Research Commentary Point-Counterpoint: Diagnosis of Giftedness and ADHD

Giftedness, ADHD, and Overexcitabilities: *The Possibilities of Misinformation*

Elizabeth Mika

This article is a response to a study "Gifted or ADHD? The Possibilities of Misdiagnosis," by D. Niall Hartnett, Jason Nelson, and Anne Rinn. A critique of the authors' claim about misdiagnosis of gifted children with ADHD, as well as their experiment and conclusions, is presented. The paper disputes an idea, prevalent in the gifted education field, that gifted children are misdiagnosed with ADHD, and points out that there is no reliable evidence of such a trend. The concept of overexcitability in its original meaning and clinical manifestations, as described by Kazimierz Dabrowski, provides a different perspective on ADHD and giftedness than that given by Hartnett et al., and common in the gifted field.

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The authors of an article published in the Winter 2004 issue of *Roeper Review—Gifted or ADHD? The Possibilities of Misdiagnosis* (Hartnett, Nelson, and Rinn) presented a study on the capacity of counseling students to differentiate between ADHD and giftedness based on a short description of a child's classroom behavior. The impetus for their inquiry has been a purported misdiagnosis of gifted children as suffering from ADHD—a phenomenon described as frequent by some experts in the field of gifted education. The authors quoted James Webb, "Some gifted children surely do suffer from ADHD, and thus have a dual diagnosis of gifted and ADHD; but in my opinion, most are not" (cited in Hartnett et al., p. 74). They continued with a quote from Baum and Olenchak, "There is little doubt that in at least some cases, students of high ability are being 'cured of their giftedness' in an exchange for controlled, compliant behavior" (cited on p. 74).

First, it is important to note that these experts' opinions are not supported by empirical evidence, whether research data or clinical examples. Their statements are opinions only, and as valuable as they may be, they should not be a substitute for facts.

Hartnett et al. (2004) admitted that there is no empirical evidence proving the existence of the problem of misdiagnosis of giftedness for ADHD, but that did not stop them from issuing warnings of such misdiagnoses' consequences:

> Diagnosing children with ADHD when they are truly gifted also leads to inappropriate treatment. It is very common to provide stimulant medication for ADHD. There is some evidence that such medication can impair cognitive performance (Cantwell). In addition, stimulant medication can have negative side effects, including appetite suppression, insomnia, irritability, anxiety, sadness and nightmares (Efron, Jarman and Barker). It seems unconscionable for gifted children to unnecessarily experience such negative effects from stimulant medication. (p.74)

One can sympathize with the authors' concern: indeed, unnecessary suffering of the kind described here, related to being needlessly medicated, is unconscionable for any child, gifted or not. However, let us remember that there is no evidence that: (a) gifted children are misdiagnosed as ADHD; (b) gifted children misdiagnosed with ADHD are unnecessarily medicated; and (c) gifted children misdiagnosed as ADHD, and medicated as a result, experience negative effects from stimulant medication. So, thankfully, we do not have to share the authors' worries about hypothetical dangers of nonexistent problems. Or do we....

The Experiment and Its Curious Interpretation

Even though there is no data showing that misdiagnosing giftedness as ADHD has ever taken place, the authors took on the challenge to prove such a possibility. To do this, they devised an experiment, in which they enrolled 44 first-year graduate students from a counseling program, whom they presented with the following vignette describing a child's classroom behavior:

> Sam is 7 years old and a second grader. He has been referred to you for assessment by his teacher. He has a high activity level and appears more restless than other children his age. Sam has difficulty restraining his desire to talk in the classroom and interrupts his teacher often. The teacher has repeatedly tried to change Sam's behavior, but Sam questions authority and has a difficult time accepting rules and regulations. Sam's homework is frequently messy because he appears careless or inattentive to details. Sam has a poor attention span, especially when he is bored. Sam's home environment appears to be normal. (Hartnett et al., 2004, p. 75)

The subjects each were randomly presented with two responding options: Form A and B. Form A asked: "If this child were referred to you by his teacher for evaluation, what do you think the underlying explanation for his behavior would be?" Form B asked, "Do you think the cause of his

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behavior could be attributed to ADHD or due to his being gifted and talented?" (Hartnett et al., p. 75).

