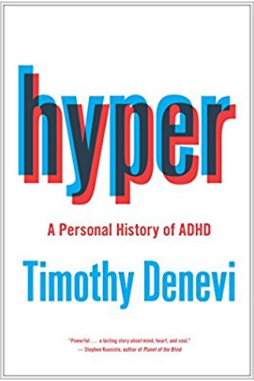

Hyper: A Personal History of ADHD

By Timothy Denevi

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The first book of its kind, this compelling and moving memoir about what it’s like to be a child with ADHD also explains the history of the diagnosis and how we have come to medicate more than four million children today.

Among the first generation of boys prescribed medication for hyperactivity in the 1980s, Timothy Denevi took Ritalin at the age of six, and during the first week, it triggered a psychotic reaction. Doctors recommended behavior therapy, then antidepressants. Nothing worked. As Timothy’s parents and doctors sought to treat his behavior, he was subjected to a liquid diet, a sleep-deprived EEG, and bizarre behavioral assessments before finding help in therapy combined with medication. In *Hyper*, Timothy describes how he makes his way through school, knowing he is a problem for those who love him, longing to be able to be good and fit in, hanging out with boys who have similar symptoms but meet different ends, and finally realizing he has to come to grips with his disorder before his life spins out of control.

Skillfully and seamlessly using his own experience as a springboard, Denevi also reveals the origins of ADHD, from the late nineteenth century when hyperactivity was attributed to defective moral conscience, demons, or head trauma, through the twentieth century when food additives, bad parenting, and even government conspiracies were blamed, to the most recent genetic research. He traces drug treatment from Benzedrine in 1937 through the common usage of the stupefying chlorpromazine and brand new Ritalin in the 1950s to the use of antidepressants in the 1970s, 1980s, and 1990s.

Riveting, thought-provoking, and deeply intelligent, this is a remarkable book both for its sensitive portrait of a child’s experience as well as for its ability to illuminate a remarkably complex and controversial mental condition. Rick Lavoie, author of *It’s So Much Work to Be Your Friend*, says *Hyper* is “a significant and singular contribution to our field.”

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Hyper: A Personal History of ADHD By Timothy Denevi Bibliography

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Editorial Review

Review
"Riveting and monumental....There's much to be learned in this book about ADHD, about pushing boundaries and respecting them, about parenting, and about the special kind of triumph that can come as a result of hard-earned self-knowledge. Denevi has written a book about a condition that has been studied for a long time, but, truly, it hasn't been talked about like this." (*BookPage*)

"Hyper is the story of all of us who have lived -- or continue to live -- with ADHD." (*Biographile.com*)

"Tim Denevi has written a vivid, moving, and gripping first-person account of what it's like to grow up hyper. He weaves into the narrative an erudite account of the history of ADHD. And he packs it all together in concise, vibrant prose, compact enough for even those of us who have ADHD to read! Excellent book!" (Edward Hallowell, M.D. *author of Driven to Distraction*)

"Enlightening...Readers with ADHD will find affirmation of their own thoughts and emotions, while those without the condition will experience revelations." (*ADDitude*)

"In this haunting narrative [Denevi] explores the world's most scrutinized childhood condition from the inside out." (*Nature*)

"Denevi skillfully blends a personal account of his experiences with ADHD with a thorough and enlightening social and medical history of the disease....Frank, moving, and instructive." (*Booklist*)

"Denevi skillfully weaves historical anecdotes into his personal account...excellent." (*Publishers Weekly*)

" In his remarkable book *Hyper*, Tim Denevi tells the story of his childhood struggles with ADHD and his evolving understanding of this puzzling disorder. His narrative captures the essence of his daily struggles and features the disarming poetic rhythm of an extraordinarily talented writer.
Over the past decade, I have often been asked to recommend books for parents and professionals who are trying to better understand ADHD. I have always responded with the titles of the three classics by Hallowell, Levine and Ratey. Now, there are four. *Hyper* is full of blazing insights, wisdom, information and inspiration. It is a significant and singular contribution to our field." (Rick Lavoie, author of It's So Much Work to Be Your Friend and The Motivation Breakthrough)

"At once both memoir and social history, *Hyper* chronicles what it was like to grow up as a kind of guinea pig for the treatment of ADHD in the 1980's. With hard-won clarity and excruciating honesty, Timothy Denevi has written a fascinating and sometimes disturbing account, never self-pitying but consistently illuminating and riveting." (Robin Hemley, author of Nola, A Memoir of Faith, Art, and Madness)

"Timothy Denevi is a wonderful, true storyteller, drawing us into his own perilous childhood while taking us through vast changes in cultural attitudes, from a time doctors described ADHD kids as feeble minded threats to civilization to the triumph of Congressional recognition of their right to treatment and education. Hyper is informative, moving, and entertaining—quite a feat." (Robert Shapard, editor of New Sudden Fiction and Flash Fiction Forward)

"In Hyper the interior life of a misunderstood boy is honored with lyric language. Tim Denevi has written a memoir about emotional vulnerability and recovery in the literary tradition of Styron and Susanna Kaysen. This is a powerful, literary book about childhood medication and its human cost. It's also a lasting story about mind, heart, and soul." (Stephen Kuusisto, author of Planet of the Blind)

"Tim Denevi tells two stories--episodes in the history of the diagnosis and treatment of ADHD and episodes of his own life, from early childhood to maturity. He shows us how terribly difficult (and time after time, inadequate) has been the scientific and therapeutic effort to alleviate the suffering of children and youths. And with immediacy and clarity he narrates his own past anguish and bafflement (and that of his parents) as they all three tried to make sense of his impulses and vulnerabilities. Over time, they found their way to everyday ordinary human success at life, and Tim Denevi has found the way to write about it--a very impressive success indeed." (Reginald Gibbons, author of Slow Trains Overhead: Chicago Poems and Stories.)

