nanna 2007, p. 63). Mirroring the general trend towards the acceptance of quantitative measures as legitimate indicators of economic, political, mental, and physical well-being, there seems to be an ever-decreasing separation between notions of intelligence and personal self-worth. This means that "for many parents their child's score does not measure just one day, or even a week, of their child's work; it mirrors the family's success, the parents' affluence, and the child's future" (ibid, p. 64). Further, as American public schools have historically relied heavily on local property taxes and have thus tended to reflect the economic and social status of the surrounding community, school test scores now also affect many aspects of a community's self-image, including property values (O'Regan int. 2006; Sax 2000).

Apart from accountability, there has also been wide support at the federal level for a closer integration of learning and behavioural health. As we saw in the previous chapter, the idea of using schools as the primary platform for the prevention of social maladjustment dates back to the first decades of the 20th century. However, in the 1950s, American education policy started to back away from the broad mission of progressive reform, which had expanded the function of schools to include vocational education, general health promotion, and "mental hygiene", in order to focus instead on the narrower mission of ensuring higher levels of academic achievement. The break with the progressive tradition was particularly marked in *A Nation at Risk*. Nonetheless, comprehensive mental health services started being developed in US schools in the 1980s, motivated by new research on the importance of "school climate" in predicting academic outcomes in disadvantaged communities, as well as by the passage of the EHA in 1975, which strengthened schools' obligation to provide support for youth with emotional disabilities (Weist 1999). More recently, focus on early identification of emotional and behavioural problems among all school children has grown due to budget reductions and the increasing costs of special education (Flaherty et al. 1996). Thus, on the background of warnings from the Surgeon General about the

widespread presence of untreated psychiatric disorder among American children, the Bush administration produced a number of initiatives that promoted the schools' role as a vehicle to address such problems. First, the NCLB set more funds aside to help "at risk" students (a significant proportion of whom are those considered to be candidates for an ADHD diagnosis), while stressing the need to develop programmes that link local school systems with local mental health systems. Similarly, the 2003 report *Achieving the Promise* from the New Freedom Commission on Mental Health focused much attention on the great potential of expanded school-based mental health services, both as way of improving children's general psychological well-being and as an important part of the efforts to improve educational attainment levels. For example, the report encouraged a greater mental health-education interface through the engagement of professional teacher organisations in educating new "frontline providers". More controversially, it even urged the creation of a comprehensive mental health screening process in the nations' schools and child care facilities, prompting socially conservative activists to argue that broader protections of children and families were sorely needed, especially since the screening was to be linked with treatment and supports, including state-of-the-art "specific medications for specific conditions" (Lenzer 2004).¹¹ Critics of the psychiatric enterprise were quick to point out who seemingly stood to gain by making screening a national issue, namely the big professional associations of psychologists and psychiatrists, various pharmaceutical companies, testing companies and researchers.

As regards effects on the curriculum, recent reform efforts in education have privileged subjects such as reading, writing, and maths, while reducing recess and subjects like gym, music and arts. Moreover, the practice of "teaching to the test" has become commonplace. According to several experts in boys' psychology, the

¹¹The commission held up the Texas Medication Algorithm Project (TMAP) as a "model" evidence-based medication plan for other states to follow. However, this project, which promotes the use of newer expensive antidepressants and anti-psychotics, became steeped in controversy when it appeared that the key officials with influence over the medication plan in Pennsylvania received money and perks from drug companies (Lenzer 2004). The Texas project itself started in 1995 and funded by a Robert Wood Johnson grant and by several drug companies which were all major contributors to Bush's election campaign.

problem is that many young boys are simply not mentally mature for a long school day with few breaks and little physical and creative activity (Kindlon & Thompson 1999). Like his morally troubled colleague Larry Diller (1998), psychologist and family physician Leonard Sax (2000) has thus described how the current school culture may often result in a dilemma for the doctor and, in the end, a prescription for Ritalin. If a boy loses interest in classroom activities around the end of the first grade, he explains, the boy's parents are typically summoned to the school for a meeting. While the counsellor and teacher will often emphasise that he is not reading at grade level and not paying attention, the psychologist will warn that he might have ADHD and advise a meeting with the family doctor. The doctor then has two choices: to diagnose and prescribe, and quickly move on the next patient, or to question the need for stimulants and do his own thorough assessment, meaning that he will be running behind schedule. As most doctors in the era of managed care have neither the liberty to allow an hour per visit, nor the education to perform their own evaluation, they will often accept the teachers' and school psychologist's judgement and prescribe – a decision which has now been made easier by the availability of once-a-day “long-acting” stimulants.¹²

The dynamics involved in ADHD identification and treatment are somewhat different in Britain, where a child is typically referred due to disruptive offensive behaviour rather than learning problems. This point emerges clearly in a recent empirical comparative study based on a sample of 150 children, which highlights how interactions between individual biology and particular environments give shape and meaning to symptomatic behaviours (Singh 2011). Here, it is argued

¹²Whereas Ritalin's effects wear off in approximately four hours, requiring dosing during the middle of the school day, new drugs and new preparations of existing drugs (Adderall XR, Metadate CD, and Concerta) require only one dose per day. When the FDA Modernization Act of 1997 provided new financial incentives to pharmaceutical companies for developing and testing drugs on children by extending their patent exclusivity, paediatric psychopharmacology research underwent a major expansion, leading to the development of these new types of drugs. Now children no longer had to be embarrassed by taking the drugs during the school day, and the medications were therefore far less likely to be diverted in school settings for illicit use. In addition, by decreasing the need for school personnel and by increasing confidentiality for families, the long-acting drugs made stimulant treatment an easier and more attractive choice for many parents and children (Mayes et al. 2009, p. 145).

that whereas difficulties with self-control are likely to be expressed in the context of a “performance channel” in a modal US school environment, in the UK state school environment, ADHD manifests itself mostly as a disorder of anger and aggression. In explaining this difference, Singh points to the purportedly low aspirations for social mobility and university attendance in lower middle class and working class families in the UK, together with what she terms “a pervasive and apparently pernicious presence of a state school-based culture of aggression”, associated with the lack of careful supervision by teachers and strong normative limits on interpersonal behaviour (ibid, p. 891). In contrast, children in the US are said to infrequently experience physical or verbal bullying from peers or teachers (due in part to institutional prohibitions on such conduct), but the pressure to do well in school is higher, meaning that good behaviour is seen to a greater extent in terms of good grades.¹³ Though Singh warns against reducing the experience and expression of ADHD to any single demographic variable, she nonetheless admits that academic ambitions and levels of aggressive behaviour often correlate with social class. Accordingly, UK students from well resourced, highly educated backgrounds are more likely to mention the importance of school performance when discussing their ADHD behaviours, while American children from underprivileged areas are more likely to experience ADHD in the context of hostile altercations.

¹³Belief in strong social and economic mobility – the “American Dream” – has always been an essential part of the American identity. In this respect, the US is often juxtaposed with Britain, a country famous for its class constraints. Thus, much like Singh, [Jacobsen \(2003\)](#) found that the relatively modest academic/occupational ambitions for children in lower middle class families and schools may partly explain the low levels of ADHD diagnosis and the dominant notion of the condition in the UK as an externalising behavioural disorder. In comparison, the American parents in Jacobsen’s ethnographic study almost all had a clear expectation that their children would attend university – partly because they were better educated themselves than their British counterparts – and these socially and economically driven expectations in turn lead to a situation where learning difficulties were seen as undermining and in need of treatment (ibid, p. 585). However, it is worth noting that new data from various large-scale studies in fact show that vertical inter-generational mobility is lower, not higher, in the US than in other developed countries, with the “stickiness” appearing especially at the top and bottom, as affluent families transmit their advantages and poor families stay trapped. A project led by Markus Jäntti at Stockholm University for example found that 42% of American men raised in the bottom fifth of incomes stay there as adults. That shows a level of persistent disadvantage much higher than in Denmark (25%) and Britain (30%) ([DeParle 2012](#)).

Demonstrating that things are far from black-and-white in comparisons such as the present, several of my interviewees also noted that despite recent testing initiatives associated with NCLB, there is still much focus in American public schools – at least at the primary level – on sports, show-and-tell, and other extrovert activities which foster pro-social behaviour, self-esteem, and communicative “selling” skills. In Britain, on the other hand, schools have recently been criticised for placing too much emphasis on reading, writing, and mathematics (even at the primary level) and the regular testing of these skills at key stages. At the same time, the introduction of comparative measures of performance – the so-called school “league tables” – has been singled out as a major cause of increasing intolerance and hostility toward difficult, disruptive pupils over the past two decades.

6.4 Market-led reforms and exclusion practices in British education

Mirroring developments in the US, the UK in the 1970s saw the beginning of a general disenchantment with education as a palliative of society’s ills, as well as rising concerns about the country’s competitive strength in a worrying economic climate. As a result, teacher accountability became a priority for both major parties, as did the growing problem of indiscipline in schools. Conservative politicians and educationalists in particular called for more teacher accountability, more national testing, and for national inquiries into everything “progressive”. These views were presented in a series of five “Black Papers”, published from 1969 to 1975, which attacked the concepts of egalitarianism and blamed comprehensivisation for preventing academically-minded students from obtaining good examination results. In the last two Papers, contributors put forward the various arguments for choice, competition and parental control of schools which would eventually be taken up with enthusiasm by Margaret Thatcher’s administrations from 1979. Meanwhile the Labour government made its own turn to the right and announced a halt to comprehensive change. In his famous speech

at Ruskin College in 1976, Labour Prime Minister James Callaghan furthermore noted that the curriculum paid too little attention to the basic skills of reading, writing and arithmetic, and that teachers lacked adequate professional skills and did not know how to discipline children, or to instil in them concern for hard work. Underlying all this was the feeling that the educational system was out of touch with the fundamental need for Britain to survive economically in a highly competitive world through the efficiency of its industry and commerce (Gillard 1997).

The move towards a “quasi-market” in education was kick-started by the 1988 Education Reform Act, a highly significant piece of legislation which on the one hand increased centralisation and reduced the power of LEAs, and, on the other hand, introduced the principles of supply and demand in education.¹⁴ Chief among its provisions were 1) the establishment of a government-prescribed National Curriculum for all LEA-funded schools in England and Wales; 2) universal testing at ages seven, eleven, and fourteen, leading to performance indicators through the publication of SATs¹⁵ and GCSE results; 3) the implementation of the principle of local financial management of schools; 4) formula funding which meant that the more children a school could attract, the more money it received; and 5) increased consumer choice. Parents could now, at least theoretically, choose a school outside their catchment area, and funding became more closely linked to student enrolment numbers, giving schools the incentive to attract and admit more students. Indeed, an increasing number of successful secondary schools were permitted to choose a percentage of their

¹⁴Higher education is another policy area that has been subject to major reform in recent decades. Historically the preserve of the wealthy, the higher education sector in the UK during the 1980s and 1990s witnessed something quite like the surge in enrolments – from around 15% to around 40% – that American higher education experienced in the 1960s. Nonetheless, attesting to wider problems of low social mobility, the relative position of lower socio-economic groups is still poor, despite attempts to further widen access. Indeed, there is evidence that the gap in participation between richer and poorer students actually widened in the mid and late 1990s, a trend which is presently set to continue with the introduction of rapidly increasing tuition fees (Machin & Vignoles 2006, p. 14).

¹⁵In the UK, SATs refer to the National Curriculum assessments which are completed at 3 Key Stages. They must not be confused with the American SATs which is a standardised test for college admission in the US.

students on the basis of aptitude and presentability. The idea was that schools perceived to be inferior would be forced to either improve or, if hardly anyone wished to go there, to close down. Finally, a four-yearly system of national inspections in state schools by the Office of Standards in Education (OFSTED) was established in 1992.¹⁶

The reform package addressed a number of concerns to which had emerged during the late 1970s, namely poor and falling standards in schools, the low staying on rate at age 16 compared to other developed countries, and the relatively poor literacy and numeracy skills of the UK population. During the 1980s, around half the cohort was leaving full time education altogether after the age of 16. More than two thirds did not achieve examination success at age 16 (the equivalent of five or more O level passes), and therefore entered on the labour market with no academic qualifications. Many of these individuals went on to take vocational qualifications, but nonetheless there was a widespread perception amongst British education policy-makers that the UK had a particular problem with its so-called “long tail of low achievement” ([Machin & Vignoles 2006](#), p. 2). Focus was therefore on creating and imposing educational targets so that British children would be competitive in world labour markets.

However, the new regulations soon raised concerns about de facto socio-economic segregation and reduced tolerance towards disadvantaged children as a result of the pressures imposed on schools to be competitive and to provide inclusive educational opportunities for all children at the same time ([Cooper 1998a](#); [Farrell & Tsakalidou 1999](#); [Norwich int. 2006](#)). Specifically, observers argued that the rhetorical emphasis on performance had negative consequences for vulnerable children, as the new accountability structures inevitably took away some of the incentive for teachers to deal effectively with disruptive and under-achieving pupils. At the same time, the new standardised curriculum – originally

¹⁶The Office for Standards in Education (Ofsted) was formed under the Education (Schools) Act 1992, as part of the major overhaul and centralisation of the school system begun by the Education Reform Act 1988. The impetus came partially from the perceived unwillingness of left-leaning LEAs and inspectors to implement elements of the Conservative government’s agenda.

presented as a great democratic project – was criticised for attempting to “squeeze square pegs into round holes” by forcing a number of children to follow curricula that may not be appropriate for them (Cooper *int.* 2005).¹⁷

With the 1981 Education Act and subsequent special education legislation, it became more difficult in legal terms to exclude a child from a mainstream school, either formally, or through the special needs mechanism into a special school. However, in spite of the widespread rhetoric of inclusiveness, the number of children formally statemented as having special educational needs due to emotional and behavioural difficulties (EBD) and placed in segregated provision rose during the 1980s, even though LEAs were educating more children with other special needs in mainstream settings (Cooper 1998a, p. 46). In the 1990s, evidence suggested that mainstream schools in the UK were becoming more and more hostile to the inclusion or reintegration of disruptive pupils with social, emotional and behavioural problems, including the subgroup that would increasingly be diagnosed with ADHD. Indeed, there seemed to be a trend to refer an increasing number of these pupils to special schools/facilities or to completely expel them altogether.¹⁸ The number of children permanently excluded increased from 3833 in 1991/1992 to 13,581 in 1995/1996, of which 12% had SEN statements. Researchers however suggested that this figure would double if it were to include pupils who were excluded for fixed periods of time, while also pointing to the use of many forms of informal, hidden forms of exclusions which are never registered (*ibid*, p. 47).¹⁹ Causing further hindrance to already poor educational progress,

¹⁷The National Curriculum and the attached testing culture does not translate directly to standardised testing in the US. In the US, individual states have considerably autonomy in determining curricula and education policy, and perhaps because American public education is a state-controlled enterprise, there is widespread opposition to a national curriculum along the lines of the British (Bilton *int.* 2006).

¹⁸According to Cooper, there are various myths around inclusion and the consequent closure of special schools, especially for this group of pupils (Cooper *int.* 2005). From the mid-1990s to the 2005, a big decrease was observed in the number of children being referred to special schools in general, but researchers suggested that not only were there still many schools especially for children with social, emotional and behavioural difficulties, but also a considerable number of children with severe behavioural issues were being placed in schools formally catering for pupils with learning problems.

¹⁹Pupils may be unofficially excluded under the guise of bogus medical circumstances, through collusion with parents, or “creatively” used authorised absence procedures. Further, so-called

many would receive only part-time and/or substandard education through home tuition or, more commonly, through attendance at small Pupil Referral Units (PRUs) (Cooper *int.* 2005). Not surprisingly, the expelled child or young person tended to be disproportionately male, black and socially disadvantaged. Similarly, schools prone to exclude were likely to have a tight budget as well as staffing and space problems (POST 1997, p. 3).

Thus, while it is clear that wider social changes are associated with a measurable and marked increase in the level of psychosocial disorders in young people since 1945 (Rutter & Smith 1995), the relationship between school exclusions and the concomitant increase in young people's psychosocial problems is hardly a simple case of the latter causing the former, especially considering the fact that big individual differences have been demonstrated in the effectiveness of individual schools and teachers in dealing with disruptive behaviour (Cooper 1998a, p. 48). Nonetheless, when Labour came to power in 1997 following an election campaign in which education and child poverty had featured prominently, there was a distinct absence of debate about the merits of the market economy approach, including the controversial school league tables. This was clearly brought out by the 1997 White Paper *Excellence for Schools* which endorsed much of the 1988 Education Reform Act and successive legislation in relation to parental choice and competition between schools in a diverse and increasingly unequal secondary school system. In spite of the rhetoric of change, many left-wing commentators argued that the New Labour education manifesto simply signalled a continuing cultural shift – encompassing the concept of excellence in itself – in the direction of an American-style education system (Gillard 1997).²⁰

“cosmetic expulsions” have been reported, referring to situations where mothers are asked to keep their children at home during Ofsted inspections (Malacrida 2004, pp. 98-99).

²⁰The idea that everybody can achieve excellence in one way or the other – even if it is only measured in terms of the amount of progress made – is a fairly new one in the UK. Existing in tension with the strong rhetoric of social justice going through education from the 1940s in particular, the British notion of excellence has historically been tied to the presence of a highly selective education system and the concept of an intellectual elite, who should ideally be given the opportunity and freedom to develop their talents in a holistic manner, and top universities such as Cambridge and Oxford of course still celebrate that to some extent. Apart from being difficult to accomplish, the inclusive approach to excellence outlined in the educational policies of the Labour

In the area of special education, the new government gave strong public support to the principle of inclusive education in the 1997 Green Paper *Excellence for All Children: Meeting Special Educational Needs*. The stated ambitious aim was to get more children with special needs into mainstream schools, while also introducing targets for both mainstream and special schools with regard to educational attainment and social and behavioural performance. Everybody was to be brought into the fold, at least rhetorically, without sacrificing the focus on increasing levels achievement. However, in the period from 2000 to 2005, the proportion of children in special schools (around 1%) and the proportion of children with statements (around 3%) plateaued. Further, attesting to the continuing failure to cope with the rising number of children with social, emotional or behavioural problems, the number of school exclusions only fell very slightly, despite the government's declared intention to tackle this much-debated issue ([House of Commons 2006](#)).

Children seen to be simply undisciplined, and those without the support of a Statement (including a significant number of ADHD children), have been especially liable to be excluded, either permanently or temporarily for up to 45 days in a school year.²¹ Compared to the US, there are more formal and regularised avenues for excluding schoolchildren in the UK, and sociologists argue that these policies in fact amount to a form of non-medical social control, which reduces the incentive and need for screening and medicating children ([Hart & Benassaya 2009](#), p. 244; [Malacrida 2003](#), p. 97).²² Conversely, it has been suggested that US

government was rather different, however, being more closely associated with measurable outcomes and the development of strictly vocational skills ([Cooper int. 2005](#)).

²¹Although there are well documented and highly significant correlations between special educational needs, school exclusion and deprivation (children eligible for free school meals have for example been shown to be about four times more likely to be permanently excluded than those not eligible), there seems to be a curious paucity of research into specific links between ADHD and social class/ethnicity indicators on the whole. However, several of my interviewees indicated that the group of excluded children and adolescents has undoubtedly come to include a fair – and increasing – proportion of pupils with ADHD ([Prior int. 2006](#)).

²²In the UK, children who are disruptive can be excluded for up to 45 days a year, or permanently in severe cases. A British school can also resort to exclusion if it cannot provide the required special-needs instruction. Although it is up to the local administration to provide a substitute as soon as possible when a child is excluded, these children often find themselves without schooling for a considerable time.

educators originally came to embrace hyperactivity/ADHD and drug therapy partly as a result of decreased access to the use of traditional punitive methods like physical disciplining and student expulsion or suspension (Conrad 1976; Kiger 1985). From a legal perspective, the option to pursue exclusion is limited in America, but as an alternative strategy it appears that educators have been prepared to identify problem children and press for medical treatment with considerable vigour, increasingly also in the group of children who were not hyperactive and aggressive, but simply had difficulties concentrating on their school work.

6.5 ADHD as a Trojan horse

When ADHD emerged on the British school scene in the mid-1990s, it is possible that the increasing accountability pressures described above to some extent fuelled the medical labelling and treatment of child behavioural problems. However, it is also likely that the availability of the disciplinary instrument of exclusion played a part in tempering the perceived need for medical responses. Furthermore, as reflected in the large body of sceptical opinion which was mobilised in professional media, the medicalisation process was slowed down by the predilection among many British educators for a social model of educational disability, and a strong antipathy toward drug-based solutions, informed by the lingering influence of 1960s and 1970s left-wing liberal critiques of psychotropic drug use as a chemical form of social control. For example, in the letters pages of *The Psychologist* during 1995 and 1996, educational psychologists and special education teachers expressed various concerns ranging from the perceived return of the individual “deficit model”; the way in which the ADHD label and Ritalin may change teachers’ view of the child in question, as well as the child’s perception of himself; and the violation of children’s rights. As one psychologist put it: “Should we risk medication becoming the norm for treatment of overactive children? From what I have seen in schools so far, this is the road to confusion, ignorance and

pragmatism” (Hayes 1996, p. 343). Whereas pragmatism would rarely have negative connotations in the US, that was clearly the case here.

Around the same time, a report from the British Psychological Society on the new phenomenon of ADHD described practices of stimulant use in the US as “very alarming”, noting that “it is important to prevent this from happening in Britain”, and that medication “must not become the first, and definitely not the only, line of treatment” (BPS 1996). Expressing the “ideal” position of the psychology profession in the UK at this point, the report stressed the importance of parent/family training, general school-based interventions, cognitive behavioural therapy, and dietary management in a small number of cases. Elsewhere, one of the key members of the BPS Working Party on ADHD argued that the construct is unhelpful to teachers and useless in planning and implementing interventions, as it does not reveal anything apart from the already obvious fact that the child is experiencing chronic behaviour and learning problems. As an alternative to the medical perspective, she instead proposed a “functional perspective”, where descriptions of behaviour would purely serve to inform intervention, rather than determine the presence of an underlying defect or disorder (Reid et al. 1998). This view was echoed by several other commentators who emphasised that creating an additional category of special need for ADHD was unlikely to make any difference in terms of interventions available through education authorities, and that existing policy guidelines already provided an entirely adequate framework for establishing the nature of children’s needs, without recourse to diagnostic categories (Prior 1997, p. 24).

As these writers themselves pointed out, obvious parallels could be drawn to earlier debates about the medicalisation of reading difficulties and specifically the concept of dyslexia, which has been quite popular in the UK, even if it is not officially accepted in government guidelines. Indeed, a child with a diagnosis of ADHD or LD in the US would often have received a label of dyslexia in the UK (O’Regan int. 2006). The debate in the early 1980s was mainly between proponents of the generic term of specific learning disability and the separate category of dyslexia respectively, with some influential educators scathingly referring to the

latter as the “unidentified flying object of psychology” while asserting that the problem amounted simply to an educational question as to how to teach more effectively. In a comment reminiscent of later critiques of the ADHD phenomenon, one educational psychologist thus concluded: “Let us deal with learning difficulties and specific learning difficulties as they arise and abandon the attempt to define a concept, half-medical, half-educational, half-magic [...] What this hybrid of a concept represents can as easily be defined in clear behavioural terms and plain English” (Whittaker in [Pumfrey & Reason 1991](#), p. 6). On the use of the medical model, she elsewhere added:

We managed to get rid of labels such as “idiots” and “cretins” and replace them with more accurate terms. The medical model is not appropriate in the case of learning and educational matters [...] Dyslexia is a hoax in need of thorough exposure... We all know that somewhere in the South of England one man still believes that the earth is flat and keeps a society devoted to this outmoded concept alive through the sheer tenacity of his will-power. A similar devotion to an outmoded concept in the field of learning seems to inspire those who work so hard to keep the dyslexia issue alive ([Whittaker 1982](#), p. 97-98)

However, one important factor distinguishing ADHD from dyslexia is the combination of high prevalence and the associated use of stimulant medication which, as a primary intervention, powerfully reinforces the idea of hyperactivity as an organic problem requiring medical solutions ([Prior 1997](#), p. 22). Indeed, the stimulant drug treatment accompanying the ADHD diagnosis was clearly a source of profound disquiet for many professionals, both due to its ability to mask external causes of unhappiness, and due to its effect on the individual’s sense of self control and free will. In *The Psychologist*, special school teacher Tim O’Brien succinctly articulated the uneasiness many educators felt: “As an intervention, it brings to the surface tensions between therapeutic and educational ideologies. Further, it sometimes raises the superficially paradoxical issue of administering an amphetamine-based stimulant to children diagnosed as hyperactive. Why give ‘speed’ to a child who already operates at 100 mph?” ([O’Brien 1996](#), p. 162). O’Brien pointed to the ethical issues involved when staff are asked to administer such drugs, and emphasised that Ritalin could pose a threat to the spiritual

development of a child with EBD.²³ Apart from the issue of adverse drug effects such as dependency, his concern was that Ritalin adds an unknown element to the process of gaining evidence on a child's educational and behavioural progress: "Perhaps 'wonder drug' is an accurate title – because each time I'm informed that another child has been placed on Ritalin, I *wonder* if I am working with the holistic, animated and unique individual or the chemical child" (p. 164) This, he added, the child would also ask himself, not knowing his real self anymore.