The authors found out that a majority of responders with the unbiased option (Form A) chose ADHD as the preferred diagnosis; while introducing the possibility of giftedness swayed the opinion of about half of the responders from the control group—the biased option B—toward recognizing giftedness as a main or contributing reason for Sam's behavior. The authors then go on, summarizing their findings in this, rather curious, conclusion:

> Without suggestion of the possibility of giftedness, the future counselors appeared unaware of the similar behaviors of children with ADHD and gifted children.... The reasons are unclear as to why no participants in the unbiased condition considered the possibility of giftedness.... Because ADHD is currently a popular diagnosis, the judgment of participants not receiving suggestion may have been overridden by this popularity in the face of no other obvious alternative. (Hartnett et al., p. 76)

What is stunning about the interpretation of the data obtained in this experiment is the very apparent omission of the most obvious explanation—that the unbiased diagnosis arrived at by members of the experimental group was the accurate one; but the diagnosis of giftedness, given by some of the control group members influenced by a suggestion presented in the Form B, was "not at all" supported by facts (i.e., presented symptoms) and was, in fact, at best incomplete, and at worst erroneous in light of the available data. By making this omission, the article's authors indeed showed the power of suggestion unsupported by facts in the process of clinical diagnosis among beginning diagnosticians. This was their intention to begin with, however mistaken their interpretation of this finding. And by doing so, they inadvertently showed perhaps the main reason why the misconceptions about giftedness and ADHD persist in the field of gifted education and counseling. That is exactly the power of biased suggestion unsupported by data.

There is no evidence of giftedness in the vignette describing Sam's behavior. There is, however, evidence of hyperactivity, poor impulse control, inattentiveness, carelessness, and oppositional behavior manifested in unwillingness or inability to follow rules. Are any of these behaviors signs of giftedness? Hardly. They all are consistent with a cluster of symptoms characteristic for ADHD, however; though, obviously, more information, including Sam's behavior in various situations, his health, developmental and family history, etc., would be needed to make an appropriate diagnosis.

Sam's symptoms can be suggestive of many other psychological problems, most notably mood disorders, sensory integration difficulties, and learning disabilities. The vignette does not contain enough information for a diagnostician to make a correct judgment; but the information it does present suggests a strong possibility of ADHD, and none of giftedness.

Of course, one could argue that questioning authority and rejecting rules and regulations could be a possible sign of giftedness. This argument may have a tiny kernel of truth in it, but only a tiny one. The tendency to question authority and societal regulations can be associated with positive maladjustment observed in many gifted individuals; but it can as easily, if not more so, be a sign of either low intelligence, and/or impulsive and thoughtless contrariness. We can suspect that the piece of information on Sam's poor attention span was also included to hint at giftedness; but being inattentive when bored in itself is neither ADHD nor gifted. It is simply being human. The characteristic of being frequently inattentive, however, combined with poor impulse control, is one of the chief symptoms of ADHD, but not giftedness.

What's truly surprising (or perhaps not) is that, in spite of a total absence of any signs of giftedness in the description of Sam's behavior, some respondents in the control group chose giftedness as a possible root of Sam's difficulties, merely upon a suggestion. This is indeed a surprising and discomforting finding, and for reasons contrary to those presented by the authors. Since the information about Sam's symptoms, although highly suggestive of ADHD, was insufficient to form a diagnosis, the respondents in the control group felt, rightly, that conditions other than ADHD could have been their cause. But the only other clear choice they were presented with, apart from the most obvious ADHD, was giftedness.

Is it a surprise then, that when presented with relatively ambiguous information in the light of outside suggestion, the responders were less certain about their diagnosis? Not at all, and the authors quote research that further explains this phenomenon while curiously undermining their own findings. Had the controls been offered another alternative cause of Sam's symptoms, let's say a purely hypothetical condition of PSMD (Pervasive School Maladjustment Disorder), and don't look for it in the DSM (Diagnostic Statistical Manual), chances are they would have been swayed toward this diagnosis. Or they may have been swayed by any other one, whether probable or not, offered by the researchers, perhaps including even absurd ones. After all, we have seen that the absence of crucial diagnostic criteria of a condition, in this case giftedness, does not preclude its diagnosis. It is indeed discomforting.