“Intriguing…A well-written, easy-to-read journey of one man’s experience living with ADHD and the history of the disorder. Parents may see their children in Denevi’s story, and adults may see themselves in the childhood accounts that are shared here.” (*Library Journal*)

“What’s been missing from the discussion are the personal accounts from people who navigate the world with this disorder coloring every aspect of their lives. Enter Timothy Denevi, who gives a first-person account of growing up with ADHD by marshaling his masterful storytelling skills[…] seeing Denevi overcome his childhood struggles with ADHD and go on to lead a normal, productive life can offer hope to families of children with ADHD.” (*Green Bay Press Gazette*)

About the Author
Timothy Denevi received his MFA in nonfiction from the University of Iowa. His writing has appeared in various magazines including *The Atlantic*, *Time*, *Gulf Coast*, and *Arts & Letters*, and he’s been awarded fellowships by The MacDowell Colony, the Virginia Center for the Creative Arts, and the Community of Writers at Squaw Valley. He lives near Washington, DC and teaches in the MFA program at George Mason University. *Hyper* is his first book.

Hyper

1

The Evil Logic of Clenched Hands

It’s late afternoon, suddenly evening. The shadows in dense fingers along the wall. As if in a dream the color begins to drain from the wallpaper. The door is gauzy, the carpet insubstantial. Puzzle pieces litter the floor like flat, monstrous teeth. Or maybe not. In truth the details are a blur; for minutes I’ve been standing near the door, sobbing, screaming, the world reduced to darkness and light beneath the thing I feel.

Northern California, 1984: I’m five years old. It’s my very first complete memory: I was having dinner with my parents and one-year-old sister and refused, when asked, to give something up. A toy car, baseball card—it doesn’t matter; I was ordered from the kitchen and into my room. All I needed to do was serve the time-out.

But the memory never changes. What I wanted is gone, I’ve lost it forever, and perhaps the last identifiable emotion is something deeper than anger, a sense of desperation akin to homesickness; there’s no way back to the place I just left.

Later, standing in the middle of my room, I’m voiceless, tensed, my face briny with sweat. There’s pain; I’ve been dragging the corner of a building block across my chest. It’s still in my fist, the color of sand. I drop it, look up. As if for the first time, I see them: my parents.

They’re enormous. My father, Mike: his dark hair, the slope of his neck and shoulders, mustache; he’s crouching, trying to catch my eye.

“Timmy!” he shouts.

For an instant they seem like strangers, a reflection. I feel a terrifying crush of loneliness, something I hate to recall even now. But I’m not the only one who’s been shouting.

My mother, Patty, is sitting next to him, her cheeks thinly drawn as if she’s been attempting to speak the entire time. Her eyes are small and bright. Huge lashes. She’s crying.

And like that the tantrum is over. The room is measured and still. Once again I’m me: a skinny, sensitive boy who can be bargained with.

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What would you do? Your child won’t stop screaming. Maybe he’s sick, exhausted—any trigger could have started it. Then, miraculously, he calms down. Later you talk to him, emphasizing that such behavior is unacceptable, that there are consequences for his actions, and that most of all you love him very much. Of course you wonder how you might have handled it differently. He has had problems before, serious ones, but this is something altogether new.

By this point my parents had been married for almost a decade. There’s a story they like to tell about their college days, right after they first started dating. A party at Santa Clara University, the early 1970s: My mother walks into a crowded dorm room. My father is sitting down. Already he’s a standout baseball player, and on his lap is a preening, blond-haired girl, a freshman, who seems to be nuzzling him. My mother screams. Not at my father. She’s telling everyone else to leave. The girl looks up—“Do you think I should go too, Mike?” But before he can answer, my mother is dragging her by the ponytail into the hallway. Only after the room has cleared out does she turn to my father and slap him. (“What was I supposed to do?” he likes to say. “The girl sat on my lap.”)

Another story: they’re seniors. For the last four years they’ve had an on-again, off-again relationship—recently they’ve broken up. My mother is going out on a few dates, my father is miserable. And yet, they still spend a lot of their time together. My father has been drafted by the Kansas City Royals. This particular afternoon he’s just finished practice. In a few weeks he’ll be reporting to a minor-league affiliate in Florida.

“I was thinking we should get married,” he says to her.

She straightens up. “Are you fucking kidding me?”

“Come on,” he says happily, impulsively. “You know I can’t live without you.”

And it was true, for both of them, has been ever since. But then my parents have always had too much in common. They were born, unbelievably, on the same morning of the same year—February 19, 1953—at Bay Area hospitals forty miles apart. Both my grandfathers were authoritative, first-generation Italians, parlaying whatever advantage they could find—the GI Bill, an athletic scholarship—into college and, later, moderate financial success. Both my grandmothers were Irish, beautiful, mildly alcoholic, and between them raised nine children in three decades.

Growing up, my mother wanted to be an actress. At Santa Clara she acted in plays, her black hair down to her waist. Even today the family home is decorated like a personal stage: crucifixes, family photos, and poems about dogs. But now, in her early sixties, she has only enough energy to engage the people closest to her. It wasn't always that way.

My father loved everything about baseball. At nine, the youngest on the team, he won the local Little League championship with a bases-loaded double. He was drafted at eighteen by the Chicago Cubs but went to college instead. He grew up surrounded by a large, excitable family, and I have a feeling he probably had more in common with me than he'd like to admit; but his mother, Jo Ann, would ignore his most egregious behavior, while his father, Pietro, would swing at him with an open hand. He hated high school; his father was the football coach. But he loved Santa Clara, and his coaches there adored him. Following an All-American senior season, he settled with my mother on a four-year plan to make it into the major leagues. Five years later, he was injured and demoted from Triple-A, so he came home to take a job in the real estate business. My mother was already pregnant with me.

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The San Francisco Bay Area, 1984: That September we were part of a family gathering in Los Gatos. The commotion! My Italian aunts and uncles speaking in loud voices, eyeing one another from behind their drinks. I kept running from group to group, shouting until I was shaking, hoarse. Then I wandered into the silence of the garage and saw, perched on a shelf, an enormous fishing pole.

I froze. I'd never seen anything like it: the slacked line, the fleshy handle. I could hear family members behind the door. The air was heated, dirty. I stared at the object for what felt like minutes. It didn't move. And then I understood: this was some sort of marvelous tool, textured, intricate, meant above all to be held in your hands. I climbed the bench and was reaching for it when my father walked in.