Similarly, educational psychologist Philip Prior (1997) criticised both the label and medication for affecting the way ADHD children (and their parents) perceive the disruptive behaviour, both in terms of causation and in terms of the extent to which they themselves have control over it. Whereas the taking of medication for medically defined conditions has powerful iconic and culturally reinforced significance, educational and psychological interventions are unlikely to carry the same instantaneous appeal and be attributed as much value:

I suppose I was worried about the attribution impact, because children pick up on it very quickly [...] Most of them wouldn't understand the concept of ADHD really, but what they did understand was, 'it's about my behaviour and this drug controls my behaviour'. I remember a kid at a PRU, hanging from the curtains, shrieking, 'it's not me, it's my ADHD', which kind of put the kibosh on, you know, made it rather difficult to do anything. The notion that there was no free will involved, all these kind of things just stuck in the throat, quite honestly, because when you're trying to do a lot of psychological interventions, you try to change people's attitudes, their perceptions, the way they behave and all that sort of stuff, and part of the deal is that they go along with it to some extent and try and do something differently (Prior int. 2006).

The resistance ADHD met with in the British education system must be seen

²³O'Brien told the story of an emotionally highly unstable boy who had been excluded from mainstream school because of verbal abuse and physical violence towards peers and staff. Educational interventions at the special school reportedly had a good effect on him, but his new foster parents complained of continued challenging behaviour at home, including self-injury. One day he arrived in school with what he described as his "good boy" tablets and an ADHD diagnosis. The Ritalin quickly suppressed his overt difficult behaviours: "Pupil A definitely became more manageable in school – his vibrancy, impulsive nature, sense of fun and his aggression had been replaced by a soporific and depressed withdrawal and passivity. One challenging behaviour had been pharmacologically contained whilst another had swiftly emerged [...] I preferred working with the pre-Ritalin challenging behaviour because a regime of passivity can be undignified and disrespectful to children, it represses their personal development and institutionalises the hierarchical abuse of power" (O'Brien 1996, p. 163).

against the background of the ascendancy of educationists in the battle for professional dominance in special education in the 1970s (Cooper & Ideus 1995, p. 106). As a consequence of this development, educational factors were brought to the fore in determining appropriate intervention and placement of children with SEN, and increasing effort was put into advancing techniques for teaching children in inclusive settings. With regard to the understanding of EBD, it meant that a preference emerged for environmental explanatory models that construe a child's adjustment difficulties in terms of social and psychological effects of hostile circumstances. At the same time, the study of "school effectiveness" – that is, the analysis of the influence of schools as social institutions on children's behaviour and performance – became a prominent framework in British educational research, inspiring many British educationists and policy-makers to adopt the philosophy that by improving the curriculum, the school milieu, and the relationships between staff and pupils, one could go a long way towards preventing and alleviating the occurrence of emotional and behavioural problems in schools.²⁴

The extent to which this view was promoted can be gleaned from the 1994 circulars on "Pupils with Problems", two of which concerned "Pupil Behaviour and Discipline" and "The Education of Children with Emotional and Behavioural Difficulties" (DfE 1994). Providing considerable insight into the government's ideological orientation towards SEN in general, these guidelines carefully avoided medical terminology and did not really distinguish between the causes of indiscipline and EBD. While they did contain references to the relevance of medical problems in a minority of cases, emphasis was clearly on the environment

²⁴To start with, there was opposition to the concept of "school effectiveness" in British educational research, both from sociologists who emphasised structural determination and from educational psychologists who believed in the primacy of early family-based experience. However, it soon became a popular theme, especially among policy-makers who adopted a crude and rather naïve version of the concept which implied that the quality of teachers and schools could be more important than social class and poverty in determining outcomes. Eventually, in 1997, one of Rutter's co-authors, Peter Mortimore, argued that the effectiveness of a school can only account for around 10% of a pupil's total performance, once background factors had been accounted for. Thus, he and sociologist Geoff Whitty criticised New Labour thinking on education for exaggerating the extent to which individual schools can challenge structural inequalities, and in this way for indirectly exacerbating the adverse effects of the market-oriented education reforms first introduced by the Conservative administration (Mortimore & Whitty 1997).

in its broadest sense as the dominant source of misbehaviour, including the reactions of the school, teachers and peers to the child's actions.

One important factor which empowered educators in relation to medics, while also moving focus away from within-child factors in psychological disturbance, was the revival of interest in behavioural psychology and the ascendancy of the general idea that behaviour can be positively managed through the manipulation of rewards and sanctions. Representing a direct method of intervention that was not difficult to learn, behaviour modification techniques had a great effect on the work of educational psychologists in the UK, who found in it techniques which they could recommend to teachers and which could be used by the child's parents in cooperation with school personnel (Laslett 1998, p. 11). After the raising of the school leaving age to 16 in Britain in 1972, the problems caused by disruptive pupils began to attract widespread attention. Although the issue was often exaggerated by the media, teachers were doubtlessly confronted with increased problems of classroom management, and the child guidance system, with its inevitable delays and focus on the child's emotional interior, did not provide enough immediate help.²⁵ In contrast, the behavioural perspective implied that interactions in the classroom were at the root of behavioural and learning difficulties, and that seeing the child away from the environment in which the troublesome behaviour occurred was an unproductive undertaking. Unlike in the US, where the resurgence of behavioural approaches in the 1960s and 1970s coincided with an explosion of medical research focusing on organic causes and drug treatments (Ideus 1995, p. 93), behavioural psychology replaced the individual pathology model in British education and came to provide a major underpinning to the legislation and "best dominant practice" relating to disruptive behaviour in schools (Cooper 1998a, p. 62).²⁶ While punitive approaches such as

²⁵This issue was also acknowledged by psychiatrists, many of whom expressed great impatience with child guidance approaches (Shepherd et al. 1966; Tizard 1973).

²⁶The spread of behavioural psychology was, however, quite uneven, with what one might call islands of excellence among special schools in particular. Properly theorised positive behavioural approaches such as token economies were not very widespread, and many mainstream schools remained rather punitive in their approach, commonly employing means such as detentions, and report cards when dealing with routine discipline problems, and formal or informal exclusion in

corporal punishment were still widespread in some areas of the UK in the late 1970s, preventive methods based on the use of positive reinforcement emerged in the country's more resourceful schools during the 1980s, and by the end of the decade the recommendations of the Elton Report ([DES 1989](#)) demonstrated that the principles of behavioural theory had become central to theories of effective behavioural management and teaching.

Coming from a medical background, ADHD was even perceived by some as a direct threat to the progress that had been made in securing educational and social rights for previously disenfranchised groups. Adopting a social conflict perspective, several British sociologists of education suggested that the medical model acted as an instrument of unfair discrimination and social control by legitimising the segregation of troublesome pupils from the "social problem classes" ([Tomlinson 1982](#); [Ford et al. 1982](#)). ADHD seen from this perspective represented a refinement and extension of the movement to individualise and depoliticise disruption in schools. Professor of Educational Psychology Paul Cooper thus identified a tendency among educationists to view the possible acceptance of the label as a "Trojan horse" through which the medical profession would reassert the dominance it once held in the special educational field and set the clock back to the time of the individual handicap model ([Cooper & Ideus 1995](#)). According to Cooper, the UK position at the time was based on the three core assumptions: 1) that emotional and behavioural problems are entirely the product of environmental influences; 2) that biomedical explanations have nothing to offer teachers and other carers for children because they are rooted in a paradigm that takes no account of social and power relations; and 3) that EBD in schools is the realm of educational psychologists and sociologists of education, and that analyses rooted in one or both of these disciplines are morally superior to those of medics ([Cooper 1997](#), p. 8). When interviewed in 2005, he argued that these assumptions were based on an outdated and inaccurate image of the medical profession, as well as on a paternalistic and patronising attitude towards

more severe cases ([Cooper int. 2005](#)).

children with special needs and their families:

These were psychologists – and there are still a lot of these today – who frankly... I don't know, there are certain bits of psychology they just don't want to have anything to do with, because they feel they're tainted with some kind of fascistic philosophy. So, whenever you talk to them about genetics, they talk about eugenics. If you propose the possibility of there being a genetic influence at work or correlation, that smacks of eugenics and we don't want anything to do with that. So that's the social justice or moral high ground sort of position ([Cooper int. 2005](#)).

In Cooper's view, the ADHD challenge was positive in the sense that it provoked professionals to consider the previously neglected individual and biological influences on behaviour, and furthermore provided educators with a golden opportunity to develop truly effective interdisciplinary collaboration with medical professionals and clinical psychologists, as well as a useful basis for professional/client co-operation ([Cooper & Ideus 1995](#)). His main point was that the diagnosis might open the door for teachers, pupils and parents to attempt new ways of solving problems, due to its ability to remove the unhelpful issue of culpability and stigma which almost always surrounds EBD and school indiscipline:

The label EBD usually translates into disruptive and it is very unpopular with everybody. The image that springs to mind is uncontrollable children, so you might as well call them delinquent or deviant, because that's the way it's used: this is a deviant child and the range of possible causes, or the way it manifests itself, can be almost anything. If you're a potential recipient of this label or the parent of a child, it is much better to have the ADHD label. EBD was supposed to replace Maladjusted in the 1970s, but now it has itself become seen as stigmatising. Whereas the argument was that Maladjusted placed the blame on the child or located the problem with the child, EBD was supposed to bring in contextual factors. But of course there's very little difference between the ways in which EBD is used now and Maladjusted was used ([Cooper int. 2005](#)).

Although a child with learning or behavioural difficulties should not theoretically need a label before educational assistance is provided, it is clear that a diagnosis is currently seen by many British parents as the only way of being taken seriously by the authorities and accessing resources. In addition, whereas there has

been a marked absence of parent activism around devalued generic labels like EBD or Learning Difficulties, having a quasi-neurological diagnosis such as dyslexia, ADHD, and Asperger Syndrome can act as a first step in directing parents towards a multitude of support groups and voluntary agencies. Coupled with a declining reverence for professional expertise among the general public, these factors may explain why parents are becoming increasingly entrepreneurial in the manner in which they seek out acceptable professional conceptualisations and interventions (Farrell & Tsakalidou 1999, p. 4). However, rather than lamenting this development, Cooper pointed to its potentially positive and empowering aspects.

Cooper's portrayal of educational psychologists as uncooperative – as professionals who constantly perceive hidden responsibility – escaping motives in the information provided by parents, teachers, and doctors about a child's handicaps, and instead attempt to identify systemic patterns of influence on the problem at hand – provoked several responses from people within the profession. Amongst those was Philip Prior (1997), who argued that such a description constituted at best a partial representation of existing beliefs and attitudes within the profession; rather than objecting to within-child explanations *per se*, Prior and his colleagues were concerned that ADHD diagnoses often seemed to be based solely on parental reports and behaviour check-lists.²⁷ When interviewed for the present thesis, he pointed to the lack of consensus on the status of ADHD among British educational psychologists and head teachers, while also questioning which extent the systemic holistic views ascribed to educationists have actually prevailed in the classroom:

Teachers tend not to be up with the debate, for the most part. Some are, but a lot of them just haven't got the time. So they're very much like lay people when it comes to the understanding of ADHD. Certainly in schools, if a child's

²⁷The sceptical attitude also extended to the growing focus on IQ assessments in relation to disorders with no clear-cut indicators of neurological impairment. Local practices vary, but at least in some areas, educational psychologists have questioned the usefulness of IQ tests in facilitating understanding of conditions like ADHD and therefore declined to perform them as part of an ADHD assessment. Apart from the difficulty of feeding the information from an IQ test back to a parent of a child with a low score, a common view seems to be that other forms of assessment can give a pretty accurate idea of the child's often limited academic abilities (Prior *int.* 2006).

misbehaving and somebody says, 'if they take this pill every morning it's going to help the behaviour', a lot of teachers will say 'great, we'll go along with that'. Ten, fifteen years ago, schools would, apart from giving out an antihistamine pill or something, they wouldn't do it, you know, they'd be really anxious... 'Should I do it? Should I be allowed to do it?' Today, schools routinely administer medication and it's no longer seen as controversial, generally speaking. But some heads are still very anti-medication, you can still hear them now ([Prior int. 2006](#)).

American educational researcher Katherine Bilton made similar observations concerning differences in outlooks among educators, based on her experiences as a visiting scholar in England in the early 1990s. Bilton identified two distinct approaches, each of which questioned the medical position on either moral or social grounds ([Bilton int. 2006](#)). Especially prevalent among teachers on the ground, the orientation of those adhering to the "moral" approach tended to be that disruptive, inattentive children were just inherently "naughty" or "bad", and deserved to be punished and disciplined more than anything else. Dominant among educational psychologists and special needs practitioners, the alternative view was that disruptive behaviours and learning difficulties are psycho-social in origin and best addressed through contextual solutions, i.e. changing situational or social settings, and creating "kind, supportive environments". While there had always been substantial debate in the US regarding the medicalisation of learning and behavioural issues, and particularly the use of stimulant medication, both of these views surprised her. More specifically, she was struck by the scepticism about matters that in the US appeared settled by science and therefore less subject to debate, e.g. the widespread American acceptance of the DSM classification system. Interestingly, despite hesitancy to apply the label, teachers would sometimes suggest treatments that supported the concept of hyperactivity as a "real" biological disorder, but these suggestions mostly rested on the idea of hyperactivity as a result of nutritional deficiencies. Demonstrating the great popular reach of this theory in the UK, mothers commonly told her how they had been approached by teachers who advised them not to give their disruptive child any sugar, refined or prepared foods, or fizzy drinks (see also [Malacrida 2004](#), p. 170).

Considering the high level of resistance to medical concepts, it is not

surprising that the drug industry has targeted the UK education sector in campaigns to further acceptance of ADHD. As pharmaceutical companies are not permitted to advertise directly to the public in the UK, they use more indirect ways of promoting their products, for example via so-called educational material about the condition that the drug is meant to treat. Thus, when a child is diagnosed with ADHD, his teacher may well receive various publications that contain supposedly neutral information on the disorder, the drug treatment, and good advice on the management of disruptive behaviour in the classroom, typically consisting of standard behaviour modification techniques based on positive reinforcement. One such teacher information booklet provided by [Celltech Pharmaceuticals \(2004\)](#) stressed that the prescribed medicine “help children with ADHD concentrate and behave”, and that “the active ingredient in the medication has been used for more than 40 years in the United States” (p. 20). ADHD is described as a developmental condition which “is not a psychological problem or just an excuse for difficult behaviour”, but “a biological problem that occurs when the brain is not as finely tuned as it needs to be” and therefore “doesn’t receive all the messages it should” (p. 4). On the final page, there is a drawing of a boy happily working at his desk, next to his smiling teacher. The caption reads: “He’s taking the pills. Everybody’s feeling better”.

By the mid- to late 2000s, the concept of ADHD as a disorder incorporating key elements of both nature and nurture had become much more widely accepted in British schools, as had the rationale for stimulant drug treatment, at least unofficially. Like Prior, Cooper conceded that the teaching profession was quicker to embrace the label than educationalists, demonstrated for example by the immense interest any kind of course or public lecture on the subject has generated ([Cooper int. 2005](#)). But rather than simply interpreting it as a matter of convenience, he argued that teachers may find the label helpful as it explains why certain children do not respond to routine discipline, which, in turn, allows the teacher to alter his/her attitude to the child in question. Nonetheless, a large number of postings on an internet forum used anonymously by teachers and SENCOs revealed that a cynical, suspicious attitude still existed in the mid-2000s

among many British educational professionals, who saw diagnoses such as ADHD and dyslexia as suspicious, invalid phenomena, often promoted by parents and exploited by pupils as an excuse for indiscipline.²⁸ Calling instead for more support for teachers facing bad behaviour caused by inadequate parenting, they criticised the explosion in children registered as having SEN (the number doubled between 1993 and 2003 to 1.4 million) and given various advantages due to diagnoses such as ADHD and dyslexia (Owen 2003). The antipathy on the part of these professionals toward medicalising poor behaviour obviously did not predominantly stem from a concern about potential social stigma. Indeed, in her study of Canadian and British mothers of children with ADHD, Malacrida speculated that British educators' anti-labelling stance may have less to do with compassion or a commitment to the "social model of disability" than with avoiding the time, efforts, and costs of providing a Statement (Malacrida 2004, p. 70).

As a way of addressing the obvious conflicts and problems that have arisen in relation to the assessment and management of the growing number of poorly functioning children in mainstream schools, several British educators have supported a partial return to some form of categorical system, providing more definitive guidelines for identifying children with special needs, as well as a return to segregated education for the most vulnerable pupils. Among those calling for the identification of ADHD as a separate special needs category is Fintan O'Regan, leader of the Florida-based private school Centre Academy in the London.²⁹ Pointing to the relative lack of understanding of the condition in the UK, he has argued that teachers would benefit from policies that offer clearer instructions

²⁸While there has been much debate in the US about the exploitation of ADHD diagnosis as a means of gaining a competitive edge, a recent empirical study of children's lived experiences of ADHD showed that British children were generally more likely than their US counterparts to mobilise the diagnosis strategically, not so much as an explanation for under-performance, but typically as an excuse for bad behaviour (Singh 2011). The authors argue that these practices translate into a perpetual discourse of suspicion in some UK schools, about who might be pretending to have true ADHD, whether diagnosed or undiagnosed.

²⁹Centre Academy is an independent international special school for children with various learning difficulties, among them ADHD, which offers a curriculum based on the National Curriculum as well as the American High School Diploma. Students with statements are placed by local authorities and the remaining students are privately funded.

regarding ADHD in the classroom, while an acknowledgment of the condition's validity could also ease conflicts between parents and individual LEAs over the level of support deemed appropriate (O'Regan *int.* 2006). Like many of his colleagues – and many parents for that matter – O'Regan emphasises that the growing emphasis on inclusion has been “disastrous” for children with severe ADHD and/or autistic spectrum disorders since they often cannot cope in the increasingly performance-focused mainstream environment, and because the statementing process is too messy, uncoordinated and resource consuming.

In fact, these observations closely mirror those made by Baroness Warnock herself, when she in 2005 called for a radical review of the SEN system she herself had a decisive hand in designing (House of Commons 2006, pp. 14-16). According to Warnock, the inclusion policy had been taken too far, driven by political correctness, and sometimes local financial motivations, rather than the best interests of the child. In particular, she expressed concern about the accelerated closure of special schools under New Labour, emphasising that the pressure to keep children with severe emotional and behavioural difficulties in large mainstream classrooms had lead to high levels of frustration among parents, children, teachers and local authorities.³⁰ After more than thirty years of inclusion, it seemed that the pendulum was swinging back towards the separation of special and normal education. When interviewed for this thesis, O'Regan's prediction was that more special schools would appear in the future, and that statementing would be substituted for a system along American lines, where a particular tariff determined by the government is attached to each category or “condition”. However, considering the current financial climate, these options now seem unrealistic, although it is possible that the local authority role will be reformed so that assessment and funding are separated, and that parents will be given greater

³⁰In 1984 there were 1548 special schools serving 118,500 pupils in England. In 2005, the number of special schools had fallen by 400 and just over 90 of these closed after 1997 (Lightfoot 2005). Warnock's perceived u-turn – which came at a time when parents were campaigning to stop the closure of special schools – caused grave concerns among some groups of parents and Labour campaigners who protested that the real problem lies in discriminatory attitudes, poor training, and lack of funding in many mainstream schools and LEAs.

choice over how the available funding is spent.

6.6 American attitudes to educational disability labelling

It is important to note that the movement away from medical categories of handicap towards a more contextual, social model of special educational needs was not unique to the UK; similar developments also occurred in other European countries ([Holm 2008](#)). However, in Britain specifically, one might speculate that the rejection of the medical model of educational disability partly had its roots in a reaction against the tradition of a highly selective, stratified schooling system ([Cooper 1998a;b](#); [Norwich int. 2006](#)). Up until the postmodern turn in the 1980s, class analysis was central to the social sciences in Britain, including the sociology of education. Thus, when discussing (special) educational selection procedures, British sociologists have typically adopted a conflict interpretation and pointed to social discrimination in the education system and the desire of the dominant classes to control the disadvantaged, as well as the role of vested professional interests ([Ford et al. 1982](#); [Tomlinson 1982](#)).

In the US, in comparison, one could argue that educational, psychological and medical approaches to ADHD have been predominantly functionalist in orientation, to the extent that identifying and treating hyperactivity is perceived as necessary to both the well-being of society and the enhancement of the individual's ability to succeed in a highly competitive meritocracy. From this perspective, the diagnosis of the disorder can indeed be described as a social obligation and a way of protecting the individual's rights, because the demands of the environment is a social reality which puts affected, untreated individuals at disadvantage compared to other "normal" individuals. Indeed, the pragmatic outlook of ADHD experts tends to reflect only modest consideration of the possibility that the political and legal system would or could use an individual's biological differences as a means of exclusion or oppression, this even despite the fact that ADHD is now seen as a chronic, life-long disability with predictable negative outcomes in the areas of

emotional adjustment, personal relationships, and economic chances.

The American psychology profession has generally followed psychiatry in perceiving hyperactivity/ADHD as a discrete disorder with a dominant biological component, and the aim of intervention as the normalisation of behaviour, typically via a combination of drug therapy, behaviour modification strategies, parent training, and various adjustments in the schooling environment.³¹ As psychologist and founder of CHADD, Harvey Parker, puts it, “psychology and psychiatry in the US have melded together in the area of understanding and treating children with ADHD”, and divided the labour between them so that psychiatrists prescribe while psychologists offer behavioural strategies for parents, advice to schools in developing educational programmes, and counselling for children in order to help them “understand the causes of their behaviour” (PBS 2000). According to Katherine Ideus, this orthodoxy also dominates among American teachers, who, although first in the “trenches”, have historically been trained to defer to the authority of the medical and psychological professions and efficiently incorporate their models and expert advice into classroom practice (Ideus 1995, p. 94). Ideus speculates that this may partly be due to the domination of the educational field by Progressive thinkers such as pragmatist philosopher and psychologist, John Dewey, whose work among other things emphasised individual improvement and a culturally based preference for all things scientific.

Thus, while there are serious concerns about the escalating costs of disability accommodations, it is probably safe to say that American school personnel have been somewhat less inclined than their British colleagues to worry about the stigmatising potential of “neurobehavioural” labels; rather, the argument goes,

³¹Ideus argues that the ascendancy of the current ADHD orthodoxy in psychiatry and psychology can be traced to the historical convergence in the 1960s, 1970s and 1980s between increasingly sophisticated medical research pointing to organic causes, and the resurgence of behaviour modification, led by figures like psychologist B. F. Skinner (Ideus 1995, p. 93). Emphasising that behaviourism supported the standardisation process through which American institutions have historically approached the task of assimilating large numbers of diverse people, she describes how behaviour management based on operant conditioning became the approach of choice for American psychologists, including school psychologists, in dealing with ADHD and a host of other problems now thought rooted in neurology. Although a rather mechanistic method, this overall approach has been framed and promoted using a humanistic rationale.

they may enhance the child's chances in a supposedly meritocratic society offering equal opportunities for all to compete for success ([Ideus 1995](#), pp. 95-96; [Norwich int. 2006](#)). A recent comparative study showed that while both British and American teachers were concerned about the dilemmas and adverse effects of labelling, American teachers tended to take more of a "no-nonsense" position, emphasising that labels entitle children to special services in education and the workplace, and that great strides have been made since the 1970s in normalising disability and reducing stigma ([Norwich int. 2006](#); [Norwich 2009](#)). As regards school psychology and counselling, the leaders of the US professional organisations have traditionally leaned towards a systemic approach to learning and behavioural problems, but attitudes among their members on the ground today tend to be more heterogeneous, ranging from scepticism to full acceptance of medical labelling, with the majority veering towards the latter outlook ([DuPaul int. 2006](#)). It should be noted that there are still dissenting voices in American educational research which are rabidly critical of the medical model, but they represent a minority fringe in the US, where academic structures are characterised by the presence of powerful monolithic organisations, like the American Educational Research Association, with a relatively strong positivist emphasis ([Cooper int. 2005](#)).