Imagine an experiment, in which subjects would be presented with a description of a child (or adult) suffering from bipolar disorder (BD). There is considerable evidence showing a correlation between bipolar illness and artistic abilities (Jamison, 1993). Based on a description of behaviors characteristic for individuals afflicted with BD, would we be able to conclude that the person in question was an artist? Surely not, if there was no evidence of artistic talent and/or activity in his/her behavior. Even though many artists suffer from BD, bipolar disorder does not make one an artist. Just like being afflicted with ADHD, or exhibiting ADHD-like symptoms, does not make one gifted.

In all fairness, the authors should be commended for taking up a discussion on such a confusing topic; but it appears, unfortunately, that their work contributes more to the confusion rather than dispels it. The goal of the article and the study is commendable; however, the theoretical bases and clinical conclusions of the authors' reasoning are flawed, rendering their study inadequate in confirming or disproving their initial hypothesis. In fact, the study proves, contrary to the authors' conclusion, that a largely intuitive and unbiased clinical judgment of a significant portion of the study's participants tends to be correct. What's more, the authors have proven, unintentionally again, the power of suggestion, unsupported by facts, in creating the unnecessarily confusing views about the relationship between giftedness and ADHD.

This conclusion about the power of biased suggestion in creating the myth of giftedness misdiagnosed as ADHD brings us to the review of literature that the authors used as the basis for their reasoning and their experiment.

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Gifted or ADHD? Or Neither? Or Both?

The authors say "Children with ADHD and children who are gifted often engage in similar behaviors"(Hartnett et al., 2004, p. 73). It could be stated, to increase our diagnostic confusion, that children, and people in general, with and without psychological problems often engage in similar behaviors, a truism that does not really tell us much.

They go on and list those behaviors, citing Webb and Latimer: "Both groups often possess high activity levels, have difficulty paying attention, act without much forethought, experience problems persisting on certain tasks, and have difficulty following rules" (Hartnett et al., 2004, p. 73). But all these behaviors can be found in many, if not most, human beings at certain times. The qualifier "often" is vague enough that it makes this passage useless as a descriptor of either giftedness or ADHD. Regardless of any similarities between giftedness and ADHD, and there is little reliable data showing that such similarities exist, a diagnosis of either is based on differences between the two conditions: differences that are unmistakable and impossible to miss.

For one, to "diagnose" giftedness, we have to be able to observe signs of such. A child we assess should show signs of giftedness, according to any accepted definitions of it, if not only our common sense. Most children tend to "often" (a) have high activity levels (e.g., on field trips, playdates, or Christmas morning), (b) have difficulty paying attention (e.g., at church sermons on Sunday), (c) act without much forethought (e.g., in sibling squabbles over an attractive toy), (d) experience problems persisting on certain tasks (e.g., while writing 20 thank-you notes after their birthday), and (e) have difficulties following rules (e.g., while following parental orders on sharing with the pesky sibling). If you have raised children, you know that these behaviors describe any child of preschool age. None of them tell us anything about a possible ADHD, much less about giftedness. And because these are ubiquitous behaviors, they are not used in making an ADHD diagnosis.

But the authors admit that many of the behaviors of ADHD children and the gifted are similar "only at a gross level" and that they considerably differ in their etiology, since (according to Barkley) "the behaviors of children with ADHD are generally thought to be caused by a neurological abnormality in the prefrontal cortex of the brain and/or neurotransmitter dysfunction" (Hartnett et al., 2004, p. 73).

They go on explaining the more subtle differences, and yet their explanations fail to make the distinctions visible or understandable. They go back to Webb and Latimer, saying that "*gifted students* inattention is usually situation specific while inattention in children with ADHD is pervasive across settings" (Hartnett et al., 2004, p. 74). They continue, stating that DSM-IV-TR requires that symptoms be present in two or more settings for a diagnosis to be made. It is not uncommon for gifted children to have attention problems at school, but none at home (Lind and Silverman), whereas children with ADHD often experience those problems in both settings (Barkley). Clearly, children who are gifted have the ability to maintain attention for long periods of time when they are interested. Lovecky states that this is also the case for some children with ADHD, but that gifted children have far more preferred activities to engage their attention (Hartnett et al.).