"Oh!" he said. "Goomba!"

In the whirlwind of the party he'd been eating and drinking, keeping track of my sister, and socializing. Who knows how he ended up in the garage precisely at this moment, but he was genuinely happy to see me—discovering his young son in the midst of such an earnest mission. A light switched on. I was scooped off the counter and carried outside.

The afternoon, its dried canvas of grass and juniper bushes. Uncles and aunts crowded along the patio, talking with bright, hurried gestures. I started shouting about the garage. I had been so close: the lure, the feathered tip, the hem of mysterious wire. I kicked and twisted, my fury amplified by a complete lack of power. Nothing helped. It was happening again.

"Hey," my father said. He looked around for my mother.

The sky was a domed, colorless vault. The grass emptied of texture. I writhed, screamed, clicked my jaw.

Shadows advanced and retreated, the ghosted angles of hands. My own voice buzzed, a reminder of something meaningful. But the world was cheap; it receded. The best way I can describe it now is in terms of a religious experience: the departure, however brief, into a space where something so limited as people—their bodies—couldn’t possibly matter.

Then the backyard was silent, windless. Aunts and uncles stood over me, blocking the sky, a fabulation of adulthood, mouths and noses etched into their faces.

Suddenly my mother broke through the crowd. She’d been changing my sister, noticing, finally, the silence in the backyard. And just like that I was taken up and away—a clutch so overwhelming that I could feel her earring on my cheek, its metallic chill.

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My mother always talked about my colicky first few years. Sleepless nights, ear infections, antibiotics and cold medicines, digestion problems, and at eight months old a serious case of pneumonia. I was born early, hyperreactive to light and sound. She was sure I couldn’t digest dairy; the special replacement formula cost over $100 a month. When my sister, Katie, arrived I started preschool in Los Gatos, but on the very first day I bit another boy on the ankle. I couldn’t sit still long enough to fall asleep during nap time or share with the other children. My mother consulted the teachers, planned strategies, and talked to friends, but no matter what she tried, my irritable behavior continued; it was, if anything, getting worse.

A year before the onset of my tantrums my mother had written to National Jewish Health (NJH) in Denver. She’d read about something called the Feingold diet, a treatment for behavior problems caused by allergic reactions to food additives put forth by Benjamin F. Feingold, MD. It was all the rage back then, though the evidence and methodology behind it had already been refuted. Nevertheless, in June we drove across a third of the country so that the doctors at NJH could put me on a liquid diet. After a week new foods were introduced; I’d spend whole days eating only carrots, then potatoes. It was like this for two months, until they finally determined that I wasn’t allergic to anything; my constant oversensitivity to the world, its agitation of people and places, couldn’t be explained by any physical discomfort.

Today a diagnosis would have been clearer. Attention-deficit/hyperactivity disorder (ADHD) has become the most studied childhood condition in the world. The latest Diagnostic and Statistical Manual of Mental Disorders (DSM)—published in editions over the past fifty years by the American Psychiatric Association—now divides ADHD into three subtypes: inattention, hyperactivity-impulsivity, and both.

To be diagnosed under the hyperactivity/impulsivity subtype, a child should meet six out of nine possible symptoms:

1.?Often fidgets with or taps hands or feet or squirms in seat

2.?Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom)

3.?Often runs about or climbs in situations where it is inappropriate

4.?Often unable to play or engage in leisure activities quietly

5.?Is often “on the go” or acts as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time)

6.?Often talks excessively

7.?Often blurts out answers before a question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation)

8.?Often has difficulty waiting his or her turn (e.g., while waiting in line)

9.?Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission)

Listing these now is like running into someone who’s wearing an outfit identical to mine—as a child I met every single one of the criteria—but how do you evaluate such behavior as being inconsistent with normal development?

The most comprehensive approach today involves gathering information from everyone involved. The goal is to limit the biases of each person—parent, child, teacher—in order to accurately judge the situation. Doctors should employ scales and aptitude tests, interview parents and teachers, review school records and grades, and eventually conduct observations in multiple environments. Of course there are shortcuts to a diagnosis, but before the physician in charge can label it ADHD, the assessment should include a decent amount of evidence-based evaluation.

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In the fall of 1984 my parents took me to see Dr. Atkinson, our family pediatrician in Los Gatos. He was a short, wiry man in his early fifties with a blooming paunch. The tantrums had been going on for months—similar to the first, often triggered by objects. I was moody and excitable. Dietary causes had been dismissed. Atkinson’s first intention was to rule things out, the most frightening of which, given my symptoms, was epilepsy. He ordered a series of tests.

I remember a weekend afternoon with my father. My mother was off with my sister somewhere. We were at the local hospital where I was being examined: the waiting room, forms, doctors, my histrionics as a nurse drew blood. I’m not sure if there’s anything in the world my father hates more than this type of situation; he has never been—and I say this without judgment since the same can be said of me—a patient man.

Before we left they needed a urine sample. We were herded into a small bathroom. Through the thin walls we could hear shuffling, wet coughs.

“I want to hold the cup please,” I told him.

“We’re almost done.”

“But Daddy.”

“Yeah.”

“I said please.”

He sighed and handed me the sterile cup, and it accidentally slipped from my hand into the toilet.

I looked up, aware of the consequence; it was the last straw. My father was staring back. Then he laughed. Maybe he snorted. He was seeing it: the walk down the corridor, the explanation, the additional delay. Were the situations reversed—had he, a quarter of a century earlier, made this type of mistake—his own father might have slapped him across the face. Instead, he bent over the toilet and fished out the cup.

“No big deal,” he said.

“But it’s dirty,” I replied.

He squinted. “You’re right.” Quickly, he rinsed the cup in the sink and held it inside the rim of the toilet. “Aim and fire.”

I pulled down my pants, but I couldn’t pee. I was terrified; at any moment a doctor could burst in and yell at us for taking too long.

He began moving the cup from side to side. “Try and hit it.”

“Hit what?”

“The target.”

And just like that I was peeing all over his hand, into the cup, onto the harsh floor.