Today, one of the strongest critiques of labelling in US schools comes from disability studies, a relatively recent area of academic inquiry which examines disability as a social, cultural, and political phenomenon. Committed to a social model of disability, scholars within this field tend to focus on the ways in which the identification of disability itself rationalises segregation, stigmatisation, and failure for some students in ways that at worst perpetuate other types of discrimination, particularly through the over-identification of minority students. Even though the EHA and its successors reflect important principles of inclusive education, current US special education policy and practice represent a medical model of disability in the sense that children's disabilities are recognised and accommodated primarily through individual diagnosis and remediation plans, rather than through a revision of the educational environment in a way that accommodates diversity. Further, parent participation is largely channelled through the highly technical IEP

process, which in effect means that challenges to schools have been limited largely to individual-level disputes about appropriate diagnoses and accommodations. According to disability theorists, the system may in this manner be seen as both providing unequal educational opportunities by design, and as shrouding that inequality in the language of rights and scientific objectivity (Ong-Dean et al. 2011). However, as noted above, these perspectives are evidently not very popular in the mainstream ADHD field and have not to any great extent influenced the outlooks of the professions involved with hyperactive children in US schools.

Critics of disability studies have argued that for the social model of disability still to be valid, the actual effects of impairment must be included, as they form a central part of many disabled people's experience. Furthermore, some have pointed out that identification with disabilities is sometimes associated with substantial privilege rather than oppression (ibid). For instance, the fact that white middle class students are found to be overrepresented in the learning disabilities, ADHD and autism statistics in the US clearly signals that privileged parents may use a medical construction of their children's needs in pursuit of valuable services and accommodations.³² Today, special education brings with it the possibility of such attractive and expensive provisions as the assistance of a personal tutor, a laptop computer, extra or even unlimited time on classroom tests and college entrance exams, a personal note taker, and immunity from severe discipline. This may help explain why nearly one in three high school students is officially designated as disabled in affluent Greenwich, Connecticut, and why clinicians in affluent communities frequently report an upsurge in parental requests for diagnostic

³²By engaging parents with different socio-economic backgrounds, national variation in the disability environment probably plays a part in shaping the contrasting social demography of ADHD in the US and the UK. In terms of state assistance, an ADHD diagnosis in the UK is typically associated with disability allowance alone, and as the incentive to seek such benefits is evidently less for more prosperous families, this may contribute to the downward social class gradient of hyperactive children in Britain. In the UK several commentators have argued that the possibility of obtaining Disability Living Allowance for ADHD children could be fuelling diagnosis in deprived areas (Winnett 2002). The opposite rationale applies in the US, where the emphasis on the legal right to educational accommodation is much more likely to attract higher-income parents anxious that their children do well at school. In turn, this may again have contributed to the extension of the diagnosis to include milder symptoms of disability.

evaluations, especially for LDs and ADHD, of high school juniors – just as high school students are preparing to take college entrance exams such as the SAT (Horn & Tynan 2001, pp. 30-31). In addition, an entire industry of professionals and paraprofessionals has arisen, dedicated to identifying learning disabilities and assisting parents in obtaining mandated services. Current special education policy makes parental advocacy crucial, but within the special education system as it is currently constituted, such advocacy often presupposes a high level of resources: to be successful, parents likely need to understand and use legal and educational jargon, and also in many cases to pay for outside legal assistance. Indeed, the threat of litigation has undoubtedly had an important effect, as some school districts have spent extraordinary sums on special placements and services in order to avoid costly lawsuits.³³

The correlation between service use, social advantage, and professional aspiration is of course not new. Since the EHA was introduced, several historians and sociologists have portrayed the rise of learning disability and hyperactivity/ADHD as a result of a confluence of interests on the part of medical and psychological experts, educators faced with the challenge of inclusion, and white middle class parents, all of whom supposedly have a stake in the identification and treatment of these disorders, be it professional status enhancement, the pursuit of scarce public resources to keep children from failing, or freedom from blame for children's educational failures (Conrad 1976; Erchak & Rosenfeld 1989). Further, more sinister versions of this account are commonly found in public debates on special education in the US, in which focus is on the financial cost to society, rather than the possible adverse individual consequences of medicalisation and stigmatisation. As special education and social welfare programmes became more accepting of children with behavioural and learning disorders in the 1990s, American conservative media alleged that parents and school officials were seeking to have children labelled with various disorders

³³In 2000, The District of Columbia for example spent almost a third of its total education budget on the 10% of its students who are identified as disabled (Horn & Tynan 2001, pp. 32-33).

because of the advantages such a diagnosis would confer: money for schools, social insurance payments for families, and accommodations for students. For these commentators, ADHD was emblematic of the “perverse” incentives created by the IDEA, and in response they proposed caps on federal funding as well as formulas that distributed money to states or districts based on the overall student population rather than according to the size of the district’s special education programme (Mayes et al. 2009, pp. 123-124).

Although such allegations were difficult to substantiate, they set the stage for a broader backlash which portrayed the ADHD-epidemic as a symptom of larger social ills and/or the result of combined professional, parental, and business-related interests. However, there is much to suggest that descriptions of self-interested parental scheming and unconstrained medical expansion are too crude, as they tend to underplay the genuine wish to help on the part of professionals, as well as the hard choices and anxiety the decision to medicate involves for parents (Malacrida 2003, pp. 174-175). Though it would be naïve to deny that some parents will seek the diagnosis in order to give their children a competitive edge, surely the majority of parents are more preoccupied with their children’s health and chances to live a normal, full life – with preventing them from “falling through the cracks” (Hruska 2012) – than with finding ways to push them upwards in the pursuit of the American dream, or to avoid feeling guilty themselves. Considering the American propensity toward anti-intellectualism, it may also be somewhat of a myth that Americans generally prefer schools that put academic excellence at a premium (Schrag 1997).

In fact, far from all parents perceive drug treatment as an acceptable intervention. In response to various court decisions supporting schools’ right to compel families to try medication as a condition of continued school attendance, some parents recently established organisations which question the very existence of ADHD and actively protest against the labelling and “forced drugging” of their children in the education system. Mirroring accusations of coercion put forward as far back as the 1970 Gallagher Hearings, such organisations have successfully lobbied Congress on matters of parental consent and the right to refuse psychiatric

services (see chapter 7). Although only isolated incidences had been reported, several states had by 2003 followed the examples of Colorado and Texas and passed resolutions to limit the ability of teachers and other officials to insist on placing children on medication, encouraging instead traditional forms of discipline to deal with problem students.

Another strong countertrend to medicalisation can be seen in the movement on the part of school administrators to resist the disability status of ADHD and LD – especially in poorer school districts – due to limited resources.³⁴ Although federal means are provided for each Individual Education Plan, the federal special education programme in reality only finances less than 40% of the cost of educating a special needs child (Ross *int.* 2006). Further, providing an educational plan for a child means more work for the school and its teachers, who will often have to spend considerable amounts of time developing new teaching and management strategies within the regular classroom. Perhaps for this reason, mainstream educators have been reported to appear reluctant to accept information or assistance on the application of school-based treatment programmes from parents or professionals who are not part of the educational system. For example, while often instrumental in pushing parents to obtain an ADHD label and medication, the Canadian teachers in Malacrida's study showed little interest in planning and participating in suggested educational interventions in the classroom, once the label had been conferred and the treatment prescribed (Malacrida 2004, p. 73). Thus, all in all, the incentives for states, public schools, and individual to over-identify handicapped children are probably a great deal smaller than critics have implied.

³⁴In fact, there is currently more controversy over the LD label than over ADHD in education circles due to the widespread view that the IQ discrepancy model rests on flawed assumptions and tends to over-identify children with difficulties. For this reason it is being replaced by the supposedly more evidence-based Response to Intervention (RTI) model which entails the implementation of a variety of pre-referral interventions that allow schools to distinguish between the children who can be brought closer to a normal level of functioning through minor alterations of the learning environment, and those who are truly learning disabled (DuPaul *int.* 2006). However, there has recently been a backlash against RTI, as some people see it simply as a money-saving measure designed to provide school districts with more ammunition to prevent a child from being serviced under the IDEA, or to stall the application process (Silver *int.* 2006).

6.7 Conclusion

The objective of the last two chapters has been to compare and contrast British and American educational approaches to children with behavioural problems, and to evaluate how, and to what extent, within-education factors have contributed to the rise of hyperactivity disorder in both settings. Among other things, I have looked at differences in the legal frameworks for the identification and handling of disability or “special needs”; at divergent views on the causes of children’s adjustment problems and the desirability/acceptability of medical intervention as a method of behavioural control and performance enhancement; and at attitudes to the question of labelling and stigma among educational professionals. Though there are important differences which go some way in explaining the national variance in diagnostic and prescription levels, it is important to emphasise that when scraping the surface, one finds that the major interests and challenges in education in the two countries have been pretty similar since the beginning of compulsory schooling. The US and the UK are both democratic societies that need a literate public which is skilled and competitive enough to fuel a capitalist economy but sufficiently cooperative to live in a civilised community. Also, the aim has increasingly been to include as many as possible without sacrificing standards, but getting there is difficult and involves conflicts such as that between inclusion and excellence, and the interests of vulnerable children versus the smooth running of the normal education system. This has led American as well as British observers to highlight the ironies attached to prevalent discourses framing difficult children as being at-risk for negative outcomes, while at the same time representing them as an impediment to other students and an undue drain on resources.

In response to the suggestion that geo-political influences on education during the 1950s and 1960s were crucial in the rise of hyperactivity diagnosis, I have argued that we need to look further ahead in time if we want to understand the recent ADHD epidemic. While the “discovery” of hyperactivity can possibly be located in the post-Sputnik panic expressed in the 1958 National Defense Education Act, and in the growth of the techniques of identification which the

panic spurred, it was another major federal document, *A Nation at Risk* from 1983, which helped to propel the diagnosis of ADHD in the 1980s, at a time when stimulant research had assumed a central role in child psychiatry. Ever since the high stakes testing programmes promoted by the report became commonplace in the 1990s, many commentators have argued that standardised testing has turned into a national obsession, with significant consequences for boys who struggle to live up to the expectations of their families and the school system. At the same time, several federal initiatives have urged a greater integration of schools and mental health systems through the expansion of school-based mental health intervention programmes, which often focus on children displaying ADHD-type behaviours.

While the New Freedom Commission's scenario of compulsory mental health screening and "specific medications for specific conditions" is still difficult to imagine in Europe, the market model of education and the frequent use of standardised assessment is far from confined to the US. In an interview conducted for this thesis, Katherine Bilton described her initial impressions as an educational researcher in Britain during the early 1990s as follows:

I found a more variegated educational landscape in Britain, perhaps more humanistic in orientation, with understandably deeper roots in the liberal arts tradition. In America, which is a relatively new, engineered society, we tend to have a more mechanistic, scientific way of doing things [...] When I was living in the UK, one of the refreshing things I experienced, personally, was the idea that everybody could sort of be their own [...] In general, I was intrigued at times by what I perceived as contradictions between British and American dominant cultural streams. The UK post-WWII collectivism was evident to me as an American of the individualist stripe. However, there seemed to be much greater tolerance for eccentricity and individuality, within a culture of consensus, as I experienced it. In comparison, the US is individualist in orientation, but at the same time there is much focus on, and acceptance of, standardisation [...] Really, it's an intriguing paradox in American society that we are simultaneously expected to be individualists and materialists... We have rights and we're compelled to go out and save the world, but at the same time there is a great pressure to conform. The tall poppies, those are the ones that are cut here (Bilton int. 2006).

Certainly, British education has historically been characterised by diversity

and significantly shaped by a humanistic tradition, which can be traced, for example, to the writings of A.S. Neill and the child-centred movement of the 1960 (see chapter 5). It is conceivable that the continuing influence of this tradition, and the marked British emphasis on the liberty of the individual, reinforced the resistance to the labelling and medical treatment of children's behavioural and learning problems. However, while observers of American and British education might at one point have been correct in characterising the US as placing more importance on productivity than the encouragement of a broad understanding of life, the UK government has over the past two decades also become increasingly focused on promoting educational "excellence" in accordance with national targets and performance criteria. In both sites, recent government reforms have fostered competitive and exclusionary practices through increased inspections, testing and publication of results, while concomitantly promoting policies that at least rhetorically commit schools to provide inclusive, community-based educational opportunities for all children, including those with special needs.

It is my contention that these institutional pressures accelerated the acceptance of ADHD diagnosis and Ritalin treatment, as the acknowledgment of biological causation in some cases provided a more satisfactory explanation of refractory difficulties, as well as a promise of more efficient solutions. On the other hand, in the UK, the relatively wide access to traditional methods of social control such as exclusion may have slowed down the medicalisation process somewhat, by decreasing the need for medical forms of behavioural control in schools. When also taking into account the existing tendency among British educators to be suspicious of medical explanations – whether from a moral perspective that construes the child as simply "naughty" or "bad" or from a psycho-social perspective emphasising the effects of the environment – one must conclude that a divide still remains between the average British teacher and his or her American counterpart, who for many years has been identified as the single most likely person to initiate the labelling process.

In sum, although changes in educational policy undoubtedly meant that more children were marginalised in the school system, I would argue that the role of the

education system in the rise of ADHD in Britain has been smaller and more subtle than in the US. This brings us to the next and final chapter of the thesis, which will examine the role of parent advocacy in the growth as well as the critique of the disorder on both sides of the Atlantic.

CHAPTER 7

Exploring the influence and limits of “parent power”: parent advocacy and the medicalisation of hyperactivity in the US and the UK

7.1 Introduction

In the late 1980s, with the support of researchers and professionals, parents of ADHD children in the US began to organise in order to demand better educational opportunities and access to treatment that reflected their own experience of inborn rather than psychogenic problems. The ADHD movement quickly became remarkably influential, both in promoting acceptance of the idea of attention deficit (with or without hyperactivity) as a distinct but broadly defined and treatable medical disorder, and in achieving educational rights for afflicted individuals. Testifying to its success, it eventually inspired the establishment of British parent groups, which, while not directly affiliated with US advocacy, have drawn on American models to further the local cause in an environment hostile to biomedical understandings of child emotional and behavioural disorders. In the UK, where the push from professionals for diagnosis has not been significant, ADHD parent support groups have contributed considerably to the widespread growth in public and medical awareness of the disorder in recent years, even if they have not achieved the same concrete political results as their American

counterparts. Like in the US, however, they have also met with a great deal of resistance. In fact, in both countries, some of the most fervent opposition has come from other parents who are strongly critical of stimulant treatment and accuse ADHD advocacy organisations of collaborating with the drug industry and medical experts in upholding a mythical disorder category.

Throughout the Western world, but especially in North America, recent decades have witnessed the appearance of a growing number of patient/carer organisations that have become vocal participants in public debates about access to and equality/quality in provision, in addition to providing information and emotional support. While some groups have expressed deep dissatisfaction with the limitations of conventional medicine, others have sought to extend medical frames of understanding. The latter trend is evident in the case of groups organised around emergent contested disorders – or “illnesses you have to fight to get” (Dumit 2006) – which demand public acknowledgement of the legitimate nature of their conditions. Classic examples of such conditions include chronic fatigue syndrome, but ADHD can also be said to belong to this category, at least in Europe.

Sociological concern about medicalisation is typically informed by the argument that medicine cannot overcome all human distress, and that labelling life experiences or social problems as diseases subjects them to medical control without necessarily conferring any curative or palliative benefits (Conrad & Schneider 1992). Medicalisation is thus said to lead to the individualisation of problems that might be better interpreted in the context of social structures and norms, to prompt the use of techniques for social control (i.e. medication), and to give medical experts a monopoly on their resolution (Conrad 2005). Such critical conceptualisations are however complicated by the fact that medical labels are often actively sought by patients, while doctors may resist medicalisation, particularly if they are sceptical that the condition in question is “real” (Broom & Woodward 1996; Klasen 2000). Indeed, labels can have significant clinical and symbolic benefits to individuals with chronic health problems, notably the possibility of reduced stigma and hopelessness, even if the role diagnosis plays in easing suffering is not self-evident, due to lingering feelings of uncertainty and

ambivalence.

In the case of ADHD, medical recognition is not a ready-made solution that signals an end to parents' and children's problems, nor does it presuppose a solely biomedical response to treatment (i.e. medication). On the contrary, all ADHD parent groups to a greater or lesser extent advocate for wider access to multi-modal treatment, while also pragmatically evaluating various bodies of knowledge and expertise in light of families' experience, in order to identify effective interventions ([Edwards et al. 2012](#)).¹ More than anything else, gaining a validating label provides a means through which parents can challenge and question the way their children are treated in school and in other life situations. In this connexion, it must be emphasised that a diagnosis often presents the most effective route to secure services. Various changes in federal disability policy which improved access to social and educational benefits certainly had a noticeable and controversial effect on rates of ADHD diagnosis in the US during the 1990s ([Mayes et al. 2009](#)).²

The proposition that labels can no longer easily be construed as stigmatising and suppressing in nature is also supported by the fact that sections of the disabled community sometimes positively adopt reshaped versions of them as proud markers of identity in their struggle for rights. As Western societies have turned from an emphasis on assimilation to a model of cultural pluralism, individuals

¹In their comparative analysis, [Edwards et al. \(2012\)](#) describe how groups in both France and Ireland have worked to broaden the professional terrain involved in the ADHD field. But whereas parents in France have opposed one-dimensional paradigms and struggled to bring together various streams of investigation, the relative medical consensus about ADHD as a neurodevelopmental disorder in Ireland has led parents there to align themselves with the biomedical approach, rather than participating in scientific debates about the nature disorder, and concentrate their efforts on increasing the number of available therapeutic options to include medical, psychological, educational, and diet solutions alike.

²In 1990, Congress modified the Supplemental Security Income (SSI) program – which provides financial assistance for the disabled – to include low-income children diagnosed with ADHD. In the first half of the decade, until policymakers rescinded this expansion in 1996, rates of new children enrolling in the program with a qualifying diagnosis of ADHD increased almost threefold. Further, in 1991, partly as a result of pressure from parent advocacy groups, Congress adjusted the Individuals with Disabilities Education Act (IDEA) to include ADHD as a protected disability. As a result, children diagnosed with the disorder became eligible for special accommodations on tests (including the SAT), homework, and other school-related activities. Finally, responding to lobbying efforts by medical professionals and activists, Congress in the early 1990s significantly expanded the number of children eligible for Medicaid, thus fuelling significant increases in spending on psychotropic drugs and stimulants in particular ([Mayes et al. 2009](#), p. 96).

increasingly demand recognition of their right to be different ([Ideus 1995](#), p. 94). In the ADHD field, this movement is most clearly expressed in the popular books by American psychotherapist Thom [Hartmann \(2003\)](#), who advances the view of ADHD as a particular – and in some cases superior – cognitive style rather than a disorder. Arguably signalling the growth of an individualistic culture in which patients/carers are becoming more consumerist in their search for acceptable explanations and interventions, such upbeat representations are most stridently put forward in the US, but they have also been taken up enthusiastically by parts, though not all, of the ADHD community in Britain.³

Reflecting the central place of community-based protest and activism in American history and political culture, the presence of self-help and advocacy groups has been stronger in the US than in Europe ([Kushner 2004](#)). But in a globally wired world, location matters less and less. By increasing lay access to health information and scientific knowledge, the internet has fundamentally changed the practice of medicine, including the encounter between physician and patient. It has also revolutionised the patient movement by connecting people in a way never before possible, facilitating not only the sharing of understandings and concerns of users across national borders and socio-cultural divides, but also fundraising and the building of vast genetic databases that allow patients to become partners in medical research efforts ([Solovitch 2001](#)). The recent shift in awareness of ADHD in the British context provides a particularly good example of the globalisation and democratisation of knowledge made possible through the internet. British mothers who pushed for a diagnosis typically received much of their information through the web, and support groups from the start provided their members with links, downloads from American sites in particular. Conversely, by providing an effective means of communicating experiences of drug

³Hartmann focuses on the possibility that ADHD, whilst describing genuine differences between people, is not a “disorder” as such, but a range of traits indicative of currently undervalued intellectual and social characteristics, such as creativity, multi-task attention, impulsivity and a preference for concreteness over abstraction in learning style. This style, he suggests, is a residual category of human genetic traits functionally adapted to hunter-gatherer societies, while maladaptive in more sedate farming/industrial cultures.

side effects, social critique, and practical advice on alternative treatments, the internet has also assisted in mobilising the ADHD opposition and in reinforcing doubt and controversy.

Just as the wider public debates about ADHD are deeply polarised, the ADHD advocacy movement is itself divided. Both in the US and the UK, parent and patient groups relating to ADHD divide broadly into two opposing camps: first, the pro-ADHD/Ritalin camp, led by the national organisation CHADD (Children and Adults with Attention Deficit Disorder) in the US, and ADDISS (the National Attention Deficit Disorder Information and Support Service) in the UK; and second, the marginal but highly vocal anti-Ritalin camp, which in turn can be divided broadly into those groups who focus mainly on advocating alternative dietary interventions, and those who take a more radical anti-psychiatry stance and lobby government on issues relating to parental consent and the dangers of drug treatment. Whereas the American scene has been dominated by CHADD, founded in 1987, the British ADHD support field sprang up along with the internet in the mid-1990s and has been characterised by diversity and struggle. Another interesting aspect of the British case relative to the US is the noticeable presence among parent activists of theories that link poor behaviour to various food chemicals and fatty acid deficiencies.

By way of introduction, this chapter first examines the history of mother-blaming in the psy-disciplines and the ways in which such attitudes on the part of professionals contributed to the rise of what one might term neurobiological parent activism. Next, I look at the story of American CHADD, and the controversies surrounding the organisation's lobbying efforts. From the start, CHADD became a powerful player in influencing national perception on ADHD and Ritalin, as well as official policies on the condition, as their campaigns resulted in major changes to federal disability laws. However, I show how their activities also helped fuel a strong backlash in which parents and conservative politicians argued that children were being diagnosed and sometimes forcibly medicated in order to obtain unwarranted resources or to maintain order in the classroom. Although few in number, these hardened critics – some of whom have been linked

with the Scientology-backed Citizen's Commission on Human Rights – have acted as a strong countervailing force to the medical community's message that ADHD is a legitimate disorder that can be effectively and safely treated with drugs.

In the UK, I focus on the high level of competition and animosity between parent support groups, and examine how the CHADD-inspired group ADDISS eventually gained ascendancy. Demonstrating the American influence also among those British groups who define themselves against mainstream ADHD science, I furthermore examine the activities of the Hyperactive Children's Support Group (HACSG) – which since 1977 has promoted a version of the American additive-free Feingold diet – and the more radical Edinburgh-based Overload Network, which managed to garner substantial media attention for their view that British children were becoming exposed to “mass labelling and drugging”.

There is little doubt that the media have often contributed to the controversy surrounding ADHD and its treatment, via sensationalist headlines and by pitting pro- and anti-medication spokespersons against each other, with little accompanying analysis. Moreover, in the UK especially, the press has regularly emphasised the argument that ADHD is vastly over-diagnosed, while at the same time offering information on alternative diet-based cures. Parents, in turn, have had to navigate the confusing morass of conflicting claims and conflicts of interests. In this situation, mothers can be said to be in a particularly vulnerable position as relatively subordinate interlocutors between various professionals, and as moral agents who are often held responsible, either explicitly or implicitly. As illustrated by a recent debate piece in the New York Times written by a well established hyperactivity researcher, parental expectation, incompetence, or lack of authority has remained a powerful explanation for troublesome childhood behaviour right up to the present, along with the viewpoint that drugs gets everyone – politicians, scientists, teachers and parents – “off the hook” (Sroufe 2012).⁴

⁴In this much debated article, Sroufe associates the still rising levels of ADHD diagnosis and Ritalin treatment with family stresses like domestic violence, lack of social support networks, chaotic living situations, and inappropriate “patterns of parental intrusiveness” that “excessively

7.2 “Mal de mère”: mother-blaming and the rise of neurobiological parent activism

When examining public debates about ADHD, one constantly comes across the view that an ADHD diagnosis is more likely the result of “bad parenting”, rather than a neurological disease that makes parenting a challenge (see for example [Petit-Zeman 2003](#); [The Times 2003](#)). In accordance with the dominant American perception of ADHD as primarily a disorder of education performance, the US media have often carried simplistic stories about parents who want their kids to excel in school, and therefore pressure paediatricians for drugs. Conversely, reflecting the common British view of ADHD as a disorder of aggression and anti-social behaviour, the UK press has focused more on the failure of parents to discipline their children and provide them with a sensible diet, as well as the possibility that single mothers especially are using the diagnosis to obtain social benefits. However, researchers who have actually talked to mothers about their experiences find much that undermines claims about the over-readiness of mothers to seek a label and medication for their children as an easy way out. For example, a comparative sociological study of mothers of ADHD children in Canada and the UK concluded that most recognised the question of whether to medicate as a hard choice; even if they decide to use a stimulant, it was often a decision fraught with guilt and anxiety, heightened by the great amount of polemic commentary the disorder and its drug treatment attract ([Malacrida 2003](#)). Furthermore, media portrayals of parents as cynical exploiters of diagnoses is complicated by the fact that families seem to worry a great deal about possible stigma and ill will they themselves may feel for seeking the diagnosis ([Singh 2011](#)).