There are several problems with the above reasoning. Human attention in general is usually situation specific, regardless of the presence (or absence) of ADHD. All of us, ADHD, gifted, or plain average, have the ability to maintain attention for long periods of time when we are interested. Quite simply, our survival depends on it, since on the very basic level the situations that invariably pique our interest and sustain our attention are emotionally charged events that have the potential to interfere with our basic needs, such as our physical safety. All of us, gifted, ADHD, or plain average, will exhibit excellent attention skills when listening to suspicious sounds suggesting that someone is trying to enter our house at night. Our interest here is a given and so is the ability to sustain our attention on the stimuli for as long as it is necessary.

In addition, individuals diagnosed with ADHD frequently exhibit a tendency to hyperfocus, particularly on activities that require little mental control and provide immediate positive feedback (such as playing video games or watching TV). What they cannot do is voluntarily focus their attention on activities that require effort and sustained mental control, and do not provide instant gratification, even if they are capable of accomplishing the necessary tasks. This leads in ADHD individuals, both gifted and non-gifted, to dissipation of attention, discouragement and easy fatigue when faced with tasks involving sustained mental effort, difficulties with starting and/or finishing such tasks, and subsequent problems with organizing their work and managing their time.

Citing Lovecky, the authors acknowledge that "some" ADHD children "can also focus their attention on their interests, but that gifted children have far more preferred activities to engage their attention" (Hartnett et al., 2004, p. 74). Again, this is not an argument for a differentiation between children with ADHD and gifted children, but at best between ADHD and non-ADHD individuals, gifted or not. In fact, this argument is utterly confusing as a possible ADHD vs. gifted criterion. Imagine a musical prodigy with ADHD who from an early age would be able to focus well on activities related to only one interest, music, and exhibit difficulties paying attention to anything else. Or imagine a budding engineer who can play with Legos for hours without end, yet cannot attend successfully to do much beyond his or her construction play. The list of gifted "monothematic" children goes on and on; in fact, strong preoccupations, bordering on obsessions about one area of interest, are a frequent sign of giftedness in early childhood. So it is possible to have only one strong area of interest and still be gifted, or gifted with ADHD, or only ADHD, or neither. Simply, the number of interests to which one pays attention, tells us nothing about either of the possibilities.

The problem with singling out a child's interest and his or her ability to focus attention on it as a differentiating feature between ADHD and giftedness relates to the next criterion mentioned by the authors: "In addition to inattention, both groups also often exhibit heightened activity levels and impulse control problems. Gifted students' high activity is generally focused and directed (Webb and Latimer), whereas according to Leroux and Levitt-Perlman, the active behavior of a child with ADHD is usually random and not goal-oriented" (Hartnett et al., 2004, p. 74).

Heightened activity levels (hyperactivity) and poor impulse control are among the main symptoms of ADHD. The authors assume that there is an overlap between gifted and ADHD children in the prevalence of these two behavioral traits, presumably on the basis of data included in their primary sources. But there simply is no empirical data to support this assumption.

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There is no reliable evidence that gifted children, by virtue of their giftedness, exhibit the hyperactivity characteristic of ADHD. What is more, the distinction between goal-directed hyperactivity of the gifted and aimless hyperactivity of ADHD children does not withstand scrutiny.

The randomness or goal-directedness of an activity is in the eye of a beholder. How can we tell whether a behavior of a hyperactive child in a school (or any other setting) is goal-directed or not? What we have learned from studying human behavior shows that most behavior is goal-directed, whether its goal is easy to discern for an observer or not. An ADHD (non-gifted) child who gets up in the middle of a lesson or a test to walk around his classroom may behave in a "random" and not goal-directed fashion in the opinion of his or her teacher and some classmates; but this apparently purposeless behavior may be directed toward releasing the anxiety associated with the boring or stressful situation. The puzzling behavior is definitely goal-oriented, even though its goal is unconventional and not aligned with the goals of others in the same setting. Conversely, a gifted ADHD child's hyperactivity manifested in a frantic, but unfinished effort to master the contents of the chemistry textbook, is clearly goal-oriented to an outside observer, yet is not effective. In short, goal-directedness of one's behavior is a poor criterion of differentiating between giftedness and ADHD. The main confusion in this line of reasoning lies in the assumption that both gifted and ADHD children exhibit signs of hyperactive behavior. But high-energy level, seen in some gifted individuals, should not be confused with ADHD symptoms of hyperactivity and poor impulse control, which result in chaotic, ineffective, and often harmful dissipation of energy that makes learning so challenging and completion of mental tasks close to impossible.