“I win!” I shouted. “Daddy, you lose!”

My young father. I’m proud of him. And I don’t mean it condescendingly. I can understand what he must have felt: taking your son to the doctor, the nurses, the demands, the broken boundary of privacy—the goal always being not to freak out your child; after all, he’s sensing things more keenly than you are. In truth, the simplest maneuvers convince: a game, a distraction. But only if you can find a way to remain calm yourself.

At the dinner table that evening the phone rang.

My mother answered it. “Wait,” she said. “What?”

“Who is it?” my father asked.

She covered the receiver. “The hospital. It’s about the tests.”

My father rose to join her and quickly explained about the contaminated cup, how he didn’t think, at the time, that it would be a big deal.

“I ask you to do one simple thing.” She uncovered the receiver. “I’m sorry. What were you saying?” She listened. Eventually she hung up. Then she pointed a finger at him.

He held up his palms.

“Everything’s fine,” she said. “But listen to me: this is serious. I can’t handle it without you.”

And that was all it took—as if he'd been waiting for this moment ever since we left the hospital. "Shut up!" he shouted, pointing back. "Don't say another word!"

Instantly she was at him. Then came the accusations: You're lazy! You overreact to everything! You're an asshole! You're a stupid fucking idiot!

My sister was screaming. The phone was knocked ajar, sounding in waves. Finally my father stormed off.

I've tried to explain my parents' fury as the flip side of their love. They've always been able to draw closer together than any couple I've known, but their intense feelings cut both ways; antagonism comes in a series of escalations, the pace increasing during periods of stress. Don't get me wrong; they've never left bruises, and no one has ever had to call the police. The goal of each is simply to make the other believe—and back down; it's like watching a knife leave a trail of blood while tracing the shape of a heart.

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What precisely is ADHD? To begin, it's a mental disorder. Dr. Russell A. Barkley, a professor in the Department of Psychiatry at the State University of New York Upstate Medical University, is perhaps the foremost contemporary expert on ADHD; over the last three decades he has written more than fifteen books on the subject. In his introduction to Lisa Weyandt's 2001 An ADHD Primer, he explains, "ADHD constitutes a failure or serious deficiency in a mental mechanism that is universal to humans (a psychological adaptation in the evolutionary sense), in this case, response inhibition and self-regulation. And it produces harm."

And so, we have a norm, i.e., the way most people act, and a deviation: impairment. But how do we explain the cause of such behavior without relying on more trying terms—catchalls such as "personality" and "temperament" eventually leading to the most inclusive concept of all, "identity," which in my opinion is really just a modern way of saying "the soul"?

To begin again: the term "attention deficit/hyperactivity disorder" is used to describe a range of behavior that's both irregular and harmful. It's different than, for example, the term "cancer," in which the malignant cells and the broader category of the disease go by the same name. ADHD, like most psychiatric disorders, doesn't include in its title a reason for how things came to be; instead it's a classification based on symptoms. So how do we define it without simply offering a list?

Dr. Barkley calls it "the most recent diagnostic label for children presenting with significant problems with attention, impulse control, and overactivity." In What Causes ADHD?, the clinical psychologist Joel T. Nigg describes it in terms of "a framework for identifying children who are impaired in meeting their developmental milestones." And Dr. F. Xavier Castellanos, director of research at the NYU Child Study Center, says, "People with ADHD can do anything; they just don't do it quite so well. It's a disorder of efficiency, or inefficiency, as much as anything, I believe."

Of course ADHD is a controversial diagnosis, and the dissent goes beyond the vocalizations of more extreme groups such as the Scientologists, who tend to discount the validity of mental illness altogether. Dr. Lawrence Diller, in his popular book Running on Ritalin, characterizes it as "a condition that psychiatry has only recently defined—in fact, is still struggling to define—and for which it has a long list of symptoms but no firm explanation." However, Dr. Peter Breggin, author of multiple books on the subject, thinks ADHD is a marketing ploy: "The drug companies, like the tobacco industry, like the alcohol industry, are highly competitive, and are always searching out new markets. . . . What medicine and psychiatry have done is to take essentially behavioral problems—problems of conflict between adults and children—and redefine them as medical problems.”

Part of this controversy has to do with the question of the disorder’s origins. Is ADHD a physical condition, like Down syndrome, rooted in a testable source? Or does it arise from a combination of factors, more along the lines of, say, Posttraumatic Stress Disorder? Or, could it be the result of our contemporary environment—the demands we’ve placed on children and their natural inability to meet our concept of “the norm”?

According to recent studies, about 3–8 percent of US children can be considered ADHD, or one or two in a classroom of twenty. It affects boys at a much higher ratio, around 3:1, though sources vary. Prevalent across the social and economic strata of society, it’s not strictly a Western or American or contemporary phenomenon. The age of onset tends to be around three or four, though symptoms can surface earlier. Those with ADHD often suffer from other disorders, a situation called “comorbidity,” including anxiety, depression, Tourette syndrome, dyslexia, and bipolar disorder. For a long time it was believed that upon reaching adulthood, the symptoms would naturally diminish, but follow-up studies that started in the 1980s now reveal that most children continue to experience some degree of impairment throughout adolescence and for the rest of their lives.

The first person to approach the symptoms and causes of ADHD in a modern, scientific manner was the early-twentieth-century physician George Frederic Still. He appears in surviving portraits as a hawkish figure, incomplete, like a man returning from some disastrous mission to the tropics: slicked hair, pencil-thin mustache, his body concealed beneath robes and a dark, flowing cape.

During a 1902 presentation at London’s Royal College of Physicians, Still outlined the findings of a study on the behavioral difficulties of twenty children. He identified several symptoms of the present-day ADHD diagnosis.

“The notable feature in many of these cases,” he said, “is a quite abnormal incapacity for sustained attention.” He argued that such behavior could be explained by “a defect in moral control.”