Historically, the emergence of the concept of “bad parenting” was, like the notion of behaviourally disordered children, closely tied to the tensions between certain types of family lifestyles characteristic of agrarian or early industrial society, and the new disciplinary requirements introduced by the compulsory

stimulate and also compromise the child’s developing capacity for self-regulation” (see also [Hruska 2012](#)).

schooling in the late 19th century ([Brancaccio 2001](#), p. 169). Mass schooling was the first form of direct public intervention into what had hitherto been a private relation between parents and children. School took over certain child-rearing activities, but at the same time created new duties for parents; in order to attend their daily lessons, children had to be fed and clothed, and relieved of family work duties. This induced deep transformations in family living patterns and authority relations, and required a great deal of parental compliance and cooperation. In every country, educational authorities and teachers had to deal with the resistance of parents who were reluctant to send their offspring to school, first and foremost because children were important contributors to the family economy. However, with the growth in attendance rates and the withdrawal of the pragmatic tolerance of absences that had characterised the establishment of schooling in some areas, school attendance came to be seen as a normal part of children's lives, and truancy as a problem created by irresponsible parents.

Ideas about parental responsibility were also transformed by the introduction of child guidance and the rise of psychological approaches in general. In the early decades of the 20th century, psychiatric discourse on unstable and morally deficient children (in Britain as elsewhere) had referred to families only to illustrate how deep was the relation between degenerate, irregular lifestyles and defective progeny. At this point, the only possible remedial solution seemed to be a strict disciplinary regime and in some cases confinement. However, with the advent of child guidance, the relationship between parents and children became an integral part of the clinical evaluation, and mothers especially were now requested to take an active part in the therapeutic process. Indeed, in the clinics, mothers were often selected as the actual focus of therapeutic intervention.

By the late 1940s, the psychologisation of child behaviour had taken on a cultural life of its own independent of the clinic, as a burgeoning industry of mental health experts began to penetrate the domestic sphere via popular publications on child rearing. Although the effectiveness of the child guidance team's interventions proved to be meagre, the general views of the mental hygiene movement ended up in advice books, magazine articles, radio programmes and

lectures ([Horn 1989](#), pp. 177-178). This popularisation was particularly evident in America. Writers clearly targeted mothers as the primary, or even sole, interested party in the child's upbringing, and features typically concentrated on boys' behavioural development. As in the behaviourist era of the 1920s and 1930s, mothers were seen as possible obstacles to boys' natural development, and in need of expert support in order to avoid becoming such impediments ([Singh 2002a](#), pp. 581-582).

After World War II, the influence of psychoanalysis on ideas about mothering and the mother-child bond grew on both sides of the Atlantic. In post-war Britain, psychoanalyst John Bowlby's ideas about "maternal deprivation" became extraordinarily powerful, not least because they could be used by the government in its attempts to reconstruct family life ([Rose 1990](#), pp.161-162). In the US, too, various psychiatrists drew attention to the adverse effects of physically or psychologically absent parents, perhaps most famously when the pioneering child psychiatrist Leo [Kanner](#) (1943; 1944) identified infantile autism as a specific syndrome and suggested that it had a psychological origin in cold, distant parents.⁵ Other influential contributions were the "double-bind" theory put forward by anthropologist Gregory Bateson, and concepts such as the "schizophrenogenic mother" (Frieda [Fromm-Reichmann 1948](#)), which specifically focused on the complex interplay between mothers and sons. Two important maternal qualities – overprotection and rejection – characterised this particular type of woman, and the result were boys who grew up to be dictatorial, weak or psychotic. Not surprisingly, when [Alexander & Selesnick](#) (1966) chronicled the history of psychiatry, they claimed the mother-child relationship to be "so important for ensuing pathology that it has probably received more attention than any other aspect of child psychiatry" (p. 383).

⁵Kanner is often said to have introduced the term "refrigerator mother", but in fact he also reported that fathers could be humourless and cold. Kanner, who always mistrusted the extremes of psychoanalysis, was dismayed that his original observation had fostered a "nothing-but-psychodynamic aetiology" that "stifled" further curiosity about the cases of autism (quoted in [Jones 1999](#), p. 211). Indeed, the famous psychoanalyst Bruno Bettelheim was a much more staunch and uncompromising proponent of the view of autism as a severe emotional disturbance caused by inadequate mothering ([Silverman 2004](#)).

There were, however, professionals who went against the tide of maternal accusation. Notable among those was Laretta Bender at the New York Bellevue Hospital, who challenged conventional wisdom about childhood schizophrenia. Bender thought the condition had a biological basis and even experimented with drug treatment and electroconvulsive therapy on her young patients (Bender 1949; 1966; Bender & Cottingham 1942). Child psychiatrist Stella Chess was another prominent voice. In 1964, Chess opened a critical editorial in the *American Journal of Orthopsychiatry* thus: “To meet Johnny’s mother is to understand his problem” – a sentence she had taken from a letter by a school counsellor requesting information about a particular pupil, but which might as well have been written by a psychiatrist, a psychologist, or a non-professional well-read in psychology (Chess 1964). In her clinical practice – at a hospital clinic with lower socio-economic child patients, and in her private middle class patient practice alike – given a child with behaviour disorder, the primary search by her predecessors had been for the maternal attitudes and consequent actions that had caused the child’s disturbances. The list of pejorative terms used was impressive: the mother, she was informed, was rejecting, punitive, pressuring, immature, overprotective, seductive, neglectful, and/or infantilising. Chess warned that maternal pathology, or “mal de mère” as she put it, was not a concept well-designed to meet the needs of troubled or troublesome children, adding that this ideology caused much guilt and anxiety to innumerable mothers who did not deserve it.

Certainly, a few years later, the new emphasis on the organic nature of boys’ behavioural problems was well received by American mothers, who in magazine articles heralded the advent of Ritalin for their son’s troublesome behaviour as a true miracle (Singh 2002a, p. 593). In Britain, where paediatric physicians rarely used the Minimal Brain Dysfunction diagnosis nor drug treatments, the waning power of psychodynamic approaches was most clearly illustrated by Michael Rutter’s appraisal of Bowlby’s work in *Maternal Deprivation Reassessed* (1972), which among other things emphasised that various longitudinal studies had demonstrated the great difficulty of predicting later functioning from early life experiences and behaviour.

However, despite such qualifications and renunciations, the idea of the mother as the ultimate cause of children's misconduct and mental illness continued to exert a strong influence on professional attitudes on both sides of the Atlantic (Chess 1982). In the end, the most significant revolt against psychiatric assertions of maternal responsibility came from families themselves, as reflected by the formation of support and advocacy associations set up during the 1970s by parents convinced of the organic nature of their children's afflictions. Originally, the mental health consumer movement arose after World War II due to a complex set of influences, including the civil rights movement of the 1960s and the concomitant grassroots self-help revolution, which in turn has been attributed to increasing individualism, a loss of belief in authorities, and a growing emphasis on the value of experiential knowledge in Western capitalist societies (Kelleher 1994, p. 113). Other important influences were the psychopharmacological innovations of the 1950s, the rise of anti-psychiatry, and deinstitutionalisation, which shifted responsibility for the care of the mentally ill from the institution back to the family and the community (Beard 2000, p. 299).

Mental health advocacy efforts were of course not unknown before the war; indeed, the National Committee for Mental Hygiene (today the National Mental Health Association), founded in 1909 by ex-patient Clifford Beers, was a campaigner for the mentally ill long before the word advocate became part of the public consciousness. But activism took on a new character in the post-war period, in parallel with the growing disenchantment with the mental health sector, not just among (ex-) patients, but also among families who were increasingly frustrated and angry at the system for failing to provide satisfactory treatment of their children, whether in the hospital or in the community.

While many of the self-help activist groups which appeared in the 1960s and 1970s fiercely opposed claims of medical expertise and discouraged professional involvement, the emerging family mental health consumer movement attempted to mobilise medical and public opinion through direct alliances with biomedical researchers, and in some cases the pharmaceutical industry. In the field of educational rights activism, the phenomenon of "parent power" had already been

amply demonstrated by the Association for Children with Learning Disabilities (ACLD), which subscribed to a neurobiological perspective from the outset, and would eventually play an important role in the making of the 1975 Education for All Handicapped Children Act. In the mental health arena, however, the Tourette Syndrome Association (TSA) was one of the first examples of a highly successful parent/patient association dedicated to establishing the physiological basis for a condition, and to obtaining assistance and legal protection for its members on this basis.

The TSA was set up in 1972 by parents of children exhibiting the characteristic tic symptoms, in close collaboration with Arthur and Elaine Shapiro, who in the 1960s pioneered the treatment of Tourette's with haloperidol and thus changed medical perceptions of Tourette's as a psychological disorder. Most of TSA's members had children under the Shapiros' care and supplied them with subjects for their clinical studies. In turn, TSA would print and distribute their studies to its membership, and to doctors and members of the public requiring assistance and information. By the mid-1970s, the association had inextricably attached itself to and encouraged every new and promising route toward identifying and treating Tourette Syndrome as an organic disorder. They also actively lobbied the US Congress and other legislative bodies for regulation that would help Tourette patients gain access to drugs and receive legal protection from harassment ([Kushner 2004](#)).

The remarkable success of the TSA owed much to the energy of its leaders, but it also drew on a wider American historical tradition that authorised grassroots movements to call professional expertise into question, in this case the expertise of the psychoanalytical establishment. On this point, [Kushner \(2004\)](#) contrasts the US with France, where the disorder was rarely diagnosed until recently, although it was originally identified and labelled there by Gilles de la Tourette in 1885. As described in chapter 4, French psychiatrists were very critical of the DSM-III and tended to see syndromes in general as American inventions. Insisting on the designation of Tourettes as a *disease*, primarily of psychiatric origin and tied to obsessive-compulsive ideation, French psychoanalysts typically drew on the

writings of Pierre Janet who stressed that tics were a “signal symptom” of an obsessional psychoneurosis. However, Kushner argues that the dominance of the organic explanation in the US, as opposed to the French preference for psychogenic explanations, was largely the product of the TSA’s success in defining the terrain of research and discourse about the syndrome in the US, and the relative absence of similar communities of suffering in France. Thus, at a conference in Paris in 1982, psychoanalyst Serge Lebovici suggested that the growing acceptance of chemotherapy and an organic concept of convulsive tics in the US was the result of the “direct participation of families at the therapeutic level [...] that has appeared as a new phenomenon, most represented in Anglo-Saxon countries”. Clearly, this was not a development that Lebovici favoured. He assumed that the interference of laypersons with diagnosis, treatment, and research was so outrageous that his colleagues needed only to learn of it in order to be appalled at this trend in American medicine (cited in [Kushner 2004](#), p. 86).⁶

Apart from the TSA, Lebovici may well have been referring to the National Society for Autistic Children (now the Autism Society of America (ASA)) which was founded in 1965 by research psychologist Bernard Rimland – author of a pioneering book about autistic behaviour seen from a neurobiological perspective – together with a small group of parents. Like ADHD, autism is a disorder which has attracted a great deal of attention in recent years, thanks to dramatically increasing rates of diagnosis, extensive organisational mobilisation, and journalistic coverage. At this time, however it was diagnosed very rarely and perceptions of the disorder were still significantly shaped by psychogenic theories emphasising emotionally cold mothers.⁷ From 1970, the ASA began to arrange

⁶The first French patient association for those affected by Tourette Syndrome was created in 1997, five years before the establishment of the first ADHD patient/parent organisation, HyperSupers ([Edwards et al. 2012](#)). In the UK, the Tourette Syndrome (UK) Association was created in 1980, as a sub-group of the American association. Occupying a middle position, British psychiatrists and neurologists have been less enthusiastic than their American counterparts, but more willing than their French colleagues, to diagnose the syndrome.

⁷Today, this still holds true for some European countries, such as France, which recently witnessed a major public controversy over Sophie Robert’s documentary *Le Mur* on the continuing influence of Lacanian psychoanalysis on French child psychiatry, and notably the perception and treatment of autistic children. In Northern European countries such as the UK, the impact and

nationwide awareness campaigns and large national conferences to facilitate the exchange of knowledge between parents, professionals, and researchers. In the political arena, the organisation's work has resulted in millions of dollars devoted to research, and its advocacy efforts played a key role in securing rights for autistic individuals through disability legislation such as the 1975 Education for All Handicapped Act. Moreover, as demonstrated by the founding of the National Alliance for Autism Research in 1994 and the organisation Cure Autism Now in 1995, parents of autistic children have in recent years been exceptionally enthusiastic in embracing their unique position to foster genetic research. In addition to raising considerable funds, both organisations have thus exploited the identities of their members to influence the direction and speed of genetic studies (Silverman 2004; Solovitch 2001).

Finally, when discussing the rise of parent activism in mental health, one cannot overlook the National Alliance for the Mentally Ill (NAMI), America's largest and most influential grassroots mental health organisation and a fervent defender of the biological paradigm in psychiatry. Focusing on severe mental illness like schizophrenia, NAMI was established in 1979 by exasperated relatives who shared experiences of being scape-goated and left out of treatment plans. Because of its rapid growth and activism, NAMI has played a key role in defining the central tenets of the family mental health consumer movement in the US (Foulks 2000, p. 361). While still in its infancy, the organisation decided that its highest legislative goal would be to get Congress to declare "a war on mental illness" which was to be achieved by substantial increases in the federal biomedical research programme. Not least due to these efforts, the National Institute of Mental Health (NIMH) is now an integral part of the National Institutes of Health, and NIMH funding increased tenfold to reach nearly \$1 billion in 2000 (Foulks

authority of psychoanalysis was never felt as deeply, nor did public pronouncements on the psychoanalytic meaning of autism have such a pervasive and lasting effect. Indeed, in 1977, Rutter and Folstein published a twin study in the *Journal of Child Psychology and Psychiatry*, which had huge impact in turning around the field to recognise the importance of genetic influence not just in pure autism, but also in the broader range of cognitive disorders which would later be termed autism spectrum disorders. As a result of the Rutter and Folstein study, as molecular genetic research grew in the 1980s, autism was one of the first targets.

2000, pp. 361-362).

Certainly, a major reason for the success of groups like NAMI, TSA and ASA is that political coalitions which unite psychiatrists with non-professional advocacy groups to lobby legislators are perceived as being particularly convincing. Combining expert knowledge with the passionate plea of a treated patient or family member usually presents a moving and convincing argument. However, in the case of NAMI in particular, critics have claimed that its rise has been almost entirely due to the substantial financial support it has received from various manufacturers of antidepressants, anti-psychotics and anti-seizure drugs. Specifically, *Mother Jones* revealed that the organisation accepted almost \$12 million from 18 different drug companies between 1996 and 1999, and that an Eli Lilly executive operated out of NAMI's headquarters directing major operations (Silverstein 1999). Further, in 2009, NAMI admitted to a US Senate probe that a majority of their funds over the preceding five years – 56% on average – came from the drug industry, with companies donating \$23 million to the organisation from 2006 to 2008 alone.⁸ This revelation prompted many commentators to argue that NAMI had duped unwitting parent members, who stridently pushed the “brain-based” agenda, to become lobbyists for drug manufacturers.

Significantly, much the same critique has been levelled at the support and advocacy group, Children and Adults with Attention Deficit Disorder (CHADD) in recent debates about standards of disclosure by non-profit groups.⁹ In 1995, the reputation of CHADD as an objective information service was damaged when the PBS TV-programme, *The Merrow Report*, revealed that CHADD had received

⁸Previous to the probe, NAMI had refused to identify its corporate donors, but afterwards began quarterly postings to their web site with a list of drug company donations and amounts (Harris 2009).

⁹NAMI was not a direct source of inspiration when CHADD was established; even as CHADD moved its headquarters to Washington D.C. in 1997, it worked almost exclusively in the area of special education law, and was not an active part of the mental health community. However, in 2000, the former CEO for public policy at NAMI, Clarke Ross, was offered a position as CEO of CHADD, partly because the board of directors were interested in learning from the largest and most influential of the family mental health movements in the US (Ross int. 2006). Ross' political connections in Congress and various federal agencies also helped CHADD to get financial support from the Centers for Disease Control and Prevention to establish and run a national information centre on ADHD. This was the first time CHADD obtained federal funding.

almost \$800,000 in grants from Ciba-Geigy alone between 1991 and 1994. While the contributions were not illegal or above the common standards for non-profit organisations, they nonetheless posed a potential conflict of interest that parents, government officials, and federal drug regulators were seemingly unaware of.¹⁰ Ciba did not help matters when a drug company executive characterised CHADD to the Merrow Report as the company's "conduit for providing [...] information directly to the population" (cited in [Mayes et al. 2009](#), p. 149).

These controversies reflected broader debates about the increasing role of the pharmaceutical industry in producing and shaping patient activism in both explicit and under-cover ways. Expanding the traditional focus on influencing doctors' prescribing decisions, drug companies have over the past few decades increasingly been targeting their marketing efforts directly at potential patients and consumers. Thus, via various media, American consumers have since 2001 been exposed to adverts encouraging them to consider specific drugs and discuss them with their doctors.¹¹ Furthermore, it has become common practice for drug companies to hire public relations firms to boost drug sales, often through the use of the so-called "third party technique", which involves using an apparently independent, credible messenger – for example a patient group or a journalist – to promote their products, either explicitly or implicitly ([Burton & Rowell 2003](#)). Since patient associations have demonstrated a growing willingness and ability to campaign on health-related issues, corporate sponsorship of patient groups is also used to mobilise grassroots lobbying muscle in order to influence policy makers on key issues such as access to medicines. The subtlety of these marketing practices is

¹⁰One might speculate that Ciba adopted the then small support group in the late 1980s as part of a comeback strategy, following a damaging Scientology-fuelled anti-Ritalin publicity campaign in the American media (see chapter 4), but it is naturally difficult to come by information from drug companies which throws light on the motives behind their decisions to fund groups like CHADD.

¹¹When direct-to-consumer advertising campaigns started appearing in the US in 2001, drug companies broke with 30-year-old international marketing restrictions to advertise directly to the public. In the case of ADHD, the ads typically appeared in women's magazines, selling mothers the idea that medication may be the answer to children's problems in school. Under a 1971 UN convention, signatory nations agreed to prohibit DTC advertising, but the US never passed such a law, leaving the DEA and the FDA no option but to express strong concern, without the possibility threaten legal action ([Singh 2002a](#), p. 593).

enhanced by the fact that they are typically presented as educational in nature. For groups, corporate sponsorship helps not only to pay for routine costs but also enable them to carry out more expensive activities such as national campaigning.

7.3 The story of CHADD

CHADD was established in 1987 in southern Florida by a small group of frustrated parents and psychologist Harvey Parker, in an effort to provide information to people in the surroundings community about Attention Deficit Disorder. At this time, school districts knew little about the new DSM diagnosis, and there were only a handful of popular books on the topic. Gradually, the local meetings attracted more and more people, and the group's newsletter began to spread to other parts of the country where support groups began to develop. By 1993, CHADD had grown to include around 30,000 members and several hundred chapters around the country. It boasted major annual conferences with prominent speakers, a glossy bi-monthly magazine glossy magazine, *Attention!*, and a professional advisory board made up of the top ADHD researchers within psychiatry, psychology and neurology (Diller 1998, p 128). Unlike the ASA, TSA and NAMI, the organisation did not aim to contribute directly to research through fundraising and other activities. However, it adopted a strongly biological view from the start, and worked hard to nurture ADHD's image as a neurobiological condition backed by a large body of evidence-based science. One of CHADD's particular strengths is that it has been very media-sensitive, with a track record of delivering speedy responses to any reports on Ritalin or ADHD that the group deems inaccurate or demeaning. Similarly, there seems to have been limited room for alternative views within the organisation. In spite of the emphasis on multi-model treatment in CHADD's literature, some parents who turned to the group and associated internet communities for information and support claimed that those who raised questions about the scientific integrity of the diagnosis, or about the safety of Ritalin treatment, were quickly challenged or simply dismissed (ibid, p. 130).

As regards alternative groups, there are very few in the US. CHADD has had competition in the adult area from the smaller organisation, Attention Deficit Disorder Association (ADDA), which was created in 1989 by professionals who felt that the needs of adults were being neglected. Due to turf issues and philosophical differences, steps to unify the two organisations have failed. In the words of a former CHADD president CHADD is based on the published “science of ADHD”, whereas ADDA is “more of a feel-good organisation” which is very attached to the issue of “coaching” and has a relatively strong focus on the potential positive aspects of ADHD, such as heightened creativity ([Kaplanek int. 2006](#)). ADDA and CHADD occasionally work together on awareness projects, often in collaboration with other mental health and disability organisations, but most of the time they ignore each other (*ibid*).

Whereas the original purpose of CHADD was to educate parents, the achievement of educational rights – and the enlightenment of teachers and school administrators – quickly became a key objective ([Ross int. 2006](#)). In general, the group gave careful scrutiny to any legal or political developments that might be beneficial or disadvantageous to the ADHD community. But CHADD turned out to be a particularly effective family advocate in the area of special education, as its lobbying and letter-writing campaigns in 1991 resulted in changes to federal laws which gave ADHD children access to special educational services.¹² However, the political success and influence of the ADHD movement was at least temporarily stymied in the mid-1990s, when CHADD, following an alleged shortage of Ritalin, petitioned the Drug Enforcement Agency to reclassify Ritalin from a Schedule II to a Schedule III drug, which would permit an increase in the production of the drug

¹²Several observers have argued that the formal recognition of ADHD as an educational disability was the main driver of the steep increase in diagnosis in the 1990s in the US. However, the government initially only added ADHD as a condition that could qualify for services under the category of “other health impairments” under existing laws (the IDEA). Whereas CHADD celebrated this change, it took a while for the schools to catch onto it and to start identifying kids proactively. It was only with the 1999 regulations of the IDEA that the separate inclusion of ADHD as a covered disability was only made absolutely clear. Therefore, one may argue that the push for ADHD evaluation to begin with mostly came from parents who had heard about the disorder through the media or from other parents ([PBS 2000](#)). Further, doctors were at this time beginning to see medication a first-line treatment in many cases rather than as a last resort.

and make it easier to prescribe.¹³ The petition was co-signed by the American Academy of Neurology, and supported by a number of other distinguished medical and psychiatric bodies (Eberstadt 1999). However, before the DEA could respond, CHADD's credibility was damaged by the Merrow Report's revelation of Ciba-Geigy's undisclosed funding.

Eventually, the DEA not only refused the demand to have the drug reclassified – it subsequently issued a report to Congress that was highly critical of CHADD and warned that Ritalin was being widely abused as a recreational drug (DEA 1995).¹⁴ “Most of the ADHD literature prepared for public consumption and available to parents”, the DEA charged, “does not address the abuse liability or actual abuse of methylphenidate. Instead, methylphenidate is routinely portrayed as a benign, mild stimulant that is not associated with abuse or serious effects. In reality, however, there is an abundance of scientific literature which indicates that methylphenidate shares the same abuse potential as other Schedule II stimulants”. The DEA went on to note its “concerns” over “the depth of the financial relationship between CHADD and Ciba-Geigy”, which stood “to benefit from a change in scheduling of methylphenidate”. Indeed, at this point, the United Nations International Narcotics Control Board (INCB) had already expressed concern about US non-governmental organisations and parental associations lobbying for the medical use of methylphenidate for children, adding that financial transfers from a pharmaceutical company with the purpose to promote sales of an internationally controlled substance could be identified as hidden advertisement and in contradiction of the provisions of the 1971 Psychotropic Drugs Convention

¹³Schedule II designates the DEA classification for highly addictive drugs that can remain legal, but with tight restrictions on use, which at least in theory raises the spectre of a “shortage”. The move to Schedule III would have lifted government limits on the annual production of Ritalin and made it easier for doctors to prescribe the drug by eliminating the need for patients to visit their GP to obtain a refill prescription.

¹⁴In the 1990s, questions about the safety and availability of stimulants resurfaced, with critics complaining that it was too widely accessible and distributed, thus encouraging abuse and addiction. The media played a key role in putting the issue on the agenda, with stories of widespread abuse of Ritalin among children, and on university campuses, where students use the drug as an exam aid. CHADD's co-founder Harvey Parker dismissed the incidences as “isolated incidences”, but while systematic studies found that Ritalin misuse was not as widespread as the media implied, it was still sufficiently prevalent to raise concern (Mayes et al. 2009, p. 147).

([UNIS 1995](#)). In the end, CHADD withdrew its petition.

Despite the ensuing criticism, the organisation has continued to accept corporate donations to help pay for its many campaigning activities and general operating expenses. Reflecting common practice among patient groups in general, this information has not been immediately obvious on the website, but slightly tucked away in the Income and Expenditures reports, which at the same time state a strict ethical commitment to assuring the avoidance of conflict of interests “or even its appearance” in accepting such financial support. The reports show that whereas CHADD received \$507,000 from drug companies in 2001/2002 alone, this amount had nearly tripled five years later in 2007/2008 to a total of \$1,205,000 and now made up 30% of the overall budget. In addition, 64% of sales and advertising, or \$466,104, came from the pharmaceutical industry ([CHADD 2008](#)).