ADHD Diagnosis

In order to diagnose a child with ADHD, we have to be able to observe a cluster of at least six behaviors indicating inattentiveness, hyperactivity, and poor impulse control that are developmentally inappropriate (i.e., persist beyond preschool age), are exhibited consistently and for a relatively long period of time in at least two different settings (i.e., school and home for at least six months), and cannot be attributed to any other identifiable stressor (trauma, abuse, etc.) or disorder (depression, bipolar disorder, autism, sensory integration dysfunction, thyroid problems, etc.). What is perhaps most important is that these symptoms have to cause a significant impairment to a child's functioning and/or subjective distress. These are well-established diagnostic criteria that allow a clinician to make a relatively sound judgment, regardless of the variety of views on the etiology and prevalence of ADHD encountered in the literature.

A clinical diagnosis is not based on occasional or even persistent occurrence of a single symptom. It is not enough only to be inattentive in class, or only to show heightened levels of activity, etc., to be diagnosed with ADHD. The diagnostic criteria are quite specific and require that a cluster of severe symptoms co-existing for a long period of time across different settings be present to make a diagnosis of ADHD. Consideration given to the three main features (multiplicity of symptoms, their duration, and severity) is essential in the diagnostic process.

As you see, it would be hard to confuse behaviors classified according to these criteria as signs of giftedness. In fact, none of these behaviors suggests giftedness in itself as they all apply to the area of self-regulation and self-control, traits that do not tell us anything about giftedness or a lack of it.

And let's not forget that in order to "diagnose" giftedness, we have to be able to observe signs of, well, giftedness—whether intellectual, artistic, emotional, spiritual, athletic, or other. This is the crux of differential diagnosis, after all. Many psychological conditions and problems share emotional and behavioral similarities. In order to tell them apart, we focus on differences between them.

DSM-IV and DSM-IV-TR allow for a possibility that gifted children "may" exhibit behaviors of inattentiveness, restlessness, etc., when placed in unstimulating environments. This qualifier, by the way, again applies to many people who are not gifted as well. Whether those children are "only" gifted, or gifted with ADHD is a matter of relatively easy diagnostic judgment. If we apply the ADHD diagnostic criteria, we would see that inattentiveness and restlessness of these children (i.e., gifted and inattentive in unstimulating settings) would be time-limited (i.e., occur after age 6 and possibly, but not necessarily, last less than 6 months) and inconsistently exhibited across different settings (i.e., observed in school and not at home). In addition, if the symptoms of inattentiveness, etc., are the result of a mismatch between a child and his or her learning environment, they should disappear when the environmental conditions are better matched to the child's abilities. And let's not forget that to recognize a child as gifted (whether with ADHD or not), we do have to have evidence of giftedness to begin with. Having delineated the differentiating criteria, we should focus on some reservations.

More on the ADHD Confusion

Here we come to the crux of the confusion about ADHD: the authors and many experts they quote appear to accept a categorical definition of ADHD as "a serious medical condition that can incapacitate a person from functioning at his or her fullest potential" (Hartnett et al., 2004, p. 74). Apart from several semantic problems with this particular sentence, seeing ADHD as a serious medical condition is based on an assumption prevalent among many medically-minded clinicians that this condition, and many other psychiatric disorders, is a separate pathological category rooted in a specific physical or physiological defect—"a neurological abnormality in the prefrontal cortex of the brain and/or neurotransmitter dysfunction" (p. 73). But ADHD, like most psychiatric disorders, is not an "either-or" entity like, for example, Down Syndrome that originates in a chromosomal defect.

ADHD is a disorder of dimension. Human capacity for paying attention and self-regulation in general shows a great variability among individuals. This variability does not yet translate into pathology. All of us can be placed somewhere on the spectrum between perfect self-regulation and no self-regulation; moreover, our capacity to self-regulate may vary throughout our lifespan and depend heavily on the situational factors. It does not yet mean that many of us who are further away on the spectrum from the perfect self-regulation point (if such a point were possible to establish in the first place) suffer from ADHD; and moreover, that this relative weakness in self-regulation is a result of a neurological abnormality or dysfunction.