Still was born in 1868 London, that happening capital of the Victorian universe. He attended Cambridge; was fluent in Greek, Latin, Hebrew, and Arabic; professed a hobby of reading ancient texts in their original languages; and was knighted. He is considered the father of English pediatrics, the first to define and categorize a host of juvenile ailments, including a form of arthritis that bears his name: Still’s disease. And while he was no doubt a product of his time and place, his ethical wording tends to provoke a complaint common against doctors in general: their failure to see illness—its suffering—from the perspective of the person actually being diagnosed.

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In the spring of 1985, after the initial medical tests, my pediatrician, Dr. Atkinson, ordered a round of evaluations at Stanford University Medical Center, a kind of group therapy that I remember, most strikingly, for its pair of note-taking doctors.

These psychiatric professionals were charged with assessing my behavior. During hour-long sessions I was kept in a pen with two other children—an asphalt outdoor playground with a high chain-link fence. We were all five years old. The boy had an enormous head, his teeth were spaced unnaturally, and he wore heavy black glasses that never fell from his face, even though he couldn’t stop moving, much less yelling. In contrast, the girl hardly ever spoke. She was small and frail; whenever I talked to her she'd gaze at my knees or at something behind me, her eyes surfacing as if through water. At the time I didn't understand any of it—especially why I'd been grouped together with them—and each new session began to feel like a mistake: soon enough the people in charge would come to their senses and realize I shouldn't be here.

These sessions lasted for about two months. On one of the last afternoons I was standing against the fence when the boy sprinted past me, heading for the girl who'd been trying, delicately, to pedal a tricycle. He grabbed the tricycle and lifted it upward, spilling her onto the blacktop. Then he leapt against the fence and began to shout.

Both doctors quickly intervened, one leading the girl inside. The other, writing on his yellow legal pad, turned to me and said, without looking up, "Timothy, would you like a turn on the tricycle?"

The tricycle was my favorite object on the playground. He knew this, of course. It was the other boy's favorite, too. Whenever things got dull, the tricycle tended to appear. But I couldn't move from the fence. The doctor kept scribbling. The boy hadn't stopped shouting. The second doctor emerged from the entrance, her eyes narrowed, keenly, on me. It was as if she could draw out and study my most alien aspect. I knew it had to do with my tantrums, and then I realized that both of these adults were waiting for me to throw one; they were betraying me. In the distance the tricycle gleamed. I was overcome with helplessness, the way I always was right before a tantrum.

Just then the session ended. My mother arrived, smiling. (They had asked her not to stay and watch.) She was always happy to see me, but this time I couldn't look at her. In the car she kept asking me how it went. I nodded, then shook my head.

"Are you hungry?" she said. "Should we stop for ice cream? Do you feel hot? Can you please tell me what's wrong?"

"What's happening?" I finally asked. "Am I sick?"

She was trying to keep her eyes on the road. "Honey," she replied. "Why would you say that?"

»

The therapy sessions ended the summer I turned six; I was about to be diagnosed and treated for the first time. Just before that I spent a weekend afternoon at a friend's house. Tony Androcetti was a boy from an Italian family very much like my own. He was dark-haired and quiet. His parents were older. We were in the backyard playing a game with a metal baseball bat: one of us would spin around, holding the bat at arm's length, before toppling to the ground. I loved it—the momentum, the dizziness, the object itself, the pine tar along the handle. During Tony's turns I would circle at an unsafe distance, wanting, even though I knew better, to reach out and snatch the bat away.

Then it was my turn. I twirled, giggling, and fell backward. But suddenly my hand was empty. The world was swooning. I couldn't stand. There was a sound like the far-off call of a siren. It was Tony, a few feet away, his hands against his face. He pulled them aside. His right cheek, just below the eye, was already blue and swollen.

I ran inside, feeling dizziness, adrenaline; for a moment I was worried I might be having a new kind of tantrum. I found Tony's mother watching television in the living room. Libby: she wore the eyeliner and red lipstick of a woman from a department store.

“Come outside!” I yelled, and she followed me.

In the backyard, Tony was sitting up, his cheek purpled, the bat alongside him. She ran across the lawn and cradled her son. Then she looked up at me and shouted, “What the fuck is wrong with you?”

I sat down in the grass next to the bat. I was waiting for a tantrum like a storm on the horizon, large enough to flood out the afternoon. But as Tony’s mother lifted him up and retreated inside, the world didn’t drain of color.

From the house I could hear shouts, a choked sob. It had been an accident, of course, something I understood even then. Up until that point, the tantrums had felt like accidents too, arriving and departing beyond my control. They’d been occurring regularly enough, perhaps once a month, each a bit less intense than the one preceding, or so it seemed. I hated them and was always confused as to what had brought them on. But this time, when Libby said, “What the fuck is wrong with you?” I could no longer separate my actions, purposeful or not—good or bad—from the thing that defined me. I was crushed. What was wrong?

»

In the same 1902 presentation on hyperactive children at London’s Royal College of Physicians, Dr. George Frederic Still, bless his cape-wearing heart, tried to walk the line.

“There is a defect of moral consciousness which cannot be accounted for by any fault of environment,” he said.

He argued that the origins of hyperactivity stemmed from a lack of “volitional inhibition.” Kids acted this way because they didn’t have the willpower to be good. He went on to suggest that this limitation might be rooted in biological causes. Like many of his contemporaries, the good doctor was a social Darwinist; he believed that lower classes and racial minorities were inferior, physically, to those of more civilized breeding—someone who could speak five languages, for example. In Still’s view, moral control represented “the highest and latest product of mental evolution”: a trait that hadn’t developed in impoverished children, not to mention all those bothersome savages the empire had yet to enlighten. He noted the physical abnormalities of a number of his patients: large head sizes and compulsive ticks that he referred to as “the stigmata of degeneration.” In the end he theorized that the problem was centered in the brain; these children were developmentally impaired because of their inferior breeding or because they had suffered “nerve-cell alteration” through some past trauma.

Let me say this about George F. Still: His outlook was regrettable. In his robed portraits, his face was that of a leering uncle. But he does seem to have stumbled in the direction of a more scientific explanation for what we now call ADHD.

At the time, Sigmund Freud’s theories of mental illness were in ascendancy. The ego, the unconscious, neurosis, repression, and a multitude of complexes were meant to explain our actions in an environmental light; Freud believed that the root cause of a behavior such as hyperactivity resided within the mystery of human experience, as opposed to the physical structure of the equally mysterious organ tasked with processing it.