For a number of years, a large portion of CHADD’s revenue came from membership fees. However, as the number of members has dwindled markedly since 1997 – in 2008/2009 it was as low as 12,000 – corporate sponsorship has clearly become increasingly vital. This development occurred in parallel with the spread of the internet, which made it possible and convenient for people to obtain information on the disorder in the comfort of their own home, without paying for it, for example from the CHADD-run National Resource Centre on ADHD. Together with the structural problems that have occurred because the local management of the organisation is completely dependent on the motivation and skills of unpaid volunteers with big family burdens, the decline in membership and revenue has also resulted in the closure of many local chapters over the past decade.¹⁵ The problem of membership retention is a big challenge for CHADD, who would like to be seen as the world’s leading patient organisation within the area of attention deficit, and to build a credible, strong social movement capable of influencing public policy and public perception of ADHD ([Ross int. 2006](#)).

Further, the growing number of negative media reports about CHADD and

¹⁵In 2006, CHADD only employed 30 paid staff, all based in the group headquarters in Washington D. C. ([Ross int. 2006](#)).

the subject of ADHD and Ritalin more generally have to some extent affected the group adversely. The Merrow Report certainly brought a good deal of bad publicity, but in fact its impact was felt most keenly in the sense that it came to act as a reference point for a series of lawsuits brought in 2000 by the Scientology-affiliated anti-psychiatry organisation, the Citizens Commission on Human Rights (CCHR), which charged the drug company Novartis with conspiring with the American Psychiatric Association and CHADD to invent and promote the ADHD diagnosis in order to boost Ritalin sales. Although all the suits were dismissed in the end, they were reported widely in the media and became a considerable financial drain and burden for CHADD ([Ross int. 2006](#); [Kaplanek int. 2006](#)).

A few years later, another media story put the organisation in an unfavourable light. In 2002, CHADD gave respected ADHD researcher, William Pelham, a lifetime achievement award and subsequently interviewed him for their publication *Attention!* Here, Pelham argued that stimulant drugs have serious limitations when employed alone, and that psychosocial treatments should be the treatment of first choice. Eight months later, after Pelham's interview was published with the critical sections on stimulants cut out, Pelham observed: "In recent years, I have come to believe that the individuals who advocate most strongly in favor of medication – both those from the professional community, including the National Institutes of Mental Health, and those from advocacy groups, including CHADD – have major and undisclosed conflicts of interest with the pharmaceutical companies [...] I believed that parents of ADHD children and the public at large should be made aware of this situation. As I think is clear from examining the edited sections, the CHADD CEO and board of directors did not share my concerns" (cited in [Hearn 2004](#)). CHADD's officials in turn responded that the decision to edit the interview was made since some of Pelham's claims were not scientifically supported.

Due to all of the issues mentioned above, it is fair to say that CHADD has lost much of the momentum they had in the mid-1990s. Yet, whatever embarrassment its supporters may have suffered, and despite its difficulties in retaining paying members and maintaining local chapters, the organisation still

receives many thousand enquiries every year from people wanting advice on how to advocate for services for their children in school, or on issues of social and medical insurance coverage. On the legislative front, CHADD also remained an influential force, especially in the area of special education law. Thus, CHADD made significant contributions to both the 1997 and 1999 reauthorisations of the IDEA (the last of which listed ADHD as a separate disability category for the first time), and in collaboration with organisations such as the Learning Disabilities Association of America (LDA) they fought certain aspects of the No Child Left Behind Act of 2001.¹⁶ Other priorities have included lobbying for mental health parity and for the preservation of the controversial social benefits programme, Supplemental Security Income, for low-income families affected by ADHD.

Last but not least, CHADD was deeply involved in recent conflicts over the role of schools as instigators of diagnosis and medical treatment. In the wake of a series of highly publicised incidents of “drug coercion”, Republican Representative Max Burns in 2003 introduced the Child Medication Safety Act, a federal bill requiring states to prevent school officials from compelling a child to take medication as a condition of attending class. However, a formidable coalition of advocacy and professional groups, including CHADD, NAMI, the National Mental Health Association, the American Psychological Association, and the American Academy of Child and Adolescent Psychiatry, lined up against the initiative, fearing that it would undermine the “vital role that teachers play in providing information to diagnosing professionals” (Mayes et al. 2009, p. 163). In the end, a group of liberal senators led by Edward Kennedy struck a compromise that pared down the bill, which then received bipartisan support in both houses.¹⁷ Later on,

¹⁶Formerly the Association for Children with Learning Disabilities, the LDA has been lobbying Congress for the rights of children with learning difficulties since the early 1960s and, much like CHADD 25 years later, it was accused of contributing to inappropriate medicalisation (Schrag & Divoky 1975, pp. 77-83). Thus, one might think that they would benefit from collaborating, but in fact the two organisations deliberately try to keep as separate as possible, underlining that learning disorder and ADHD are two separate disorders (although most studies show a high level of co-morbidity) (Larry Silver int. 2006). Significantly, a major difference between the LDA and CHADD is that the former does not receive any money from the drug industry, as stimulants have not been shown to work in LD.

¹⁷The compromise provisions were included in the 2004 reauthorisation of the IDEA, which was

CHADD would campaign with the same organisations against another bill, The Parental Consent Act of 2005, the aim of which was to prohibit the use of federal funds for mandatory mental health screening programmes – like those urged by President Bush’s New Freedom Commission (Lenzer 2004) – or any instrument of government that used the refusal of a parental consent as the basis of a charge of child abuse or education neglect.

7.4 Ablechild and the campaign against “forced drugging”

The coalition of pro-family and citizens rights activists who supported the Parental Consent Act pointed to the intimate involvement of the drug industry in the promotion of mass screening in the nation’s schools, and the financial incentives for certain patient groups like CHADD to assist their sponsors with claims that cases of educational and medical malpractice are few and far between. Among the most vocal critics was the organisation Ablechild (Parents for Label and Drug-Free Education), which describes itself as a national parents’ rights grassroots organisation, dedicated to protecting full informed consent and the right to refuse psychiatric services.¹⁸ The organisation works to educate parents on the risks associated with psychotropic drugs, and to uncover “real” educational problems and medical issues behind behavioural problems.¹⁹ Furthermore, it has developed a website to give parents a venue for sharing their personal stories, informing them

amended to include a specific section prohibiting “mandatory medication” in schools. However, this meant that restrictions on school officials extended only to special education students covered by the IDEA, and not to all students.

¹⁸The origin of the organisation’s name is explained on their website as a reference to the 1958 National Defense Education Act. It is argued that the original intent of this important piece of legislation was gradually perverted as the money allocated for the strengthening of science education programmes for able children was diverted to the National Institute of Mental Health and their “unethical and questionable clinical drug research on children”. From this point, argues Ablechild, the “mental health industry” succeeded in revamping the educational model, as an increasing number of school psychologists were employed to identify children, based on subjective behavioural characteristics.

¹⁹Although one of the goals of Ablechild is to promote natural alternatives to Ritalin, the organisation is more focused on the political fight against the “psychopharmaceutical complex” than with advising parents on issues such as diet.

about legal issues and legislation, and urging letter-writing campaigns and petitions.

Ablechild was founded in 2001 by Patricia Weathers and Sheila Matthews, two mothers with personal experiences of fighting school authorities over the issue of ADHD and medication. In September 2002, 32 years after the first congressional hearing was held on the use of behaviour modification drugs in children (Gallagher 1970), Weathers’ story made national headlines and quickly became a rallying point for conservative pro-family groups after she testified before a committee on government reform (Burton 2002). Here, she recounted how school officials in her hometown of Millbrook, New York, had dismissed her son, Michael, after she had refused to medicate him at their request. In the first grade, after his teacher had argued that he would not be able to learn normally without medication, Michael was given an ADHD diagnosis and a prescription for Ritalin. By the third grade, in addition to experiencing sleep problems and loss of appetite, he became withdrawn and agitated. But instead of recognising these symptoms as possible drug side effects, the school psychologist referred him to a psychiatrist who quickly diagnosed social anxiety disorder and added the antidepressant Paxil to the stimulant. When he soon thereafter became violent and started to hallucinate and hear voices, Weathers decided to stop the medications. The psychiatrist however wanted to hospitalise Michael and try different sedatives until they found “the right one”. When she resisted these recommendations, the school proceeded to call child protective services, charging Weathers and her husband with medical neglect.²⁰

Around the same time, several other accounts of “forced drugging” and intimidation by school districts appeared in the media. It was unclear how widespread the phenomenon was, but several states nonetheless moved to limit the ability of teachers and other school personnel to insist on drug treatment. In 1999,

²⁰The complaint filed by the school stated in part: “[Michael’s] behavior at school is bizarre: He hears voices and appears delusional, he chews on his clothes and paper, and talks to himself.” Subsequently, a month-long investigation cleared the charges and independent psychiatrists determined these behaviours were primarily caused by the drugs (Burton 2002).

the Colorado Board of Education passed a resolution that urged teachers to employ “proven academic and/or classroom management solutions” – that is traditional forms of discipline – rather than drugs in dealing with problem children (Mayes et al. 2009, p. 161). The Texas Board of Education followed suit, and by 2003 a dozen states had followed Colorado and Texas’ examples and passed even more stringent laws that limited what teachers could say to parents about their children’s behavioural or academic problems. Ablechild took an active part in this development. After co-founder Sheila Matthews had testified in her home state of Connecticut in 2001 to secure the enactment of the first state law in the country to bar school administrators and teachers from recommending or compelling any psychotropic drugs for a student, she continued to work with parents to push for the ratification of similar bills in other states. The conflict entered national politics in 2003 with the Child Medication Safety Act, and although it was not passed, Ablechild was instrumental in the lobbying and passing of the compromise prohibition on mandatory medication which was included in the 2004 reauthorisation of the IDEA.

Doubtlessly, an important part of the explanation for Ablechild’s success lies their ability to garner national media attention for their message. Weathers and Matthews have made appearances on many popular TV shows, including ABC’s *Good Morning America* and *the Today Show* on NBC, and they have been interviewed for front-page stories in many of the major American newspapers and magazines. However, they have also had support from powerful players. Despite Ablechild’s website statement that they are a separate organisation with no religious or political ties, it is unquestionable that they have close links with the anti-psychiatry organisation, the Citizens Commission on Human Rights, which in turn functions as an arm of the wealthy Church of Scientology. Ablechild’s members are generally not members of Scientology, but the organisation receives a significant portion of its funding from the Church (Berntsen 2005, p. 1583). While claiming to be independent, it is thus clear that both the pro- and anti-ADHD advocacy groups are intimately connected with larger economically-driven interest

groups with opposing motives.²¹

The CCHR was established in 1969 by Scientology, represented by founder L. Ron Hubbard, and psychiatrist Thomas Szasz (who, himself, remains an atheist and was never a member). The organisation maintains that there is no evidence to support the view of mental disorder as a medical disease, and that the use of psychopharmaceuticals and other physical psychiatric therapies is fraudulent and highly dangerous.²² In its effort to portray psychiatry in a negative light, the CCHR has sought to champion the rights of psychiatric patients by lobbying for legislative reform on various mental health issues, including involuntarily commitment and treatment in mental hospitals. Furthermore, beginning in 1987, the organisation has organised a series of campaigns, including a large number of lawsuits, against various psychiatric organisations and drug companies, including Eli Lilly, the manufacturer of Prozac, and Ciba/Novartis, maker of Ritalin. Claiming medical negligence, the Ritalin court cases pitted parents against psychiatrists and succeeded in generating a large amount of negative media publicity, creating a climate of anxiety among parents and teachers (Safer & Krager 1992). Similarly, the Prozac campaign was so effective that sales of the drug dropped from 25% to 21% of the market sales for antidepressants in 1991 (ibid).

As a result of these activities, the general critique of biopsychiatry has become so closely associated with CCHR and Scientology that critics – radical and moderate alike – regularly feel compelled to dissociate themselves from these.

²¹It is worth underlining that the complementary medicine industry also seeks to boost profits by sponsoring parent support groups. Thus, Parents against Ritalin, formed in the late 1996 allegedly in response to school pressure to medicate children, was reportedly run by a distributor of Ephedra, a “natural” herbal alternative to Ritalin (Gugliotta 2000).

²²Despite sharing key views with the parallel anti-psychiatry movement, Scientology doctrine differs in some important respects. For example, scientologists have advocated for the outright destruction of psychiatry as a discipline, and promoted a series of psychiatry-related conspiracy theories. This “war” against psychiatry has been integral to Hubbard’s mission since 1950, when his first book on the self-help philosophy, Dianetics, announced that the mental health establishment was out to undermine and destroy the West. Throughout much of its history, the status of Scientology as a religious community has been highly controversial, with critics maintaining that it represents a profit-driven, psychologically manipulative, totalitarian enterprise with world-dominating aspirations (Kent 1999). Scientology has fought innumerable lawsuits to defend itself against such charges, and as a result gained recognition as a tax-exempt religious group in a number of countries, most notably in Australia in 1983 and the US in 1993.

Thus, some anti-psychiatry websites and psychiatric survivors groups explicitly emphasise that volunteers must in no way be affiliated with the church and its various affiliates; even psychiatrist Peter Breggin who initially worked with the CCHR has declared that he stopped all collaboration in 1974, as he soon found himself opposed to Scientology's values, agenda, and tactics (Breggin & Breggin 1994). However, Ablechild are not this explicit. In fact, both founders have accepted "Human Rights Awards" from the CCHR for their efforts as national spokespersons for the anti-medication cause, and several professional members of the Ablechild Board of Directors, including retired neurologist Fred Baughman and the osteopath and nutritional therapist, Mary-Ann Block, are known as medical consultants to the organisation.

7.5 The ADHD movement spreads to the UK

Although present, the potential for drug companies and other stakeholders to "colonise" groups has been less significant in the UK, where the ADHD support community is made up of many independent groups, and several attempts to establish an umbrella organisation or even an alliance have failed, primarily due to significant inter-group struggle. This lack of integration may partly explain why the UK ADHD community has not succeeded in gaining much concrete political influence compared to the American ADHD movement, which has achieved significant political results in the education area in particular, both on its own, and in cooperation with other disability advocates. Certainly, a marked culture of "turfism" also characterises the US voluntary sector²³, but coalitions of professionals, parent, children's welfare advocates and disability activists were nonetheless very active in the passing of the 1975 Education for All Handicapped Children Act and its successors, and in lobbying for changes in public policy to

²³In his comparison of American and British patient organisations, Wood actually argues that this culture of autonomy is particularly pronounced in the US, where he found many organisations representing the same or related medical conditions (Wood 2000, p. 13). However, this conclusion does not apply in the case of the ADHD movement.

expand the number of disabled children eligible for social benefits and Medicaid.

Whereas CHADD built on the already existing achievements of parent and disability rights advocates in pushing for recognition and better services, the corresponding history of community-based activism in Britain is not quite as prominent. The first UK parent pressure group within the child mental health area was the British Society for Autistic Children (later renamed the National Autistic Society) started in London in 1962 by a small group of mothers who were frustrated at the lack of understanding and help available for their families. In the wake of the closure of institutions for the ‘mentally retarded’ and the integration of children with learning disabilities into schools following the 1959 Mental Health Act, these parents campaigned for better diagnosis and worked hard to ensure that new treatment methods were developed to enable their children to adjust. The Society began to set up its own schools in the early 1960s, which were exclusively for autistic children, and also campaigned to the Ministry of Education to regard all autistic children as “educable”.

One can also draw parallels to the British equivalents of the American LDA, namely the British Dyslexia Association and the Dyslexia Institute, which have been prominent in promoting of the needs of dyslexic children in Britain, as well as in the training of specialist teachers, since 1972. Like ADHD, dyslexia and autism (especially mild forms such as Asperger Syndrome) are blurry disorder categories, which often involve conflicts between parents, professionals, and authorities over accommodations and services. In all three cases, parents have lobbied for their inclusion as specific categories of need in British educational legislation, but so far government has resisted such attempts. In fact, the first ever disability-specific law in the UK was the Autism Act 2009, which was passed after campaigning from the National Autistic Society. However, it only makes provision about meeting the needs of adults with autism, by improving the provision of relevant health and social services.

Countering Wood’s pessimistic conclusion that patient associations generally

remain politically ineffective (Wood 2000)²⁴, Allsop and colleagues (2004) have argued that an influential health consumer movement is developing in the UK, as alliances between groups have grown, and recent governments have increased opportunities for public participation in policy development and resource allocation. However, a predominant image to emerge from their large-scale study is that of diversity, both in terms of patterns of fragmentation and collaboration across condition areas, and in terms of the differential prioritisation attached by government to various conditions. In the UK, the activities of ADHD groups, in collaboration with medical experts, have been important in putting ADHD its long-term social and educational consequences on the health agenda (NICE 2000; 2008). Nonetheless, an abundance of issues remain which prompt calls for collective political action from advocacy groups at the national level. There is as of yet no overall strategy or statutory guidance concerning ADHD for the UK, only clinical recommendations made to the NHS by NICE, and in education the disorder is still seen as controversial and potentially very costly. It is therefore not surprising that the current SEN Code of Practice does not even mention ADHD, meaning that local authorities can to a great extent determine how they approach and prioritise the condition.

When trying to explain the fragmentation of the British ADHD support community, I would argue that one needs to look at the role of the internet in shaping ADHD-related parent mobilisation in the UK. Whereas CHADD was established about a decade before the internet became widely available, the British groups sprang up alongside with it in the mid-1990s, in a rather uncontrolled and chaotic manner, creating less centralisation and hierarchy both within and between associations. Of particular importance in the beginning was the ADHD forum on the US-based CompuServe²⁵, through which British parents, especially mothers,

²⁴According to Wood, acceptance of patient groups as partners in policy making has not been the norm on either side of the Atlantic, not least because their image as partial and self-interested remains a serious obstacle. Further, Wood mentions the lack of effective alliances and charity status as a factor that has restricted overt political activity. Most of the organisations he studied emphasised activities to raise public awareness, but only a minority focused on campaigning and lobbying as their main priority.

²⁵CompuServe was the first major commercial online service provider (email, file transfers, and

got to know each other, and communicated with parents and professionals in the US and other countries. This web communication also facilitated several visits to the UK by popular ADHD authors who toured the country and gave public talks that attracted many parents and considerable media interest ([Wheatly 1996](#)). From the US, these included psychologist Sam Goldstein and psychotherapist Thom Hartmann, who ran the CompuServe forum, and from Australia, paediatrician Christopher Green, who had been instrumental in heightening awareness of ADHD in his home country. Now, he appeared on British TV shows such as *Richard & Judy* to spread the message that hyperactivity in children is rarely the family's fault, and that parents should go to their doctors and demand an assessment for ADHD.

Soon, support groups had been established in most areas of the country, in addition to websites such as Adders.org and Milton Keynes ADHD, where people from around the world could find information and practical help, and exchange experiences in the associated chat rooms. By the late 1990s, Britain had many more online support groups and chat rooms relating to ADHD than both Canada and the US had at the time (Malacrida 2005, personal communication). The groups regularly provided parents and sufferers with links, downloads and digested information from US sites in particular, and often it was suggested that members download the information in order to give it to teachers and various professionals.

Though the number of local support groups exceeded one hundred around the turn of the century, many of them were small and rather unstable. The main actors included no more than a handful of groups, but whereas the playing field was quite even to start with, the National Attention Deficit Disorder Information and Support Service (ADDISS) eventually came to dominate, and some of the original groups closed down. ADDISS was set up in London in 1995 by Andrea Bilbow, after her son was diagnosed in a private psychiatric service. Wanting to learn more about the disorder, she went to a big CHADD conference and met key people in the American ADHD movement. This turned out to be a life-changing experience,

world wide web) which was later bought by AOL.

which made her determined to set up a similar national organisation, supported by a board of leading professionals, in the UK. The primary aim of the organisation would be to offer a national helpline and to educate professionals, parents, sufferers, and policy makers – an ambitious approach which differed somewhat from that adopted by already existing British groups, such as LADDER in Wolverhampton and the ADHD Family Support Group in Wiltshire, who focused mainly on providing mutual support and free advice for families (Bilbow [int. 2006](#)).

With the help of her contacts in the US, Bilbow and ADDISS quickly took the lead in furthering the cross-Atlantic pollination, and in promulgating knowledge that supports a neurobiological model of ADHD. Inspired by CHADD, ADDISS has from 1996 been instrumental in putting on workshops, professional and parent training days, and big annual conferences with well-known American, Australian, and UK experts as keynote speakers.²⁶ Further, they imported hard-to-find American books on ADHD “American style”, which they would sell through the group’s bookstore. Attesting to its emerging status as the UK’s leading ADHD support group, ADDISS managed to attract the support of key ADHD researchers and clinicians in Britain, such as professors of child psychiatry, Eric Taylor and Peter Hill, and several leading paediatricians in the area of neurodevelopmental disorders. In addition, ADDISS was supported by a Department of Health grant to set up the helpline.

From the beginning, the British ADHD community saw professionals as the most immediate obstacle to diagnosis and appropriate assistance, due to their tendency to place the responsibility with the family, and the mother in particular. Often those mothers who eventually obtained an assessment and diagnosis for their children did so outside the bounds of typical referral processes between educators and psychiatrists/paediatricians, learning about ADHD and locating

²⁶In recent years, ADDISS has focused on school consultancy and on setting up teacher and parent training programmes based on CBT. Moreover, they provide training for voluntary organisations working with families, as well as helping Youth Offending Services to deliver CBT programmes to young people.

“ADHD-friendly” specialists, frequently in private practice, through the internet, books, magazines, and information from friends and acquaintances, sometimes from overseas. This typically happened after years of traditional psychological interventions, such as family therapy sessions, where a label was never provided. Instead, hyperactivity was typically described as a “middle-child syndrome” or a product of divorce or inappropriate parenting techniques ([Harris int. 2005](#); [Lacey 1996](#); [Burne 1999](#)). Educational psychologists were perceived to be particularly uncooperative and unduly sceptical about the validity of ADHD, placing the responsibility with the family instead of considering the extent to which a severely disruptive child can cause a family to break down.

Educators in turn described parents as aggressive, defensive, and unwilling to accept the idea that environmental influences were important, insisting that children who have problems because of familial issues could easily be distinguished from true ADHD children with inborn difficulties. In many areas, relations were quite tense for a long period of time, and emotions would run high at local meetings arranged by the groups. While parents protested against the notion of ADHD as a so-called “one-parent” or “council estate syndrome”, many educational psychologists were concerned that boys from white working class homes with a multitude of social problems seemed to be overrepresented among the diagnosed and medicated ([Prior int. 2006](#)).

A number of studies conducted in the late 1990s confirmed that raising a hyperactive child in the UK was often associated with a profound sense of despair, anger and alienation. Apart from the struggle to obtain a diagnosis, parents would talk about their own experience of loneliness, and about the exclusion of their children from normal activities such as school trips and birthdays, and, increasingly, from school altogether. In a comparative ethnography, [Malacrida \(2003\)](#) described British professional demeanours towards mothers’ feelings and insights as arrogant and dismissive, especially in the case of teachers, and contended that UK professionals apparently still enjoyed high levels of respect and prestige compared to their North American counterparts. Interestingly, reflecting wider cultural attitudes, the British mothers in the study were themselves found to

be highly ambivalent about ADHD, expressing concern about the relying on medicine as a “chemical crutch”, and feelings of remorse over the presumed permanence and stigma, even while seeking the label on a personal level (see also [Lacey 1996](#)). In the end, British and Canadian mothers alike saw the label primarily as a means of getting help, and of avoiding social isolation (*ibid*, pp. 174-175). Similarly, in a study of GPs and parents of ADHD children, the majority of parents described their first encounters with doctors as discouraging and unhelpful. Although saddened and ambivalent about the implications of the diagnosis, most tended to experience medicalisation and labelling as an important validation of their experience of reality, which gave them a sense of relief and control.²⁷ Also, it acted as a first step towards self-help by directing them towards parent support groups, be they conventional or alternative in orientation ([Klasen 2000](#), p. 343 see also; [Broom & Woodward 1996](#)).

By the mid-2000s, group leaders felt that parents had become more articulate and more confident, and that doctors were now much more well-informed and accepting of ADHD. However, they all agreed that support services and resources had not kept up with the development in professional knowledge, with the lamentable result that the officially recommended combination of psychological, educational and medical approaches remained elusive in most places, effectively leaving medication as the only available treatment option ([Bilbow int. 2006](#); [Hensby int. 2006](#); [Sheppard int. 2006](#)).²⁸ Parents still had to struggle to see a specialist due to long waiting lists, and the level of services varied greatly from one area to the next, depending on the outlook of the CAMHS leader, the Primary Care Trust, and the local economy. As for social services, education, and the youth justice system, the general view was that they still lagged behind in terms of

²⁷One thing that struck me when I was interviewing the founders of various ADHD support groups was the extent to which they seemed willing to embrace the idea of faulty brains and to identify themselves and their children as genetically compromised, in spite of the stigma that may entail. Further, the concept of ADHD as a heritable, chronic disorder allowed them to retrospectively make sense of their family history, and the lives of now deceased family members.