In fact, there is no conclusive proof that a physical or

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physiological abnormality or dysfunction is the cause of behaviors associated with ADHD. The literature provides examples of studies showing differences in brain functioning between ADHD and non-ADHD individuals, but none of those studies prove a causal relationship between the observed differences and symptoms. In other words, we know that brains of ADHD and non-ADHD individuals differ. We have been able to document it but we do not know whether the observed differences are the cause or the result or just an associated feature of the clinical condition we know as ADHD.

It is possible, as some ADHD experts believe, that ADHD symptoms are a developmental delay arising from a dysfunctional attachment with a primary caregiver in infancy, experienced by individuals who are genetically predisposed to be particularly sensitive (Mate, 1999). Such children suffer from long-standing and persistent difficulties in self-regulation. They do not have an opportunity to develop appropriate self-regulatory skills; and their hyperactive, erratic behavior reflects that neglect. Their neurological functioning, shaped from the very beginning of their lives by anxiety, insecurity, and an associated flood of stress hormones, may be reflected in brain scans as different, as a defect or abnormality. But simply acknowledging the abnormality of the brain scan results does not tell us whether we are observing the cause or the result of ADHD, or perhaps something else.

Research and speculations on the etiology of ADHD will and should continue, but they are not of primary importance to a clinician dealing with suffering caused by the condition. There is no doubt that, regardless of its origin, symptoms of ADHD present a significant developmental challenge for a child as well as his or her parents and educators. When basic attention and self-regulatory skills are very weak or absent, the possibility of learning—the basis of intellectual, emotional, and social development—may be severely compromised. Apart from obvious educational challenges in childhood, the long-term developmental prognosis of ADHD individuals is associated with an increased risk of emotional and behavioral problems such as depression and personality disorders, substance abuse, and patterns of unstable relationships and work history. These are all the good reasons why early symptoms of ADHD should be considered carefully and seriously, and treated with appropriate available interventions, without trying to dismiss them as signs of undefined giftedness.

Overexcitability (OE) or ADHD, or a Difference That Isn't

To support their contention of a possibility of misdiagnosis between ADHD and giftedness, Hartnett et al. (2004) bring in the concept of overexcitability. However, their discussion of psychomotor (PM) overexcitability is based on misinterpretations. In their defense, these misinterpretations are uncritically repeated in the available literature in the field. Judging by the pervasive misinformation in the literature about overexcitability and giftedness, Dabrowski saw psychomotor OE as a somewhat extraordinary trait, associated with giftedness only, as opposed to ADHD, which is just an ordinary pain in the neck afflicting less talented mortals. But it is simply not true. The authors say,

> Piechowski, working from Dabrowski's theory of positive disintegration, argued that children who are gifted may possess "overexcitabilities" in five areas: psychomotor, sensual, intellectual, imaginational, and emotional. Children who are gifted are said to often have intense expressions in these domains and these expressions are thought to indicate advanced development.... Of particular relevance for this discussion are the psychomotor and imaginational overexcitabilities. Psychomotor overexcitability is indicated by behaviors such as rapid speech, impulsive actions, and increased bodily movement, while imaginational overexcitabilities are shown by intense visualization and daydreaming (Piechowski and Colangelo). Citing Cramond, clearly the psychomotor overexcitability of the gifted child could be labeled as "hyperactive" by the observer uninformed of some gifted children's tendencies. The gifted child expressing imaginational overexcitability through daydreaming may look inattentive, but could be using this uninterrupted time to think creatively. (Hartnett et al., 2004, p. 73)

Let's parse this paragraph. The concept of overexcitability—or increased psychic excitability, a.k.a. nervousness—indeed originates with Dabrowski, and plays an essential role in his Theory of Positive Disintegration, which describes human personality development. Overexcitability is a significantly higher than average sensitivity of the nervous system that finds its expression in those five areas mentioned above. According to Dabrowski, OE is one of the essential components of a person's developmental potential, and often, but not always, contributes to accelerated personality development through positive disintegration.

But the sheer intensity of expression, associated with OE is not, and never has been, considered an indication of advanced development. Whether such intensity has a positive developmental value depends on many factors, the most important of which is the constellation of other components of developmental potential.