Still’s theory on physical causes represented a fresh starting point for future researchers. The encephalitis epidemic of 1918 offered additional evidence: children who managed to survive the disease—their brains swelling horrifically—exhibited many of the symptoms he'd outlined, along with a host of others. Further support was provided by frontal lobe ablation studies: observations of monkeys with lesions along these hemispheres. Researchers began developing the link between behavior and biology. In 1947, Dr. Alfred Strauss, a psychiatrist and neuroscientist working in Racine, Wisconsin, identified hyperactivity as one of the most prominent symptoms of children who'd suffered documented damage to their brains; as for all other cases of hyperactivity—i.e., those lacking documentation—he claimed that such behavior could be the result of minimal brain damage (MBD, also known as "minimal brain dysfunction"), which was undetectable with certain instruments at his disposal. This was perhaps the first official term to describe hyperactive children.

With MBD, the brain of the hyperactive child is seen as a static thing, broken at some point in the past and incapable of developing in any measurable capacity. The therapeutic goal becomes the management of immediate surroundings. Which makes MBD a prognosis in the strictest sense: a prediction of how things will go. It's as if the problematic behavior was sunk into a child's very core, where biology meets personality: identity beyond repair.

Today we know that the millions of American children diagnosed with ADHD did not contract it as a result of blows to the head. In Dr. Alfred Strauss's time, brain damage was thought to be a much more unified concept—one with overarching symptoms, the most common of which was considered hyperactivity.

»

The summer I turned six, Dr. Atkinson completed his series of tests. Then he referred me to a psychiatrist in Los Gatos for a final evaluation. Dr. Frank Smythe—a skinny man in his sixties—was, in my mother's words, "the biggest asshole ever." She couldn't stand the way he talked down to her. Local psychologists didn't like working with him either because he never incorporated anyone else's behavioral input. Briefly, he examined me. Then he offered his diagnosis: In 1985, more than half a century removed from encephalitis epidemics and ablation studies, this man told my mother that I was suffering from minimal brain damage.

She didn't freak out, as I'd like to imagine, didn't pull at her hair and shout, Not Timmy's brain! She knew enough already to ignore what the term implied: that I was suffering from some trauma inflicted on my frontal lobes. And while it was absurd of Smythe to use the term, older doctors at the time would still employ it as a catchall description for hyperactivity, in the way that ADD is now often used in place of ADHD, despite the fact that Strauss's theory had long since been debunked.

Throughout the 1960s, tension persisted between the organic and environmental explanations for ADHD; meanwhile, medical research looked for causes within the brain's structure and nervous system. The second edition of the DSM labeled it "Hyperkinetic Reaction of Childhood," a term that implied familial and social causes. Then in 1980, the DSM-III—a revolutionary document in the world of psychiatry—helped solidify the long-developing view that the causes of mental suffering could reside, at least in part, within the human body's chemistry.

Hyperactivity was completely reclassified as a subtype under the newly coined (and since revised) Attention Deficit Disorder. Additional diagnostic criteria were provided—a detailed, categorical approach that could be employed by all levels of medical professionals, including pediatricians. As a result, funding for research increased dramatically; now doctors had a more coherent framework in which to recognize and treat the symptoms, though how they utilized such information was another matter entirely.

Dr. Smythe had a treatment in mind, but first he wanted to run one more test: a sleep-deprived electroencephalogram (EEG) to measure brain patterns. My parents were tasked with keeping me awake an entire night. I still remember their extraordinary proclamation: No bedtime! I thought of it then as a reward, even though I couldn't figure out what I'd done to deserve it.

The night started off well enough. My father had recently purchased a VCR, promoting its life-changing applications to anyone who would listen ("Hey Timmo, now you can watch Scooby-Doo whenever you want!"). So he rented movies and invited over his best friend, Carlo Silvera, who'd played baseball and football with him at Santa Clara. Carlo was Catholic, from a Portuguese family and, as my mother always liked to point out, was raised by women; she enjoyed his careful but no less emotional perspective on life.

We ate a large dinner. My sister fell asleep. I snacked on candy. My father drank beer. Around eight my mother went to bed; she'd take the late shift. By eleven I was nodding off. More candy. Movies ran in a continuous flicker. Then jumping jacks, twenty questions, even a game of tag. Soon enough I was being shaken awake at intervals by my father, a sensation like falling through the heft of the world, then being yanked all the way back to a life that, until then, had been delicately, if inelegantly designed. And I was overcome by the same emotion I'd felt on the Stanford playground: once again the known universe had reversed itself, except this time it was instigated by the people I knew best, which heightened the sense of betrayal.

"I want to go to sleep," I said to my father.

His eyes were heavy, blinking, the television a distant murmur. "What?"

"Daddy."

"Yeah."

"Am I in trouble? Are you mad at me?"

He looked up from the TV. "Say that again?"

"Please!" I stomped my foot. My wrist caught a beer bottle. It clinked against another and another until one fell to the floor and shattered.

My father jumped up. So did Carlo Silvera.

"Why don't I take him outside for a bit?" Carlo said.

Just then my mother emerged in the kitchen light, her nightgown an unearthly yellow. I knew what was about to happen. Desperately, I wanted to apologize—for the broken glass, my attitude, the tantrums in general. Even then my concept of right and wrong had a distinctly Catholic slant, something I'd gleaned from Sunday school. If only my parents would yell at me instead of each other, everything could go back to normal.

She glanced at the bottles on the counter. "How many beers have you had?"

"Not enough?" My father smiled at his own joke.

"You're so drunk you're breaking things?"

“Go back to bed,” he said. “We’re handling it.”

“I can see that.”

He pointed at her. “Go back to bed!”

In the next moment they both started shouting, each finding fault with the other’s approach to the problem—me—while Carlo picked me up and headed out the front door. I wanted to run in between them and yell, “Look!” And somehow reveal the boy I really was. Maybe then they’d stop trying so hard to fix me. But Carlo and I were already moving toward the sidewalk. The horizon was distant, its arch of lights: downtown San Jose, the mountains beyond. I’d never been outside so late at night.