²⁸For a good summary of ADDISS’ position and aims, see the Eli Lilly-financed survey ADHD: Paying Enough Attention? ([ADDISS 2003](#)), which issued a call to action to improve recognition and services for those living with ADHD.

accepting the condition as “real”, despite increasing public awareness. Some of the most common calls received by groups reportedly came from parents who complained that the school had excluded their children without recognising the presence of any disability. According to Bilbow, this occurred because teachers were not being trained, and individual schools, just like the Department of Education itself, had produced no specific policies and guidelines on ADHD. Groups also advised many parents who fought with local education authorities over placements and accommodations, often due to lack of funding for special schools. Although parental choice had increasingly become the mantra of policy makers, as reflected by the SEN and Disability Act 2001, such disputes were increasing.

In order to spread the message more efficiently, several efforts were made to create a UK ADHD alliance, but they were repeatedly disrupted, seemingly not so much by structural obstacles as by personal feuds and rivalry among the various groups. Philanthropic politics is also competitive politics, both externally in the search for sponsors, funds and support, and internally within the confines of a particular medical condition. Often, the competition to represent people results in a strong culture of autonomy which restricts the extent to which groups find themselves able or willing to work together in coalitions. Acknowledging this, group leaders in both the UK and the US emphasised that the whole voluntary sector is full of “self-made” people who are loath to compromise. In the case of ADHD, however, they added that cooperative efforts are further hampered by the circumstance that groups are likely to be led by adult sufferers who are themselves impulsive, aggressive, and unable to communicate diplomatically.

Although present from the start, the struggle between the UK groups was amplified when ADDISS emerged on the scene and proposed to create an umbrella organisation somewhat like CHADD, with a central office and database, and local satellite groups which people could join against a fee. Sensing that the overall impact of the ADHD community was too small, Bilbow wanted “to move things forward a bit faster”. However, not wanting to give up their own identities, the original groups rejected the idea. The first real attempt to create a UK alliance that

would improve coordination was made in 1999/2000. Due to the continuing animosities, an outside party – the charity Contact a Family – was approached to help bring everyone together. The charity managed to obtain a grant of £100,000 from the Department of Health for a project administrator and subsequently proceeded to employ someone with no background in the ADHD community, who according to the groups did little with the awarded funds. Feeling excluded, everybody eventually abandoned the project ([Adders.org 2000](#)). Three years later, on the initiative of Bilbow, new efforts were made to coordinate the groups. A committee was set up, but disagreements flared up once more, as the smaller groups could not accept that rules and regulations had to be approved by ADDISS' board of trustees and professional advisers ([Hensby int. 2006](#)).

When interviewed in 2006, Bilbow had managed to establish a programme of affiliation that groups could join if they wished to work closely with ADDISS and support their aims and objectives in local areas. Ideally, she would have liked to organise a British umbrella organisation run like a franchise, using managers in order to avoid local burn-out. However, because the alliance was not organised from the start like in the US, she noted that it was probably too late. Quarrels were still rife within the support community in the mid-2000s, with arguments centring on the question of who had the leading web presence, or the backing of the county's top experts, and on "copyright" issues when groups used things from each other's websites. As a result of these conflicts, groups hesitated to share information, and refrained from arranging joint events, even when they managed to get prominent speakers from the US. The allocation of financial support, particularly from drug companies, was clearly a particularly sensitive issue.

The groups generally seemed conflicted about the question of drug company sponsorship, and increasingly so after some critical articles appeared in the press which asserted that ADDISS was secretly funded by drug companies ([Foggo 2005](#)). Many had at one point accepted small "educational grants" from drug companies, but mostly they got by on donations from individuals, lottery funds, local grants, and small fundraising activities like jumble sales. Indeed, quite a few group leaders admitted that much of the cost of running websites and help-lines had

been paid out of their own pockets ([Hensby int. 2006](#)). Bilbow pointed out that she herself ran up debt during the early years before she was awarded Department of Health funding, and at the same time emphasised that ADDISS, in accordance with the charity commission's guidelines, would only ever accept unrestricted grants from the drug industry. On the occasions where companies had asked ADDISS to support various projects, they had declined to do so. According to Bilbow, the grants they received from the drug industry were specifically for setting up conferences, not general funding for the development of the organisation. Thus, she was very unhappy about how her group had been portrayed by the media and her detractors, as being "in it for the money" ([Bilbow int. 2006](#)).

Recognising the crucial role of the media in shaping public opinion and in creating public awareness about the disorder and the support community, the leaders of British ADHD groups regularly appeared in the press in the late 1990s ([Lacey 1996](#); [Burne 1999](#); [Browne 2000](#); [Mack 2000](#)). The British media have generally tended to be supportive of health consumer groups, but not all causes receive equal or necessarily positive coverage, and mental health groups in particular have regularly complained about being ignored or being the subject of negative stereotyping ([Allsop et al. 2004](#), p. 747). Certainly, the British ADHD community seemed to grow increasingly wary of the press, seeing it as only too ready to twist statements and discredit the movement. As a result, Bilbow claimed that ADDISS was uninterested in "playing the media", adding that even negative publicity could be positive in the sense that it would highlight the condition, and ironically result in many calls from families asking how they could get help ([Bilbow int. 2006](#)). Most of the groups felt that newspaper and TV features on ADHD had been tremendously negative and unbalanced, and that journalists were generally swayed by the idea that ADHD does not exist. The widely watched Panorama documentary *Kids on Pills* ([BBC 2000](#)) was held up as a case in point.²⁹

²⁹The documentary drew heavily on psychologist Steven Baldwin, the British counterpart to America's Peter Breggin. Another interviewee, Dr Geoffrey Kewley of the private Learning Assessment & Neurocare Centre, ended up filing a complaint to BBC for unjust and unfair treatment. The BBC partly upheld the complaint, noting that the excerpts from his interview used in the programme gave only a partial account of his views.

While some parents of ADHD children commended the programme for highlighting the inadequate diagnostic and follow-up process as well as the lack of multi-modal treatment, it provoked many angry responses and letters of complaint to the BBC from members of support groups, who found the programme “highly inflammatory” and insulting to affected families ([Adders.org 2006](#)).

In fact, a brief examination of newspaper articles on ADHD between 1995 and 2005 reveals that the British press focused not so much on the actual validity of the disorder as on the debates about its treatment with stimulants. Nonetheless, the press has doubtlessly contributed significantly to the polarisation of public debates about ADHD in the UK, as the drug treatment became more common and therefore more controversial, with headlines such as “Ritalin made my son a demon” ([Browne 2000](#)), and “The Curse of Kiddie Cocaine” ([Reid 2003](#)). In today’s fast-paced news-world, journalists have little time to verify information and often simply reproduce statements from various stakeholders. A connected problem, not least in the reporting on controversial subjects such as ADHD, was that sources were frequently chosen from opposing camps – such as those for or against medication – and pitted against each other with little additional discussion, to create drama and debate.

7.6 The British Ritalin opposition: hyperactivity as a symptom of food intolerance

Arguably, the group that did the most to cultivate media contacts was the small Scottish-based charity, Overload Network. Like Ablechild, they aimed to convince politicians and the public that Ritalin is a dangerous, addictive drug, used indiscriminately by doctors, and forced on children and their families by schools, not only in the US but now also in the UK ([Reid 2003](#)). Though the press would often pitch Overload Network as the archenemy of the British ADHD movement, the main ADHD groups – although frustrated with the group – did not appear overly concerned about their influence, seeing them as representing a small extreme minority connected to the CCHR and their formidable press mechanism

(Bilbow int. 2006).³⁰

Inspired by the Hyperactive Children's Support Group, Overload Network was originally founded by Janice Hill in 1983 after her daughter was helped significantly through the elimination on certain foodstuffs, and the addition of vitamins, zinc and essential fatty acids to her diet. However, the group became much more politically active when ADHD and Ritalin appeared on the scene in the mid-1990s, and it began to receive an increasing number of calls from parents wanting advice on alternatives to medication (J. Hill int. 2005). Most often, they claimed not to have been informed about the potential risks of the drugs, nor were their children monitored or offered any other services and treatments. Moreover, Hill emphasised that many of the mothers she talked to were socially disadvantaged and dependent on disability allowance – an issue that was only very reluctantly discussed by the leaders of the conventional groups. Generating a good deal of sympathy, but no concrete results, members of Overload Network petitioned the Scottish Parliament several times on the prescription of stimulants and antidepressants for children, and on the possibilities of affecting the behaviour of prisoners through a change of their diet, with reference to the work of Oxford-based physiologist Bernard Gesch³¹, and former police officer Peter Bennett, whose work with youth offenders was highlighted in the BBC documentary *Little Monsters* (1992).

Until his death in the Selby rail crash in 2000, Hill worked closely with psychologist Steven Baldwin, who founded and ran the Cactus Clinic at Teeside University. This clinic was the first of its kind in the UK to offer alternative

³⁰Despite its claim to be independent, it is indeed indisputable that the group was in regular contact with the CCHR, and campaigned with them on various issues, for example against Ritalin-enthusiastic doctors such as private psychiatrist Patrick Cosgrove, who in 2004 was suspended for 12 months by the General Medical Council for serious professional misconduct. Although the main complaint of Overload Network and the CCHR related to Cosgrove's practice of prescribing stimulant drugs off-label to children under six, he was officially suspended for sending letters to GPs questioning other psychiatrists' competence, and forwarding copies to their patients.

³¹In 2002, Gesch published the surprising results of a double-blind, randomised pilot study in the British Journal of Psychiatry, which suggested that re-offending by juvenile delinquents could be cut by 25% if they added vitamins, minerals and essential fatty acids to their diet (Gesch et al. 2002).

nutritional treatments and counselling to affected youngsters. Baldwin was very active in media debates about ADHD, Ritalin, and the growing use of antidepressants in children. Indeed, in a tribute, Peter Breggin described him as “the leader in Great Britain in defending children against behavioral control through psychiatric medication”, and a “close friend” with whom he often spoke about “the potential costs and moral rewards of being brave in the face of bio-psychiatry and the psycho-pharmaceutical complex” (Breggin 2001). However, indicating the central importance of individual personalities to the survival of such initiatives, the Cactus Clinic closed in 2008 due to lack of NHS funding, just as Overload Network itself is no longer a visible actor in the ADHD landscape. When interviewed in 2005, Hill mentioned that the group had difficulties obtaining financial support, perhaps, she felt, because they appeared “too aggressive” or “too political”.

Like its American sister organisation, the Feingold Association, the Hyperactive Children’s Support Group (HACSG) in Sussex has been less concerned with criticising Ritalin and the ADHD diagnosis than with promoting dietary treatment and generating public awareness of the role of food and synthetic additives in behaviour and learning. Set up in 1977 by Sally Bunday after her 2-year-old son had been diagnosed as suffering from severe Hyperkinetic Disorder, HACSG was the first parent group associated with hyperactivity in the UK. Feeling abandoned by the conventional medical system, Bunday began her own investigations and came across the work of American allergist Ben Feingold. She quickly witnessed an extraordinary transformation in her son’s behaviour on the diet, and wanted to communicate this to other parents (Bunday int. 2005). After meeting David Horrobin, the controversial British medical entrepreneur and promoter of evening primrose oil, she furthermore became interested and involved in research on the role of fatty acids. Indeed, in 1980, Bunday and her mother published one of the first papers to associate hyperactivity with essential fatty acid deficiency – a link which would later receive much attention from UK researchers

(Richardson & Puri 2002; Richardson & Montgomery 2005).³²

Whereas pro-drug organisations like ADDISS and CHADD operate within biomedical discourse, HACSG and the Feingold Association reject conventional therapies and practices, while still positioning themselves within a biological framework that invokes individual genetic susceptibilities to digestive complications, metabolic disorder, and allergies. From this perspective, short attention spans and impulsive, restless behaviour is indeed seen as indicative of an “individual chemical imbalance”, but one caused by certain food chemicals, and exacerbated by the typical American or British child’s frequent consumption of altered, sweetened, fatty and refined foods. Groups advocating dietary approaches in this way occupy the position of both insider and outsider, as they accept medical definitions, but simultaneously identify themselves as critics of biomedicine. In an analysis of materials from British fatty acid supplement manufacturer, Efamol, Malacrida (2002) thus observes that whereas such alternative texts promise a counter-narrative to medical-pharmaceutical hegemony, they in fact tend to support medical-scientific claims about ADHD as a legitimate, serious and threatening disorder, and most often fail to acknowledge the controversy that underlies the diagnosis.³³

This sets them apart from other factions in the anti-medication camp, which according to Jane Hersey, director of the Feingold Association, is divided on several

³²The Feingold Association was established in 1976 to incorporate the many local parent self-help groups that had sprung up in the US in the wake of Feingold’s rise to fame (see Smith 2011a, for a thorough history). Concentrating solely on promoting parental self-empowerment through Feingold’s methods, the Feingold Association does not have any listed scientific or medical advisers, and has made a decision not to take money from food supplement manufacturers (Hersey int. 2006). HACSG on the other hand is associated with a number of nutritional experts, in addition to working with Equazen – maker of the popular combination supplement Eye Q – and a British nutritional laboratory which performs testing for mineral deficiencies and excess toxic metals. Both organisations survive mainly on the sale of their own publications, and on private donations.

³³Moreover, Malacrida (2002) contends that they may end up reinforcing traditional medical discourses of maternal regulation, as they draw on normative understandings of mothers as responsible for their children’s physical and emotional well-being, as requiring professional education and intervention, and as placing their children (and society) at risk if they fail to seek treatment. One may even argue that alternative therapeutic discourse can add an extra burden of care and blame, since it demands more of mothers than do conventional approaches, and typically demonstrates little awareness of social class constraints in its invocation of stressed lives, working mothers and reliance on convenience foods.

key issues, the most important being the validity of ADHD. Thus, both women disagree strongly with the proposition that hyperactivity/ADHD is a myth. Conversely, opponents of ADHD and Ritalin have objected to the idea of dietary intervention as a cure for hyperactivity, expressing scepticism about the way adherents of nutritional therapy refer to hyperactivity as a purely physical ailment, and tend to couch their views in terms of certainties, rather than hypotheses that leave room for psycho-social influences and complexity. Commenting on this reductionist inclination, British child psychiatrist Sami Timimi in an interview underlined that while he had reasonable success with nutritional approaches, he suspected that it partly stemmed from the way such interventions introduce more structure and discipline, and change the parent-child relationship ([Timimi int. 2006](#)).

Considering the plausibility of the proposition that behaviour could be affected by a high intake of artificial food additives – some of which look remarkably like neurotransmitters – one might expect that the medical community would have taken a considerable interest in Feingold's theories ([P. Hill int. 2005](#)). Nonetheless, following a brief period of initial enthusiasm, they were marginalised by the American medical associations, and public interest withered away, leaving only the Feingold Association to continue to employ and promote the diet in the US. In Britain, physicians also noticed and discussed Feingold's work, and eventually, with some delay, studies were carried out on children whose parents suspected food intolerance. Reflecting the pluralistic British approach to hyperactivity, several respected British physicians at Great Ormond Street Hospital and at the Institute of Psychiatry were thus involved in trials of so-called elimination diets during the 1980s and 1990s, with positive results ([Egger et al. 1985](#); [Carter et al. 1993](#)). This was welcomed by parents who felt vindicated in their belief in a clear link between their children's hyperactivity and their intake of certain food items, namely those with synthetic dyes and preservatives. However, apart from appealing to some paediatricians, they did not greatly affect the attitudes of leading clinicians, many of whom ridiculed the findings ([Graham int.](#)

2006).³⁴

Thus, for the most part, the British medical community continued to display what can best be described as an overbearing attitude towards parent groups like HACSG. Similarly, although they knew and respected Bunday, and occasionally referred parents to HACSG, the mainstream support groups generally maintained that diets only works for the small minority of severely hyperactive children with food allergies – a condition which they were very careful to distinguish from the much broader and more common problem of inattentiveness (Bilbow *int.* 2006; Hensby *int.* 2006). Emphasising that one should try to avoid medicating unless absolutely necessary, all the group leaders told stories of how they had repeatedly tried and eventually failed with various dietary interventions, but several were keen to point out that they kept an open mind, having witnessed good effects of natural treatments in several cases (Harris *int.* 2005; Sheppard *int.* 2006); one thought that stimulant drugs were too readily prescribed, and even argued with the local health authority to make fatty acid supplements available on prescription.

When interviewed, Bunday expressed her disappointment that the nutritional approach had not yet been fully accepted, given the existence of what she perceived to be plentiful evidence for its efficacy. Like Hersey in the US, she first and foremost put this down to inertia and prejudice among physicians, lack of research funding and profit opportunities, and the involvement of big economic interests, represented by the food industry especially. But though dietary

³⁴According to child psychiatrist Philip Graham, who was involved in the Great Ormond Street studies, “the results didn’t make much impact on the clinical practice of UK doctors. I don’t think they were believed. In general, British and other European studies are little noticed in the USA. As I’m thought of as rather mainstream in the British scene, my colleagues found it hard to believe that I regarded our findings as credible. People heard me give the results and said ‘You don’t really believe this, do you?’ and I had to say ‘Well, I do’. I continued to talk on the subject until the mid-1990s and occasionally carried out literature searches on diet and hyperactivity. It was very striking that the review articles all came out against the diet having any effect, while the articles reporting original data reported positive results providing appropriate methods were used. That says something about the prejudices of people writing apparently dispassionate review articles. I think a Cochrane review would show dietary manipulation is an effective treatment for a small proportion of affected children” (Graham *int.* 2006). In fact, Graham admitted that even he did not have full confidence in the results, adding that the idea failed to gain wider influence in British medicine at least partly due to the fact that no authoritative figure, like himself, was prepared to “go out on a limb” and fully endorse it.

treatments have received scant support from the mainstream ADHD establishment and its supporters, the idea of food chemicals as a cause of mental and physical health problems clearly holds significant cultural currency among the British general public, as demonstrated for example by the recurrent emphasis on food intolerance and the potential hazards of sugary fizzy drinks or coloured sweets in media features as well as political debates on hyperactivity/ADHD in the UK.³⁵

Being rooted in a complex set of historical and cultural factors, this preoccupation with “E-numbers” and other dietary triggers in the UK cannot be fully accounted for here. However, in brief, I would argue that it reflects longstanding social concerns among the middle and upper classes about the safety and nutritious value of the food supply, and the eating habits of the working class population. These anxieties have been clearly expressed in the organic food movement, which boasts a long history in Britain and had attracted both right and left wing adherents. More specifically, it was developed in the 1930s by a motley collection of individuals, including dissident agricultural scientists, physicians, and rural land-owning aristocrats, who were worried about the dangers posed by industrial farming, namely inorganic fertilisers (Gill 2010). Whereas the doctors were mostly interested in the issue of malnourishment³⁶, the landowners were deeply disturbed by the social changes associated with industrialisation and globalisation, and developed various nostalgic visions for a revival of British rural life (see also Conford 2001).

Given that early exponents of the organic movement belonged to conservative groups that were reacting to the increasing threat to traditional country life, it is arguably no coincidence that the HACSG project has been openly supported by

³⁵On a more general level, this tendency is demonstrated by the popularity of books such as Maurice Hanssen’s *E for Additives*, which became an instant bestseller in the UK in the early 1980s, and prompted the removal of several additives from a range of supermarket products (Hanssen 1987, p. 11).

³⁶During the interwar period, there was considerable discussion in Britain about nutrition, and numerous authors drew attention to the fact that a large proportion of the population was malnourished due to poverty. Mostly, public debate focused on the quantity rather than quality of food. However, emphasising that the working class population subsisted on foods that had little or no nutritional value, a small group of medical authors argued that much ill health was the result of people eating too much of the wrong types of food, rather than too little food in general (Gill 2010).

several representatives of the political elite, including Baron Ramsbotham, expert on matters relating to prison reform, and Sir Richard Body, who was an early supporter of environmental causes within the Conservative Party, and an avid critic of EU agricultural policies. Thus, in a 2003 debate in the House of Lords, Lord Colwyn argued that the UK approval of stimulant drugs as the treatment of choice was perplexing, given that both American and British studies had already convincingly linked hyperactivity to food allergy: “Although study after study backs Feingold’s theories, many standard clinicians still label his approach a fad and are happier to reach for their prescription pad and sentence a small child to many years of stupefying, potentially addictive medication” (Hansard 2003, column 306). Referring to research showing good effects of dietary changes in prison inmates, he proceeded to claim that “intolerance to a number of foods is always found in those diagnosed as having ADHD, or who are excluded from school and have special educational needs. The solution to a child’s problem or to an offender’s behaviour may only be a matter of some careful detective work to locate the culprit”.³⁷

At this point in the early 2000s, a number of influences helped to highlight and reinforce the focus in Britain on dietary causes of hyperactivity. As described earlier, medical interest in the Feingold diet had already begun to move from the US to the UK in the mid-1980s. However, another two decades would pass before the diet-behaviour link grabbed national headlines as a result of the work of researchers from the University of Southampton, who responded to calls from the British Food Standards Agency to test Feingold’s hypotheses once again. While their first double-blind trial received limited media attention due to its reliance on subjective parental ratings (Bateman et al. 2004), the next study, published in the *Lancet* in 2007, quickly became famous, as its findings provided “strong support for the case that food additives exacerbate hyperactive behaviours [...] in children

³⁷Finally, like many of his colleagues, Colwyn lamented the power of the EU to “restrict natural nutritional supplements, giving more power and control to the pharmaceutical industry to extend synthetic and artificial chemicalisation rather than natural, unadulterated nutrients in foods” (ibid, column 307).

at least up to middle childhood” and showed that such increases were seen in the general population and across the range of hyperactivity severities ([McCann et al. 2007](#), p. 1566). The authors added that the “implications of these results for the regulation of food additive use could be substantial”, and the FSA proceeded to revise their advice to parents about the safety of food colours, and to ask food companies to voluntarily phase out the implicated additives.³⁸ Although the studies did not result in any official acknowledgement by the US authorities, they still garnered a great deal of attention, not least from the American Association of Pediatrics, which published a commentary stating that practitioners now had a reasonable alternative to offer parents, given that “the overall findings of the study are clear and require that even we sceptics, who have long doubted parental claims of the effects of various foods on the behavior of their children, admit we might have been wrong” (cited in [Smith 2011a](#), p. 157).

The recent burst of interest in the diet-behaviour link must be seen in the context of the serious crisis of confidence which characterised the British public’s perception of the food and pharmaceutical industries during the 1990s and 2000s – a crisis which echoed many of the issues that contributed to making the Feingold diet popular in US 30 years previously ([Smith 2011a](#), p. 160-163). Firstly, there were serious concerns about the side effects of a range of pharmaceutical products, among them psychotropic drugs like Ritalin, and the group of SSRI antidepressants which were contraindicated in children by the UK drug regulators in 2004. However, the best example of public distrust of drug companies and conventional medical knowledge in the UK was possibly the controversy over the measles, mumps and rubella vaccine (MMR) that emerged during the late 1990s, when British surgeon Andrew Wakefield alleged a possible connection between MMR and autism. Like the Feingold debates in the US, the ensuing debates about

³⁸In 2009, the European Union placed warning labels on food containing the six artificial colours used in the study, and the British FSA asked food companies to voluntarily phase out these additives. In the US, the Southampton study also inspired petitions from consumer advocacy groups demanding a ban, but having reviewed the literature, the FDA was not prepared to take similar steps, as it decided that colour additives do not directly cause ADHD, although they might exacerbate pre-existing symptoms in a subgroup of hyperactive children ([Gardner 2011](#)).

the MMR vaccine pitted the majority of the medical profession against parents and anti-vaccination activists, as well as a small number of unorthodox medical professionals.

Secondly, from the mid-1990s, the organic movement was boosted by several events, including the British BSE epidemic, which not only raised questions about animal welfare, but also about the purity and safety of the food supply more generally. Concerns about genetically-modified foods, pesticides, food poisoning, obesity, and diabetes had similar effects. But perhaps most influential in terms of influencing public attitudes to children's diet was celebrity chef Jamie Oliver's [2005](#) documentary "School Dinners", which demonstrated the appalling quality of the food served to school children in a disadvantaged borough of London. Backed by the British Soil Association, Oliver launched a big campaign to provide children with organic, seasonal food, and later that year, the Blair government pledged £280 million in support of improving dinners in the country's schools. On his website, Oliver listed poor concentration, hyperactivity, behavioural problems, and mood swings as effects of processed junk foods, thus reinforcing the link between nutrition and mental health in British consciousness. Although there were clearly important financial, educational, and social class obstacles to changing children's diet in the UK, the success of the Feed Me Better campaign indicated the readiness of the British government to make nutrition a public health policy priority.