As the authors continue, they imply a clear distinction between psychomotor OE and hyperactivity of ADHD. But in fact, Dabrowski's views on etiology and symptomatology of psychomotor OE almost completely overlap with our current understanding of ADHD. The term ADHD was non-existent at the time when Dabrowski created his theory. The symptoms he saw as characteristic of psychomotor OE were clustered under names of various conditions describing the same clinical phenomenon.

Psychomotor OE in Dabrowski's view—a view that, by the way, is consistent with the current clinical knowledge—has its possible origins in several sources, including genetic heritability, Fetal Alcohol Syndrome, trauma and abuse, and other biological and environmental factors. When we look at Dabrowski's description of children with psychomotor OE, we can see that he is talking about symptoms of ADHD:

> The real difficulties (for children with psychomotor OE) start with the beginning of formal education. The greatest number of children who obtain bad grades for behavior come from this group. These are the children who fidget in their chairs, disrupt their peers' work, play with pens and notebooks, have thousands of excuses to leave the classroom and show (over)fluctuations in attention. After school, and even during school, they start and lead fights and other physical escapades. Boys, who excel in independence and exhibit tendencies to rebellion at school, are most frequently individuals with psychomotor OE. Their symptoms are particularly strong in adolescence, but they are also abundant in other periods. During this

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time (adolescence) psychomotor OE takes on the form of truancy and wandering. Among children hanging from the back of a tram, among those who sell newspapers, tramps or those who travel without a ticket, we meet primarily these types. In schoolwork and adult employment these individuals are characterized by unevenness or breaks in the work patterns. There are periods of great intensity of work; in some we find shorter or longer weakening of ability to work. These individuals are incapable of sustained effort, and are explosive at their workplace. Their work interests diverge in many different directions; we often see frequent changes from one job or subject to another. In youth, we see tendencies to change schools, in young adults—jobs. (1964, p. 76)

There is little in the above description indicating that giftedness is associated with symptoms of psychomotor OE itself. Psychomotor OE, like all OEs, has a potential to contribute to personality development, if and only if it co-exists with other components of developmental potential, namely high intelligence, special talents, and other types and forms of OE. Moreover, Dabrowski stressed that psychomotor OE, to have positive developmental value, must be subsumed under the guiding forces of emotional, intellectual, and imaginational OE.

When occurring by itself, or in less desirable developmental combinations (such as high PM and sensual OE, and little or no emotional and intellectual OE; low intelligence; etc.), psychomotor OE leads to negative developmental outcomes. The combination of high sensual and psychomotor OE, at any level of intelligence, is frequently found in individuals diagnosed with psychopathy, for example.

Glamorizing Trouble

There are undiagnosed gifted children suffering from ADHD who would benefit from appropriate treatment including medication, if necessary. They are not helped when their parents and some professionals believe that their ADD/ADHD symptoms are expressions of their giftedness.

Such unfortunate beliefs, not supported by solid data, reflect a tendency to glamorize pathology. This is an exaggerated reaction to its opposite—pathologizing exceptionalities, which is something also encountered in clinical practice. Since we still do not know much about origins and connections between both abnormality and exceptionality we sometimes tend to fall into extremes when assessing either. But glamorizing pathology—and that includes perpetuating a sanitized version of OE, plus the myth of misdiagnosis of giftedness and ADHD—is as unhelpful as its opposite, and contradicts our clinical experience and knowledge.

We know and can see that not much creativity, in most domains of human activity, can take place if one cannot focus well enough to learn, or is unable to complete his or her basic tasks, or sit still for long enough to do so. There are variants and degrees of impairment associated with attention deficit syndrome(s); and according to a type and severity of symptoms, different compensation and treatment strategies can be used. The need for medical and other helpful intervention depends on both subjective and objective criteria of impairment. If, for example, a child suffers "only" from inability to concentrate, which makes him or her unhappy and tense, even if it does not significantly disrupt his or her daily life, we need to be able to provide him or her with appropriate help, and not deny the existence of subjective suffering, or attribute it to giftedness. Such attribution is unhelpful, as it is based on the myth of pervasive confusion between giftedness and ADHD: a myth that should be put to rest.

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