“When I was your age,” Carlo said calmly, setting me down, “I used to climb onto the roof of our house. Have I ever told you about that?”

He’d grown up only a few miles north of here. His father was a boxer who died young from brain damage inflicted in the ring. Carlo was raised by his mother and Portuguese grandmother, who were even more emotional than my Italian relatives. As a child he was willful. So were the women in charge. When the fights got really bad—everyone shouting, crying—he’d simply crawl out the window and spend the night on the roof where the women couldn’t reach him.

“In the morning when I came down, they acted like nothing happened,” he said.

I was walking alongside him, listening, barely awake. Then I heard my name. “Timmy.” We turned around. My mother was standing outside in her nightgown, calling us both.

The next morning, we arrived at our local hospital just as the sun was coming up. I hadn’t slept. I was, to put it mildly, a mess. My mother no longer remembers Smythe’s explanation for ordering the test. It was probably an attempt to eliminate any remaining possibility of epilepsy, but she thinks that he was actually looking to confirm his diagnosis that I had a damaged brain—which is how she explained it to me at the time, in a watered-down version, of course.

I was taken into a white room. The EEG scanner sat in the corner.

“I don’t like that thing,” I said.

The nurse planted sensors along my scalp and across my forehead and temples, the wires trailing back to the machine.

I turned to my mother and said, “It’s going to read my mind.”

“Timmy!”

“Turn it off,” I told her.

“Honey, everything’s okay. It’s just a test.”

She patted me on the back and began to sing softly. And then I saw myself from a distance: a small, scrutinized shadow. Something oily was being hooked and drawn out of my chest.

I opened my eyes, blinking. There was nothing I could do; the machine was ruthless. It was looking into the deepest part of me. And I understood the message being transmitted along the veil of wires, spoken as if in my own tongue: I am evil.

»

If we’ve spent the last hundred years working toward a medical model of mental illness, where, exactly, have we arrived with ADHD?

Technology has helped to sketch a crude map. Thanks to advanced forms of neuroimaging, we have a better idea about which regions of the brain influence hyperactivity: the prefrontal cortices, the structure responsible for big-picture stuff; the basal ganglia, its subcortical weave housing our comprehension of consequences and our impulsivity, along with the ability to interrupt behavior like a tantrum; then the corpus callosum, a ribbon of thick fibers connecting the hemispheres; and finally the cerebellum, involved in among other things timing, patience, and the ability to learn from mistakes.

However, a complex behavior such as hyperactivity does not originate in a single region but rather in how those regions interact, their communication facilitated by neurotransmitters like dopamine, serotonin, and norepinephrine. The brain, in its assemblage of clearly labeled destinations, is much better characterized as the result of its own multiple pathways. Such combinations are finite but at times our most essential organ can seem like the perfect paradox: too intricate, perhaps, to perceive the extent of its own intricacy.

But over the last two decades, studies have begun to show disparities in both structure and transport. Dr. F. Xavier Castellanos has found that in ADHD children overall brain volume is less, by about 5 percent, a reduction that increases to 10–12 percent within key structures like the prefrontal cortices, basal ganglia, and the center of the cerebellum. There’s also a deficit in communication: how neurotransmitters are used and stored, especially dopamine, which is thought to modulate the complex circuits of reward-response behavior. So while the brain is constantly changing, and a toddler can seem hyperactive and inattentive compared to a six-year-old, and a teenager compared to an adult, certain vital pathways appear to be developing at a slower rate in children with ADHD.

Two decades of research by the Harvard Medical School psychologists Stephen V. Faraone and Joseph Biederman, including an analysis of over twenty previous studies of twins with ADHD, show that the disorder is overwhelmingly inherited—nearly 80 percent, which is greater than most forms of mental illness.

“For comparison,” Dr. Russell A. Barkley writes, “consider that this figure rivals that for the role of genetics in human height.”

Which is not surprising—after all, the development of the brain, like eye color, ear size, or the inglorious hook of a nose, follows a template established the moment we first become ourselves. The pertinent genes are thought to govern neurotransmitters: their transport, reuptake, and creation in key areas of the brain. And yet, unlike Down syndrome or Huntington’s disease, where the cause can be tested, the genetic origins of ADHD may never be isolated in a single source. As with all neural mechanics, the triggering mechanism is interaction. It’s called the G x E effect: the complex exchange between our genes and the environment.

Which gives way to the non-biological aspect of the equation.

“These types of genetic influences on ADHD are probabilistic, not deterministic,” Dr. Joel T. Nigg writes.

Our brains develop along a genetic blueprint, but they can also change shape according to the events they're processing. To quote a common metaphor: Biology loads the gun, environment pulls the trigger. Or, as the developmental neuropsychologist Dr. Bruce F. Pennington states, "We do not have evidence that the social environment in general, or parenting practices in particular, can directly cause ADHD. At the same time, there is no doubt that the social environment influences the course of ADHD—especially whether ADHD develops into another disruptive behavior disorder, such as conduct disorder."

So the G x E interaction helps explain most cases—but not all. The remainder fall perilously close to earlier misconceptions, and allow us now, from the enlightenment of our contemporary perch, to offer a begrudging shout-out to Still, Strauss, and all the rest of those dead white doctors who spent their days slicing ever so thinly the organic roots of ADHD: up to 20 percent of children suffering from the disorder may have acquired their symptoms from external issues like low birth weight, maternal smoking, fetal alcohol syndrome, lead exposure, and, in some rare cases, head injury.

Is it enough, then, to say that hyperactivity is the result of a genetic predisposition that's influenced, but not caused, by the environments we find ourselves growing up in? It makes sense on an intuitive level: all you have to do is gaze up at the many branches of your family tree. Mine? The uncles in legal trouble; cousins struggling to finish high school; a whole host of athletes, blue-collar workers, and salesmen. They are not simply the byproducts of social factors; they share personality traits—engaging, impulsive, unpretentious, and mildly manic—that have been carried forward for generations.