Moreover, to a much greater extent than their counterparts in the US, many large companies in the British food industry took pro-active steps to completely eliminate or reduce artificial additives associated with hyperactive behaviour and allergic reactions in their products, partly in order to pre-empt legislative action but also because it was seen as a profitable move due to high consumer demand ([Smithers 2007b](#)).³⁹ Sainsbury's was the first to remove synthetic colours and flavours from all their own-label food products in 2007, and other major

³⁹In the US, federal consumer protection lessened significantly during the Reagan administration. However, although the American food industry has not taken measures comparable to those adopted in the UK, it must be noted that organic supermarket chains like WholeFoods and Trader Joes have experienced increasing success, and forced more mainstream supermarkets to offer healthy alternatives ([Hersey int. 2006](#)).

supermarkets such as Marks and Spencer and Tesco followed suit. Having pressured for such large-scale initiatives with limited results since the early 1980s, HACSG were delighted with these developments, albeit slightly disparaging of the fact that it took 25 years, a good deal of celebrity-driven publicity, for their message to be heard.

7.7 Conclusion

Since the 1960s, parent support and advocacy organisations have played an important role in defining both professional and lay understandings of a number of contested child psychiatric disorders, especially in the US but also increasingly in the UK and Europe. The purpose of this chapter was to examine the role of parent support groups both in advancing and contesting ADHD as a legitimate medical condition. In the US, I have explored the emergence of the ADHD movement, represented by the organisation CHADD, in the context of broader historical developments in mental health activism, notably the reaction against the psychogenic “mother-blaming” paradigm in psychiatry, and the rise of advocacy organisations that collaborate closely with medical researchers and the pharmaceutical industry. Further, I have shown that while CHADD successfully fought for the formal recognition of ADHD as a covered disability, it also stimulated a violent backlash orchestrated by conservatives focused on the need to cut public spending, and by parents whose widely publicised allegations of “forced drugging” in the country’s schools eventually led to legislative restrictions at both the state and federal levels.

Whereas doctors, teachers and school administrators have all been highly involved in the medicalisation process in North America, in the UK it was parents who advocated most fervently for the recognition and diagnosis of ADHD during the 1990s. Giving access not only to material disseminated by professionals, but also to the personal narratives of patients and carers in “ADHD-friendly” countries such as the US, the internet was an important catalyst of mobilisation in Britain,

creating less centralisation and hierarchy among the various groups from the beginning. Apart from the fact that British groups have not received the same level of financial support from the drug industry, I have argued that the fragmentation and ongoing competition and strife within in the British ADHD community has been a key obstacle to gaining true political influence in an environment already adverse to the recognition of medical disability labels. Also important was the relatively weak political tradition of parental involvement in legislation processes affecting disability and education. However, although the UK groups have not succeeded in directly influencing legislation like their American counterparts, several experts and professionals interviewed for this thesis argued that parental campaigning was hugely important in spreading public awareness of ADHD in Britain. Here, it is important to emphasise that parent organisations cannot easily be seen as “hostages” of stakeholders who want to extend their influence by gaining their support. Parent activists actively engage with expert knowledge in a reflexive way on the basis of their own experience and preoccupations, and for organisations in both countries, spreading the message of the reality of ADHD does not simply entail alleging its medical reality; it also means stating its complexity and advocating for better school services, and a multimodal therapeutic approach to the disorder.

Lastly, I have drawn attention to the differences as well as similarities between the anti-Ritalin factions in the US and the UK, highlighting the relatively strong cultural presence in Britain of alternative groups promoting the idea that hyperactivity can be caused by food additives or – more controversially – a high sugar intake. Originating with American allergist Ben Feingold in mid-1970s, I have shown that dietary theories of hyperactivity eventually became more influential the UK, where parent groups like the Hyperactive Children’s Support Group have both channeled and reinforced long-standing cultural and political concerns about the negative impact of industrial mass food production on the health of the nation. With a few notable exceptions, British physicians have like their American colleagues been sceptical of the claims of proponents of nutritional therapy. But by continuing to employ and promote the Feingold diet, as well as

emphasising the effects of essential fatty acids on learning and behaviour, parents have helped encourage a handful of British researchers in the 21st century to seriously reconsider the role of diet, in the context of growing media-fuelled public distrust of the pharmaceutical and food industries.

CHAPTER 8

Summary and discussion

The aim of this thesis has been to explore, on the one hand, the great historical discrepancy in child hyperactivity diagnosis and treatment between the US and UK from the early 1960s, and on the other, the increasing convergence in perspectives and management practices from the early 1990s, when rates of ADHD diagnosis and Ritalin prescription rose exponentially on both sides of the Atlantic. The key questions I set out to answer were how two medical communities faced with patients displaying the same symptoms could come to such different conclusions over this period of 25 years, and how ADHD and Ritalin emerged as prominent medical and cultural phenomena in the UK and the US respectively, looking at the interplay of political, professional, institutional and socio-cultural factors that contributed in each case.

In engaging with these issues, I chose to concentrate on three distinct but interconnected spheres which, both separately and in combination, have underpinned and shaped approaches to hyperactivity in the two countries: medicine, education and the wider public arena, represented by parent groups. While chapters 2, 3 and 4 focused on the medical debates and practices surrounding hyperactivity, and the points of connection and disconnection between the two medico-psychiatric communities, chapters 5 and 6 examined the role of schooling, disability activism, and educational policy, especially that

relating to special educational needs. Finally, chapter 7 explored the issue of parent activism which has been an important factor in both the growth and critique of ADHD since the late 1980s.

Although, as I have shown, these sites overlap and interact with each other, I separated them out in order to identify their essential characteristics, including key actors, and to better understand the historically shifting ideas and practices surrounding hyperactivity/ADHD within each sphere. In the medico-psychiatric arena, I was particularly interested in the way perceptions and treatments of hyperactivity have been shaped not only by the changing ideologies and power relationships of the professions involved in child mental health, but also more broadly by different research traditions, agendas, and contexts, and by the organisation of health care in the two settings. My main focus was on the parting of British and American ways in the late 1950s, when conceptions of hyperactivity expanded in the US concurrently with the rise of stimulant therapy and biological psychiatry, and the increasing intolerance of troublesome, inattentive behaviour in schools. Meanwhile, British doctors retained their view of hyperkinesis as a rare condition most often related to obvious neurological damage, and continued to rely on familial and environmental explanations and interventions for the vast bulk of disruptive child behaviour. Lastly, I explored the growing convergence in professional outlooks following the advent of DSM-III and its Attention Deficit Disorder category in Europe, and questioned the claim that local perspectives have been displaced by global, uniform neurobiological construct, underpinned by cognitive neuroscience, psychopharmacology, and genetics.

Within the educational setting, I was mostly interested in the extent to which growing concerns about national competitiveness, and the introduction of market models and an educational audit culture, have influenced attitudes to disruptive and underperforming children in the US and the UK. Throughout, particular attention was given to the differences between the “disability environments” in the two countries, including educational and social policies, and their consequences for the labelling of behavioural disorders in school children. While I explored the significance of the lobbying efforts of the disability rights movement from the

mid-1960s in the US, in Britain I provided a historical context for understanding the mistrust among educators of medical label which informed the sceptical, or even hostile, reception of ADHD in British schools in the 1990s. I also highlighted the existence of other factors, such as the greater access to exclusion, which may have slowed down the medicalisation process.

Moving to the public sphere, I argued that ADHD advocacy as a transatlantic social movement has played an important role in furthering the acceptance of the disorder in both countries, but that the organisational characteristics of the national ADHD support communities, as well as the differing local histories of parent activism, have resulted in varying levels of political influence in the respective settings. Another aim was to examine how parent groups also nurtured the opposition against ADHD, some through an anti-psychiatry discourse stressing the use of Ritalin treatment as a tool of social control, and others via environmental campaigning and the promotion of dietary treatments. Ultimately, when looking at the contribution of the medical and educational sectors in both countries, we should not lose sight of the fact that the ADHD boom has been driven to a large extent by wider social and cultural currents, such as the increasing individualism, competitiveness, consumerism, and the penchant for pragmatic technological solutions which characterise contemporary Western societies. Similarly, drawing on various critiques of modernity, alternative discourses and critiques surrounding ADHD and Ritalin have brought these trends into sharper focus by lamenting the frantic pace and fragmentation of modern society, and the erosion of supposedly more natural practices of food production and consumption.

Instead of dealing with each country separately, the chapters juxtapose and discuss developments in the US and the UK together, so that points of connection as well as departure stand out more clearly. My purpose in doing this was not simply to identify the differences and symmetries, but to tease out the interrelationships between the two countries and their medical, educational and public spheres. The contribution of this thesis to the history of ADHD mainly lies in its comparative aspect. By adopting a historical comparative perspective, it is possible to show how the hyperactivity category developed differently within local

traditions and settings, in complex interaction with phenomena occurring at the global level, while also addressing persisting tensions between local and global construction of psychiatric entities. However, rather than presenting a simple account of contrasts and similarities, it emphasises the *distribution* of different styles and the dynamic cross-Atlantic exchange of people, tools, ideas, and social movements which have nurtured the global spread of ADHD and increasing acceptability of treating children with psychoactive drugs. Black-or-white generalisations centring on the notion of distinct national medical cultures will clearly not suffice, since the very cleavages which have existed between the two countries and their professional communities have to some extent also been present *within* them, and since British and American psychiatry have shared many features, notwithstanding the exceptional influence of psychoanalytical thinking in the US in the post-war period. Such similarities stand out more clearly when seen against certain European perspectives that have emphasised deep interpretation and mistrusted biomedical and statistical models in psychiatry. Whereas social theories are often rather abstract in their attempt to explain broader trends and the uptake of particular medical ideas, historical analysis can bring critical and contextual perspective to enhance understanding of why certain medical theories achieved legitimacy in a particular time and place. Even if one loses some detail, a comparative perspective can add an extra dimension, by simultaneously highlighting local variation and points of exchange. Provided that the researcher is sensitive to the complexities of the subject at hand, and the limitation of the unit of comparison, comparative work may illuminate paths not taken or policies not pursued, and thus deepen the historical narrative.

With this thesis, I have demonstrated that the development of knowledge about, and practices relating to, hyperactivity have been considerably more complex than commonly suggested. When scrutinising the suggestion that the history of what is now called ADHD merely reflects the progression of scientific knowledge, one discovers instead a history of cultural difference, ideologically charged debate, professional rivalries, technological advances, commercial manipulation, changing labour markets, educational pressures, and dissatisfaction

with mainstream medical explanations and treatments. More specifically, I have challenged the assumption held by proponents of the neurobiological model of ADHD that local cultures of child psychology/psychiatry are fast vanishing, as medical disagreement is resolving in the face of mounting medical evidence on the main features, causes, and optimal ways of treating ADHD.

Certainly, as dialogue across Western nations about hyperactivity increased, a common understanding emerged among researchers about the existence of a group of children whose impulsive and hyperactive behaviours are qualitatively different and more severe than those of other groups of children. But the difficult question of where to draw the diagnostic boundary between these groups still remains, as does to some degree the question of the relative contribution of environment and biology. Moreover, one cannot simply reduce the long-standing differences between the US and the UK in hyperactivity diagnosis and treatment – and the recent reduction of those differences – to a product of classification disputes and varying medical ideologies. We must also examine how medico-psychiatric concepts and their uptake have been shaped by various social, cultural and political forces. Thus, changes in how hyperactivity has been understood and managed in the US and the UK during the 20th century were also fundamentally informed by organisational constraints and incentives, drug company marketing, and broader debates about the education of children, the blaming of mothers, the use of psychoactive drugs and medical labels, the effects of diet, and the presence of chemicals in the food supply. As I have demonstrated, these factors were influential, although not equally important, in each context.

Medicalisation is now an increasingly an international phenomenon, due to the expanding hegemony of western biomedicine, facilitated by multinational drug companies and the global reach of the mass media. But despite powerful globalising tendencies, and all the information now flowing between sites and nations, Western mental health ideologies and practices continue to differ between places, not only from a cross-Atlantic perspective, but also within individual nations and regions. In sum, rather than framing recent developments as a global wholesale conversion to the concept of hyperactivity as a relatively common

hereditary neurobiological disorder, it is arguably more correct to speak of a general shift in balance between the environmental and biomedical frameworks – a shift which remains contingent and subject to renegotiation in the light of new research and changing public attitudes.

This thesis opens open several obvious opportunities for further research. Firstly, as a way of enriching and nuancing the comparative analysis, it would be interesting to examine the significant local and regional differences in attitudes and practices relating to ADHD in both countries. Within the UK, a comparison of Scottish and English/Welsh developments is an obvious possibility, considering the fact that Scotland has had its own distinct traditions within education as well as its own National Health Service. Further research is needed to assess the extent to which these bureaucratic variations have affected attitudes and approaches, and how research cultures and ideologies may have differed between London and Edinburgh. From a broader perspective, it could also be fruitful to add a second European country to the comparison, such as Italy or France, where psychoanalysis continued to play a dominant role right up until the beginning of the 21st century, and where hyperactivity is still only partially medicalised today. Here, many psychiatric commentators have in fact explicitly defined and defended their position against the perceived reductionist and conformist values and practices of their American and British colleagues. Adding this third dimension to the comparison would put the “mid-Atlantic” British position, between the extremes of psychodynamic and biomedical interpretations, into a wider perspective. All the strategies mentioned above could allow one to better avoid and nuance the slightly clichéd portrayals of the UK as conservative, or even backward, and the US as the embodiment of naïve scientism, and overzealous technological and therapeutic enthusiasm.

Thirdly, it would be productive to delve deeper into the history and context of the relatively marked British preoccupation with various forms of food intolerance and their effects on learning and behaviour, as well as the strong public concern in the UK with the adulteration of the food supply more generally. There is certainly scope for a separate thesis looking at the evolving interest in alternative, diet-based

approaches to hyperactivity and learning difficulty in Britain, both in terms of research and public involvement, especially since the growing body of UK-fuelled research on the link between poor nutrition and poor behaviour/school performance has some potential to challenge current ADHD orthodoxy. In future work, I hope to follow this fascinating topic in the kind of detail it deserves.

Finally, I would like to emphasise that the history of ADHD in both countries overlaps significantly with that of other neuro-developmental disorders, such as autism and dyslexia, which may affect children's behaviour, social skills, and ability to learn and concentrate. As with ADHD, the aetiology of these disorders is disputed and involves public and professional debates which include the potential role of diet. In both the US and the UK, debates about dyslexia (or specific learning disability) during the 1970s and 1980s in many ways foreshadowed the controversies over ADHD in the late 1990s and early 2000s, and today we are seeing how Asperger syndrome is beginning to displace ADHD in the public consciousness as the newly fashionable child psychiatric syndrome on both sides of the Atlantic. Although lacking the central contentious element of a specific pharmaceutical treatment, it would seem that the emerging public and professional understandings surrounding Asperger syndrome, in key respects, draw on and rearticulate the controversies and discourses that this thesis has revealed within the history of ADHD.

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APPENDIX

Is MBD* why Johnny can't read?



He can't sit still for a moment. Doesn't take direction well. He's easily frustrated, excitable, often aggressive. He's got a very short attention span.

The problem seems to be more than the mischief and hyperactivity that occur as a phase of normal growth. All of which makes Johnny a very disrupting influence in the classroom. But the real tragedy is that he's simply not developing basic learning skills. And the failure to learn in these formative years could mean that he'll never catch up. Johnny could become a school dropout.

Yet this tragic waste of human potential might be averted. For Johnny is a victim of Minimal Brain Dysfunction, a diagnosable disease entity that generally responds to treatment programs.

And Ritalin (methylphenidate) can be an important part of the total rehabilitation program which includes remedial measures at home and at school. Ritalin, an effective and well-tolerated CNS stimulant, can help control hyperactivity and other symptoms that so often beset the MBD child.

Of course, Ritalin is not indicated for childhood personality and behavior disorders not associated with MBD.

Ritalin® (methylphenidate) helps overcome MBD* learning disability



RITALIN® hydrochloride (methylphenidate hydrochloride) TABLETS

INDICATION
Minimal brain dysfunction in children (often manifested in the form of hyperkinetic behavior), as an aid to learning.

CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate them. Patients known to be hypersensitive to the drug and in patients with glaucoma.

Ritalin should not be used for severe

established. Therefore, the benefits must be weighed against the potential hazards. Ritalin, when used in low dosages in the rat, revealed no adverse effects on reproduction.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, particularly those with a history of alcoholism, since such patients may be particularly susceptible to the marked tolerance and psychic dependence which may develop with chronic use. In such cases, withdrawal symptoms, including behavior, may occur.

Use cautiously in patients with hypertension and in patients with a history of seizures, since it may lower the seizure threshold.

Ritalin is not recommended for children under six years, since safety and efficacy have not been established.

Drug Interactions
Ritalin may potentiate the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may potentiate the effect of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenhydramine, and tricyclic antidepressants).

Warnings
A few instances of angina and cardiac pain and weight loss during prolonged therapy have been reported and may occur in susceptible children.

DOSAGE AND ADMINISTRATION
Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage should depend upon indication and individual response.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by low dosage and omitting the drug in the afternoon.

HOW SUPPLIED
Tablets, 10 mg (pale green, scored); bottles of 100, 500, and 1000. Strip dispensers of 100.

Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Product literature before prescribing.

***Minimal Brain Dysfunction**
disturbances involved.

CAUTIONS
Ritalin may react adversely, discontinue therapy, and weight loss during prolonged therapy have been reported and may occur in susceptible children.

Periodic CBC
Periodic CBC and platelet counts are advised during prolonged therapy. Ritalin should be given cautiously to patients with a history of impaired medical follow-up including appropriate laboratory tests.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by low dosage and omitting the drug in the afternoon.

HOW SUPPLIED
Tablets, 10 mg (pale green, scored); bottles of 100, 500, and 1000. Strip dispensers of 100.

Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Product literature before prescribing.

Figure A1: Advert for Ritalin (Ciba-Geigy 1971a) in the American Journal of Psychiatry.

His parents say:
"Unmanageable, clumsy,
destructive..."

His teachers say:
"Overactive, easily distracted,
impulsive..."

Physicians would say:
"FBP*, MBD*, MCD*,
or HYPERKINESIS..."

Whatever the terms used
to identify the affliction, many
investigators confirm that
Ritalin, as an adjunct to
special educational measures and
specific parental attitudes,
helps control the child's hyper-
activity, increase his verbal
productivity and attention span,
improve his behaviour and
learning abilities.

*FBP — Functional Behaviour Problems
*MBD — Minimal Brain Dysfunction
*MCD — Minimal Cerebral Dysfunction

Ritalin
helps 'the problem child'
become lovable
again.

INDICATIONS
Oral: In functional behaviour problems in
children (hyperactivity, stuttering, etc.)

DOSAGE
Oral: In hyperkinetic children: start with
small doses (e.g. 5-10 mg. t.i.d.) with gradual
increments of 5-10 mg. weekly. Dosage
should be individualized on the basis of
factors such as age, body weight and
individual response. Daily dosage above 60
mg. is not recommended.

SIDE EFFECTS
Nervousness or insomnia, if present, can be
avoided by dosage-reduction or by omitting
Ritalin in the afternoon. Reports note a few
cases of anorexia, dizziness, headache,

palpitations, drowsiness, skin rash, overt
psychotic behaviour and psychic dependency.

CAUTIONS
Not recommended for severe depressions,
except in hospital under close supervision.
Patients with agitation may react adversely.
Use cautiously in the presence of marked
anxiety or tension.
Ritalin may potentiate the effect of pressor
agents; exercise care in use with epinephrine,
levarterenol, or angiotensin amide. While
oral Ritalin has little or no effect on normal
blood pressure, use cautiously in patients
who have hypertension. Ritalin is stable
indefinitely in lyophilized form but should be
used within 2 months after the solution is
prepared. Do not inject Parenteral Solution

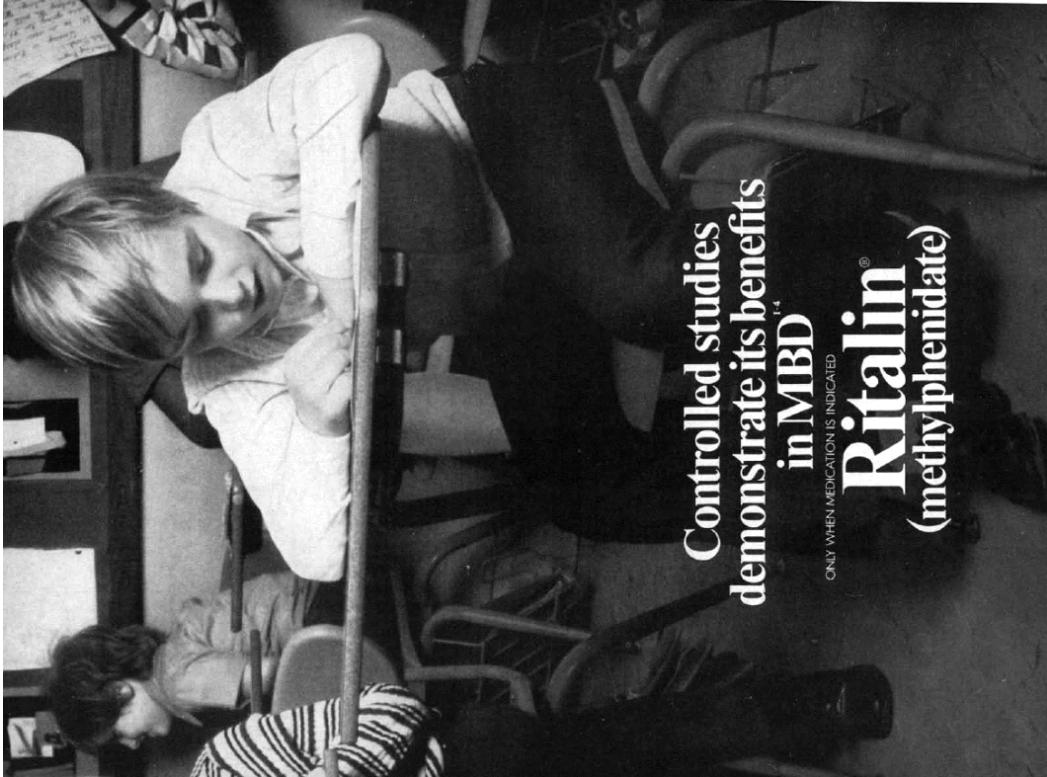
through tubing or a syringe which contains a
barbiturate or strongly alkaline solution, since
a heavy precipitate is formed.

CONTRAINDICATIONS
Glaucoma, epilepsy.

SUPPLIED
All forms contain methylphenidate
hydrochloride. Tablets of 10 mg. (pale blue,
scored); bottles of 100 and 500. Tablets of
20 mg. (peach, scored); bottles of 100 and
500. Ampoules of 20 mg. (lyophilized);
boxes of 10 and 100.

C I B A
DORVAL, QUEBEC

Figure A2: Advert for Ritalin (Ciba-Geigy 1971b) in the Canadian Family Physician journal.



Controlled studies demonstrate its benefits in MBD

ONLY WHEN MEDICATION IS INDICATED

Ritalin®
(methylphenidate)

Ritalin achieves results with the MBD child

Ritalin has earned a special place in the management of the child with Minimal Brain Dysfunction (MBD). As part of a complete therapeutic program, it has been shown to improve behavior, attentiveness, performance IQ, motor control, and speech productivity ratings.¹⁻³

Currently the drug of choice in many MBD situations.⁴ Ritalin is well tolerated. Compared with the amphetamines, there have been fewer serious side effects observed with Ritalin.^{4,6}

Dosage should be periodically interrupted in the presence of improved motor coordination and behavior. Often, these interruptions reveal that the child's behavior shows some "stabilization" even without chemotherapy, permitting a reduction in dosage and eventual discontinuance of drug therapy.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.

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1. Riddle, RM, Hinkin, CG. *J Nerv Mind Dis* 146:433-453, 1960.
2. Gadow, RD, Wolfinger, C. *J Speech Hear Res* 10:623-628, 1967.
3. American Psychiatric Association, Boston, May 13-17, 1968.
4. Gadow, RD, Wolfinger, C. *J Nerv Mind Dis* 146:433-453, 1960.
5. Charlton, MH. *NY State Med J* 16:2562-2566, 1972.
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Ritalin® hydrochloride (methylphenidate hydrochloride) TABLETS

INDICATION

Minimal Brain Dysfunction in Children—as adjunctive therapy to Special Diagnostic Considerations. (Diagnosis of MBD is unknown until there is a single diagnostic test. Ritalin (methylphenidate) is the use not only of Ritalin but of special psychological, educational, and social measures commonly reported includes: chronic history of short attention span, hyperactivity, impulsiveness, and/or conduct disorder, moderate to severe hyperactivity, minor neurological signs and symptoms, and/or a family history of MBD. The diagnosis of MBD must be based on the presence of one or more of these characteristics and not solely on the presence of one or more of these characteristics.)

Drug treatment is not indicated for all children with MBD. Stimulants including psychotics. Appropriate educational placement is essential in the management of MBD. Ritalin should be used only when the child is to environmental factors and/or primary psychopathological disorders are insufficient. The decision to prescribe stimulant medication should be based on a thorough clinical and laboratory assessment of the child's condition.

WARNINGS

Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug, and in patients with glaucoma.

PRECAUTIONS

Sufficient data on safety and efficacy of long-term use of Ritalin in children have not been established. Although a causal relationship has not been established, suppression of growth has been reported in children receiving Ritalin. Therefore, children requiring Ritalin should be carefully monitored.

Ritalin should be used only when the child is to environmental factors and/or primary psychopathological disorders are insufficient. The decision to prescribe stimulant medication should be based on a thorough clinical and laboratory assessment of the child's condition.

HOW SUPPLIED

Ritalin is supplied in two strengths: 2 mg and 5 mg. Each contains 100, 500, and 1000 tablets. 10 mg (tablets green, scored); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

Ritalin® (methylphenidate)
ONLY WHEN MEDICATION IS INDICATED

C I B A

Figure A3: Advert for Ritalin (Ciba-Geigy 1974) in the American Journal of Diseases of Children.

Tested by time and experience in the treatment of MBD

1962

"...a considerable decrease of hyperactivity..."
Knobel, 1962

Over a decade of controlled studies and clinical experience has shown the effectiveness of Ritalin in reducing the hyperactivity,^{1,2} distractibility,³ and disorganized behavior⁴ in the MBD child.

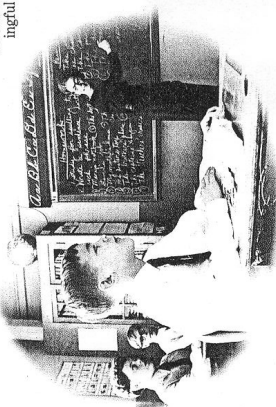
By lessening the effects of motor and attentional disorders, Ritalin enables the MBD child to better focus his attention on meaningful stimuli and

thus can often improve cognition and promote learning.^{5,6} And side effects — insomnia and appetite loss — with Ritalin have occurred less frequently than with dextroamphetamine.^{7,8,9}

Indeed, Ritalin is currently a drug of choice in many MBD situations and can prove to be an important element in a complete remedial program for MBD.

Therapy with Ritalin should be undertaken only after a medical diagnosis of MBD has been made. Drug treatment is not indicated for all children with MBD.

Dosage should be periodically interrupted. Often, these interruptions reveal some "stabilization" in the child's behavior even without medication, permitting a reduction in dosage and eventual discontinuance of drug therapy.



1974

"...an effective agent in the treatment of the hyperkinetic disorder..."
Finan et al, 1974



Ritalin[®]
(methylphenidate)
Only when medication is indicated

A 320

Figure A4: Advert for Ritalin (Ciba-Geigy 1975) in the Psychiatric Annals.

Mischief or MBD?

(Don't mistake one for the other)

From Huckleberry Finn to the Katzen-
jammer Kids, the mischievous child has been
an integral part of American folklore.
But his normal, youthful
over-exuberance can be difficult
to distinguish from MBD.



**Ritalin (methyl-
phenidate): an
important
element in the
remedial
program**

Only ac-
curate medical
diagnosis can
differentiate
the child with
MBD from the
child who is
simply over-
active, as many
normal children
are, and from the child who has
personality and behavioral
disorders not associated
with MBD.

When the diagnosis
is MBD, Ritalin can
prove to be an important
element in a remedial
program that can pro-
vide immediate and
long-term benefit.
For Ritalin
has demonstrated
its effectiveness in
reducing such
manifestations as
hyperactivity,* dis-
tractibility, and
disorganized behavior.

without medication. In some MBD chil-
dren they permit a reduction in dosage
and eventual discontinuance of drug
therapy.

**Only when medication
is indicated**

*Please turn page
for brief prescribing
information.*

Ritalin® (methylphenidate)

An effective
member of the MBD
management team



C I B A

Figure A5: Advert for Ritalin (Ciba-Geigy 1979) in the Archives of General Psychiatry.



"He cannot sit still for one minute..."
"He can't concentrate on a thing..."
"He is easily frustrated and explodes..."
"He just can't be reached for long."

This child is not a model. In all the photos, as in this one, the children are MBD patients, and the adults are health care professionals.

The diagnosis of MBD

MBD is not uncommon
"Minimal brain dysfunction is probably the single most common disorder seen by child psychiatrists. Despite this fact, its existence is often unrecognized and its prevalence is almost always underestimated."¹

It has been reported^{2,3,4,5} that the hyperkinetic syndrome occurs in 3 to 10 percent of the elementary school population.

MBD most frequently recognized in the classroom
The teacher appears to be the best barometer of change in a school-age child with symptoms of MBD such as hyperactivity. The child, who is usually a male, is generally having both disciplinary and academic problems.

Patient history is diagnostic key
Because the child may function quite normally on a one-to-one basis, when he is receiving extra attention, clinical impressions from a single office visit can be misleading.

"... I want to re-emphasize that in the practical management—the diagnosis and treatment—of children with suspected MBD, the traditional (neurological) diagnostic measures are of little help."⁶

"The poor correlation of the neurological examination and electroencephalogram with the final diagnosis indicates that these procedures are of limited utility in assessing hyperactivity in childhood."⁷

"The diagnosis of hyperkinetic syndrome is based upon the history and the symptom profile rather than upon special tests or examinations."⁸



The MBD child may not exhibit unusual behavior on the initial office visit. Sometimes, however, subtle signs can be revealing. Note in the photos that the child's hands are in constant motion.

Figure A6: Advert for Cylert (Abott 1975) in the Archives of General Psychiatry.

A symptom profile of the hyperkinetic child

Marked hyperactivity: most pronounced in home or school; in more severe cases, the child seems "driven"; is constantly in motion, in a random, purposeless way.

Short attention span: concentration fragmented or easily fatigued, particularly in static activities such as reading or schoolwork.

Distractibility: easily diverted from the task at hand; leaves work unfinished; becomes impatient easily.

Emotional lability: wide swings of mood, with frequent temper tantrums; often destructive, yet "can't help himself"; frequently creates serious problems in classrooms.

Impulsivity: acts or speaks abruptly without consideration of the consequences.

Impaired coordination: often shows in simpler motor tasks requiring concentration (i.e., drawings lack cohesion, handwriting is poorly organized).

Learning disability: a frequent underachiever, though I.Q. may be normal or above; problems often relate to perceptual difficulties—poor differentiation of words and letters, confused directionality.

As a result of his disabilities, the MBD child is tormented by daily frustrations and feelings of failure. "Aware that their controls are inadequate, they can accurately foresee that they are likely to act in ways that have resulted and will continue to result in rejection, rebuff, loss of love, and shame or guilt."⁹

Treatment of hyperkinetic behavior

In treatment of MBD, the stimulant drugs often serve as an



adjunct to other remedial measures (psychological, educational, social). Specifically, they act to help redirect hyperkinetic behavior into controlled, purposeful activity.

Conners observes that "It is definitely the *quality* of activity, not the total *amount* of energy expended, which is changed by these drugs."¹⁰

According to Wender, "The stimulant drugs are of the greatest practical use in the treatment of the MBD syndrome."¹¹

"Because the ages of 5 to 12 are crucial to the child's development and self-image, treatments which permit the child to be more accessible to environmental resources are warranted and useful."¹²

Still, it is important to recognize that the stimulant drugs, including Cylert (pemoline), have limitations and are intended only as adjuncts in an overall treatment program.

Roughly one third of children treated with medication may show no improvement at all. In the remaining two thirds, the improvement may vary from marginal to dramatic. Drugs do not have a direct effect on learning ability, but they can serve to increase attention span and permit the child to attend more purposefully to the world around him.

Long-range considerations

Some investigators feel that failure to take appropriate and adequate therapeutic measures may pose a threat to the future development and well-being of the child.

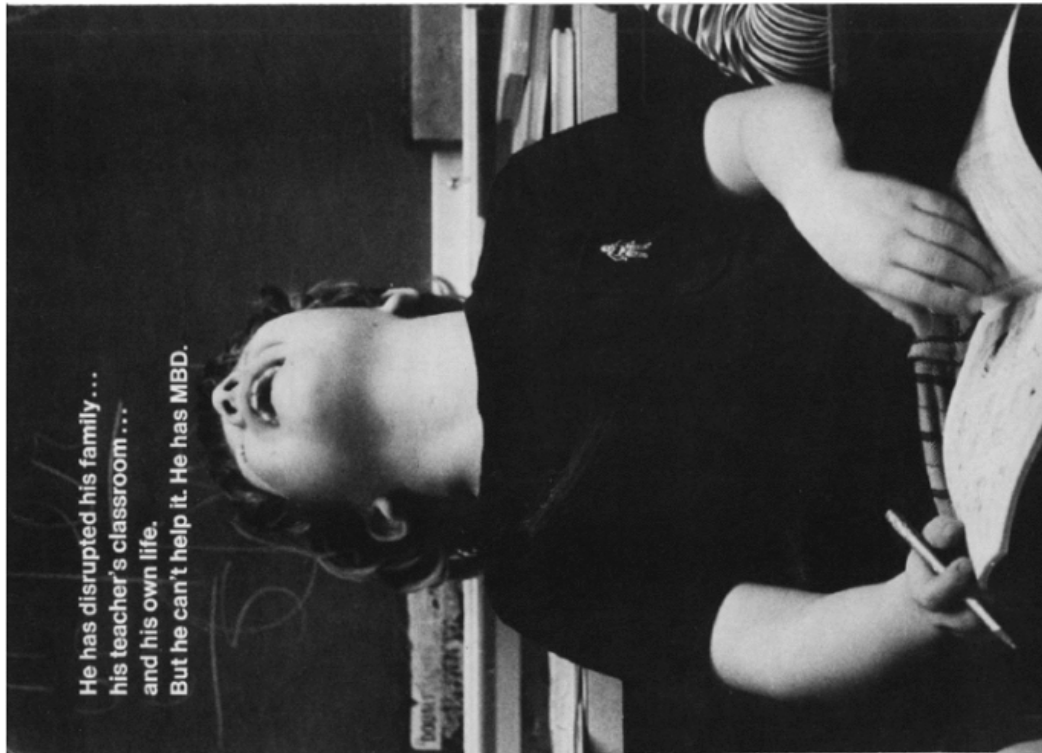
Wender points to two possible consequences: "(1) the possibility of long-term effects of early psychological deviancy on the child; (2) the possibility of long-term effects of non-treatment on the family."¹²

Sixty-four hyperactive children were restudied five years later at adolescence. "While the hyperactivity had diminished, other handicaps, notably social and intrapsychic difficulties, attentional, and learning disorders persisted."¹³

Eisenberg observes: "The hyperkinetic syndrome is no mere matter of developmental phase to be endured until it is 'outgrown.' The data from the longitudinal studies reviewed earlier provide evidence for persisting educational handicap and enduring behavior disorder."¹⁴

1. Wender, P.H., *Minimal Brain Dysfunction in Children*, Wiley-Interscience, New York, 1971, p. 1.
2. Mastand, R., Testimony before a Subcommittee of the Committee on Appropriations, House of Representatives, 99th Congress, First Session, April 3, Washington, D.C., July 1, 1986.
3. Stewart, M.A., et al., *Am. J. Orthopsychiatry*, 36 (1981), 1966.
4. Huesz, H.R., *Acta Paedopsychiatry*, 34:130, 1967.
5. Report of the Conference on the use of Stimulant Drugs in the Treatment of Behaviorally Disordered Young Children, sponsored by the Office of Child Development and the Office of the Assistant Secretary for Health and Welfare, Wash., D.C., Jan. 11-12, 1971.
6. Wender, P.H., *Ibid.*, p. 72.
7. Kenney, J.K., et al., *J. Am. Acad. Child Psychiatry*, 10:69, 1971.
8. Wender, P.H., *Ibid.*, p. 147.
9. Conners, C.K., *J. Am. Learning Disabilities*, 4:476, 1971.
10. Wender, P.H., *Ibid.*, p. 93.
11. Wender, P.H., *Ibid.*, p. 128.
12. Weiss, G., et al., *Arch. Gen. Psychiatry*, 28:609, 1971.
13. Wender, P.H., *Ibid.*, p. 147.
14. Wender, P.H., *Ibid.*, p. 147.

"Within the mind"



He has disrupted his family ...
his teacher's classroom ...
and his own life.
But he can't help it. He has MBD.

Figure A6: Continued.

As an adjunct in a treatment program for children with MBD...

ABBOTT INTRODUCES

Cylert®

(pemoline) ^{IV}



An effective aid for transforming undirected hyperkinetic behavior into purposeful activity

Among the noteworthy properties of Cylert (pemoline)

- It is structurally different from the amphetamines and methylphenidate.
- It has shown no evidence of producing tolerance with long-term administration.
- It is taken but once daily, sparing the child the need of mid-day doses at school.
- It has produced significant improvement in behavior according to ratings by physicians, parents and teachers.
- It has shown minimal cardiovascular effects, with little or no effect on pulse or blood pressure.

The place for Cylert (pemoline) in a treatment program for MBD

The adjunctive use of Cylert
As an adjunct in an overall treatment program, Cylert can increase attention span in the hyperkinetic child and enable him to gain greater control over his actions.

A child successfully treated may show marked improvement in concentration and become more responsive to instruction and counseling. Typically, the parent or teacher will report fewer emotional upsets and temper tantrums, and far less "squirming" and disruptive motion.

As his attention span improves, the child has less tendency to leave things unfinished. Often in directed activities such as handwriting or drawing exercises, there will be visible improvement in organization.

Cylert in itself will not "enhance learning" or resolve difficult behavioral problems. But it can enable the child—perhaps for the first time—to channel *undirected* hyperkinetic behavior into purposeful activity.

How Cylert differs from other agents
Cylert is a mild central nervous system stimulant which is structurally different from the amphetamines and methylphenidate.

Onset of action
Using the recommended schedule of dose titration, significant benefits may not be seen until the third or fourth week of drug therapy. Side effects may be seen prior to optimum clinical results.

Dosage is taken only once daily
Cylert is usually administered once daily, in the morning.

The importance of single daily dose administration
Among the benefits:
The parent maintains control of medication; there is no need for the child to carry drugs to school.



With Cylert, dosage is usually given in the morning, at breakfast time. There is no need to carry medication to school.

The child is spared the embarrassment of having to "take his medicine" while at school.

There is no continuing reminder to his classmates that he is "different".

There is no need for a nurse or teacher to supervise the taking of a mid-day dose.

Finally, there is no interruption in therapy caused by missed, forgotten or delayed doses.

Cylert, alone among CNS stimulants used for treatment of hyperkinetic behavior, is inherently long-acting, permitting once-a-day dosage.

When NOT to use Cylert
Cylert should not be used for simple cases of overactivity in school-age children.

Neither should it be used in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis.

The physician should rely on a complete history of the child and a thorough description of symptoms from both parents and teacher before postulating a diagnosis of MBD.

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There is no continuing reminder to his classmates that he is "different".

There is no need for a nurse or teacher to supervise the taking of a mid-day dose.

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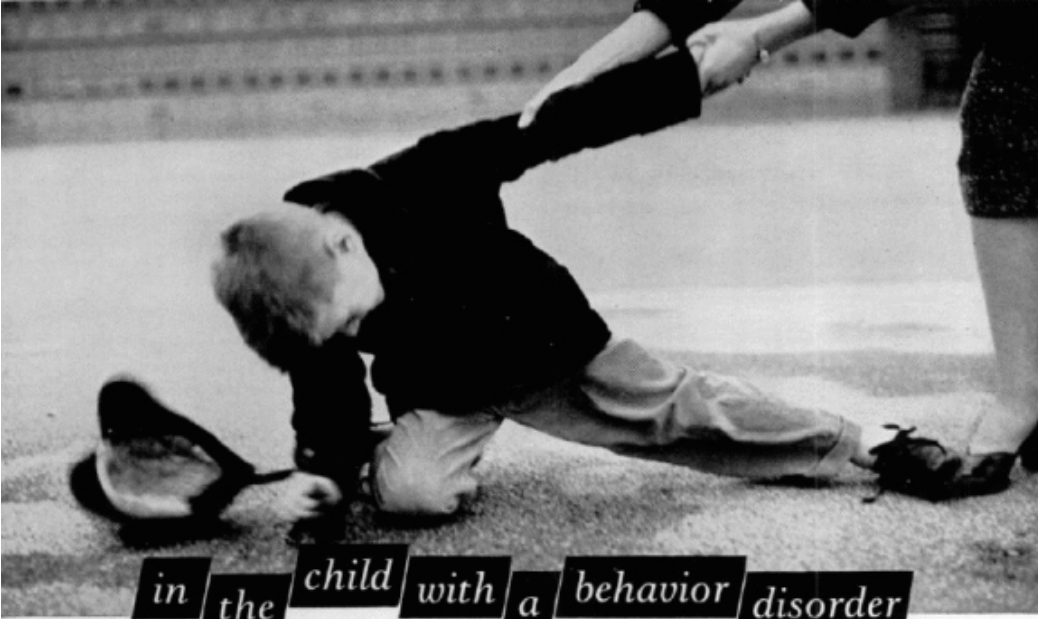
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Figure A6: Continued.



in the child with a behavior disorder

THORAZINE*

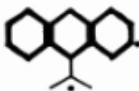
reduces hyperactivity and aggressiveness
decreases anxiety and hostility
improves mood, behavior and sleeping habits
establishes accessibility to guidance or psychotherapy
increases amenability to supervision

facts to bear in mind— Even though the dramatic calming effect of 'Thorazine' on belligerent, overactive children may give the impression of a cure, simultaneous supportive counseling and guidance are necessary if lasting benefits are to be assured.

Adequate 'Thorazine' dosage for certain seriously disturbed youngsters will sometimes exceed 50-100 mg. t.i.d.

'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

'Thorazine' is available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

 Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

Figure A7: Advert for Thorazine (Smith, Kline & French Laboratories 1956) in the Mental Hospitals journal.

safe...for your little patients, too

*"a definite relaxant effect"*¹

With NOSTYN "...almost without exception the children responded by becoming more amenable, quieter and less restless."¹


without depression, drowsiness, motor incoordination

"The most striking feature is that this drug does not act as a hypnotic..."¹ "No toxic side-effects were noted, with particular attention being paid to the hematopoietic system."²

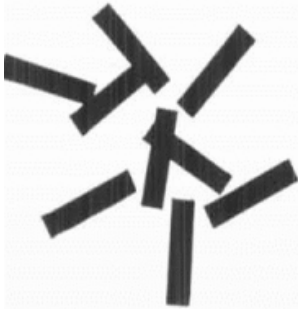
dosage: Children: 150 mg. (½ tablet) three or four times daily. Adults: 150-300 mg. (½ to 1 tablet) three or four times daily.

supplied: 300 mg. scored tablets, bottles of 48 and 500.

(1) Asung, C. L.; Charcowa, A. I., and Villa, A. P.: Sea View Hosp. Bull. 16:80, 1956. (2) Asung, C. L.; Charcowa, A. I., and Villa, A. P.: New York J. Med. 57:1911 (June 1) 1957. (3) Report on Field Screening of Nostyn by 99 Physicians in 1,000 Patients, June, 1956.

 AMES COMPANY, INC · ELKHART, INDIANA

41087

 calmative **nostyn**[®]

Ectylurea, AMES
(2-ethyl-cis-crotonylurea)

"of value in the hyperactive as well
as the emotionally unstable child"³




Figure A8: Advert for Nostyn (Ectylurea, AMES 1957) in the Psychosomatic Medicine journal.



To facilitate psychotherapy in the emotionally disturbed child, and to enable him to lead a stable life during such therapy, adjunctive treatment with PROZINE is often advantageous. In reporting on 176 disturbed children who received PROZINE, Ehrmantraut et al.¹ found that 85.8 per cent showed moderate to marked improvement in behavior reactions and adjustment to institutional care.

PROZINE, designed for the treatment of moderate to severe emotional disturbances, helps control psychomotor agitation as well as anxiety and tension.

1. Ehrmantraut, W., et al.: Scientific Exhibit Presented at the District of Columbia Medical Society Meeting, Nov. 24, 1958, Washington, D.C.

Wyeth Laboratories Philadelphia 1, Pa.


controlled: an acute behavioral problem



PROZINE[®]

meprobamate and promazine hydrochloride, Wyeth

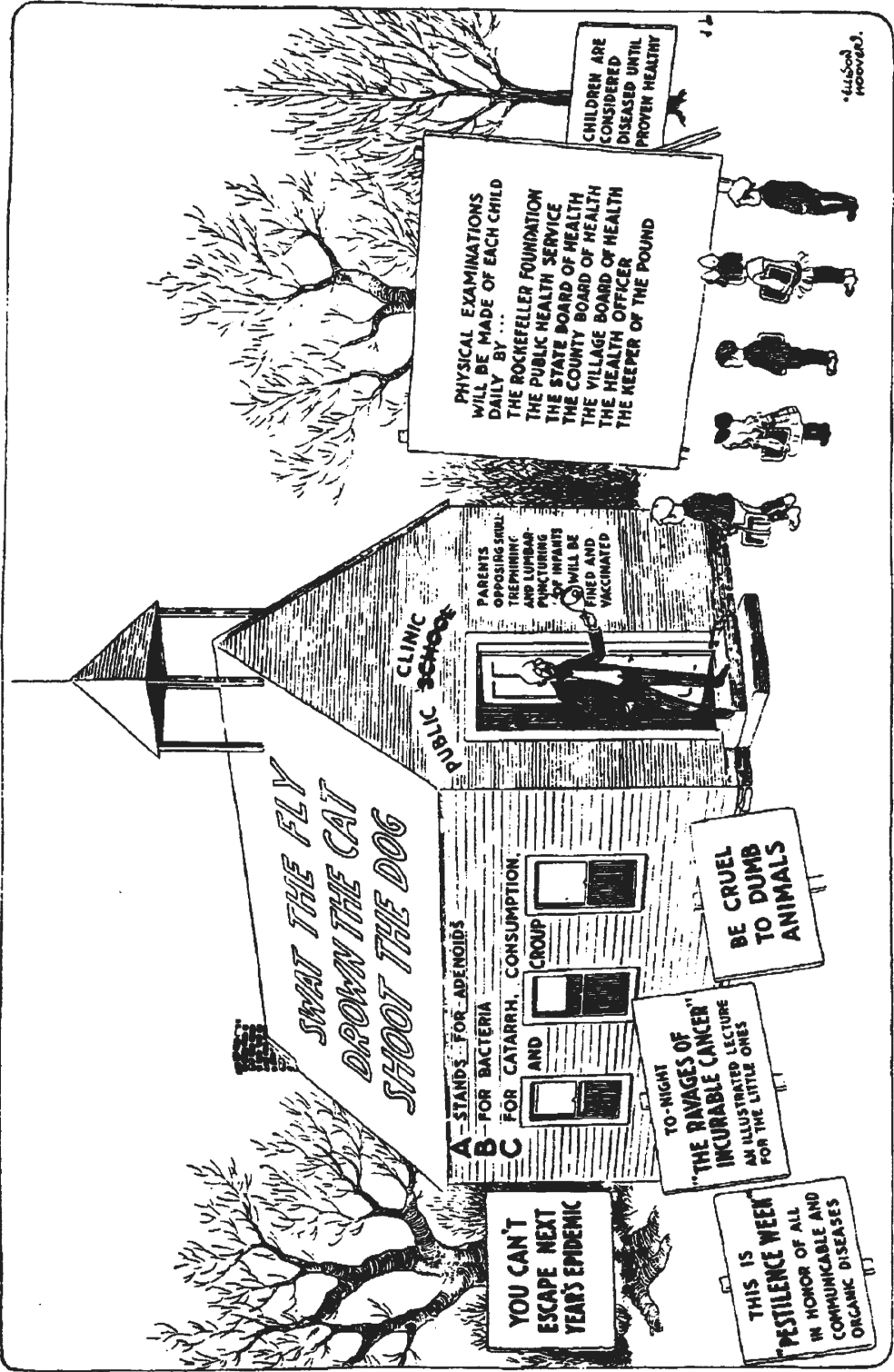
SPECIFIC CONTROL THROUGH DUAL ACTION



A Century of Service to Medicine

PHILADELPHIA 1, PA.

Figure A9: Advert for Prozine (Wyeth 1960) in the Psychosomatic Medicine journal.



The Little Red, Serumized, Materia-Medicated, Politically-Exploited School-House !
Figure A10: Source: Life Magazine, 24 May 1917, taken from [Petrina \(2006\)](#).