»

After my sleepless night's EEG, Dr. Smythe prescribed five milligrams of methylphenidate—Ritalin. Dr. Atkinson would oversee its administration. My mother had heard about the drug; she thought it was a new approach to treating hyperactivity, but she was hesitant to put me on it. She was worried about my response to drugs in general, a sensitivity she shares. Already I'd had a paradoxical reaction to the over-the-counter antihistamine Benadryl; when she gave it to me for a cold, I spent hours jumping around my room, even though the main side effect is drowsiness. I also broke out in hives after taking the antibiotic amoxicillin. And these were familiar drugs. She'd never had any experience with Ritalin. The whole idea confused her.

"Why would a child who can't sit still become calmer on a stimulant?" she asked Smythe.

He explained something about "contraindications" and moved on.

Eventually, despite their reservations, she and my father agreed to try it.

During the first week I was kept at home. Outside of day care—the structure, its demands—it was difficult to tell just how well the Ritalin was working. But every evening, I became extremely irritated, refusing even the simplest requests. After a few days my mother called Dr. Atkinson's office. He said it was a rebound effect: the suppressed symptoms were returning more forcefully as the drug left my system. He compared it to how people tend to feel tired when the sugar or caffeine they've ingested wears off.

On the fifth day—with my father at work and my two-year-old sister playing in her bedroom—my mother asked me to come to the dinner table. I wanted to finish the television show I was watching. I wasn't hungry.

"Leave me alone," I told her. She spoke softly, counting to three. "Shut up!" I shouted. She reached down. I began to scream, writhe. I probably weighed about forty-five pounds, small enough to be subdued. But I jumped to my feet and darted from the room. She found me at the silverware drawer, grabbing a butter knife.

My mother approached from behind. I wheeled around. She stopped. I placed the knife against my wrist.

“I’m going to kill myself,” I said.

In the next instant my mother wrapped her arms around me. She held on until I stopped struggling. Then she called Dr. Atkinson and left a frantic message. She also called Dr. Smythe. His receptionist took her information. And she waited.

»

How would you respond if your own son, in the midst of taking a stimulant for hyperactivity, told you he was going to kill himself? Ritalin may be the catalyst, but in what sense? Could it be a matter of dosage—the “rebound” effect exacerbated in some extreme manner? How does a six-year-old even know about suicide?

My mother says I looked like a robot. As I stood in the kitchen with the butter knife at my wrist, my eyes were blank, my body rigid. This was nothing like the previous tantrums—it wasn’t me—and she recognized the difference.

The next day we drove to Dr. Atkinson’s office. Dr. Smythe had still refused to call her back, claiming through his secretary that such issues should be dealt with by her pediatrician. In fact, my mother never spoke to him again.

Dr. Atkinson gave me a brief physical examination—tapped knees, a light to the eyes, ears, some hearty coughs. Afterward I sat in an adjoining waiting room that always smelled like suntan lotion, no matter the season.

“Okay,” my mother said to the doctor once I was out of earshot. “Tell me why this happened.”

Dr. Atkinson began explaining the “rebound” issue again: how my reaction, in this context, was normal enough.

“You think a six-year-old threatening to kill himself is normal?” she said.

He asked if she might want to keep her voice down. A number of variables could have led to my behavior, and the worst thing she could do now, he said, was to abandon the course of treatment they’d spent so long preparing.

“Are you kidding me?” she said.

He wanted to try a lower dosage. Maybe breaking the pill in two and taking it at intervals would soften the impact. If this didn’t work there was also Dexedrine: an amphetamine that was supposed to last longer than Ritalin.

“No,” she told him. “He’s not some guinea pig.”

“His problems aren’t simply going to disappear,” he replied.

She stood up to leave. And with a flourish, she turned to Dr. Atkinson and asked, “Have you been listening to a word I’ve said?”

Let me say this about my suicide threat: it’s a blank spot. When I was told about it the next day, I don’t think I understood what I had done or what it meant. I do remember the uneasiness in my father’s voice when he sat down to talk to me about it, but, try as I might, I can’t recall the emotion. It lacks shape; unlike the earlier tantrums, there’s no point of departure, no return. To tell you the truth, in the aftermath of the incident I remember feeling better, which had everything to do with my mother. Somehow she had managed, in the brilliant way that parents have of stabilizing the world, to make me believe that Ritalin was to blame—for all of it.

»

The following week, we stayed home together, my mother and me. My sister was at day care, my father working. I remember it like a vacation. Something had gone wrong. We’d tried to fix it. But it had made whatever was wrong worse. Now we weren’t doing anything at all: no more doctors, tests, therapy, pills—even the variable of preschool had been removed. In the mornings we’d watch cartoons together, eat cereal, build forts, and fill in coloring books. My mother would tell lengthy, imaginative stories. In the afternoons, following a nap, we’d walk outside and pick dandelions from the heated sidewalk. It was as if we’d struck a truce: there were still skirmishes over minor issues—nap time, dessert, television—but really, for this one week, I could do whatever I wanted.

It was the end of August. I was about to start kindergarten at St. Lucy’s, a Catholic school five miles up the freeway from our house. My mother needed to get back to work; we missed the money from her retail job. I knew it was temporary, that my problems weren’t magically cured. The EEG scan had been the climax: the evil logic of clenched hands, grating teeth, profound and irredeemable in the most simplistic way—something that even for a six-year-old was more comprehensible than you might imagine.

On one of our last afternoons together, we were still wearing our pajamas, an extravagance allowed after my nap. The summer light was shadowed in clear shapes along the carpet. The radio was playing a Madonna song, “Lucky Star,” just as my father was coming home from work, carrying my sister; he looked up to discover me and my mother in the living room, dancing. My sister screeched, struggling to join us. It felt spontaneous; I hadn’t even realized how much fun we were having until that moment. And as the lyrics rose precipitously my mother flashed an enormous smile, a gesture for my father, for all of us.

“Patty?” he said. Madonna’s childlike, theatrical voice. My mother clapping to the beat.

Finally my father smiled. He swung my sister, offered me a high five. When the song was over, we followed my mother into the kitchen and, just like any other night, we ate dinner together as a family.

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