The Royal Australasian College of Physicians

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Draft "Guidelines on Attention Deficit Hyperactivity Disorder (ADHD) Project Scope and Literature Review"

Feedback Template

In your submission please note the relevant page number/s that contain the issues on which you are providing comment. Please also provide complete references for any research articles you deem relevant that may not have been considered in the development of the guidelines. All comments will be considered by the RACP.

Closing Date for Comments: 23 November 2007, 5pm AEST

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Specific Comments

Chapter	Sub-Chapter	Page number	Comments
		p 185.	Green S A., Bloch S. *An Anthology of Psychiatric Ethics*. Oxford University, 2006.
Introduction Part 2, Part 3	**Child & Adol. Symptom Patterns – SCA Axis Overview of Empirical support for DSM**	**3, 270-2, 675-9**	PDM Task Force. *Psychodynamic Diagnostic Manual*. Silver Spring, MD: Alliance of Psychoanalytic Organizations, 2006.

General Comments

NH & MRC Guideline Development on ADHD

Submission by Dr George Halasz

23 November 2007

In my submission I focus on the NH & MRC 'Terms of Reference' where point 1 looks at the current conceptualization of ADHD. I address some concerns with the current concept and turn to the fresh look offered by the recent publication of the Psychodynamic Diagnostic Manual (2006)

Background

In 1937, Charles Bradley (1) reported the beneficial effects of psychostimulants on 30 children aged between 5-14 with behavioural disorders 'severe enough to have warranted hospitalization'. Seventy years later, parents of children who present with behaviour problems suggestive of ADHD often ask me "where did it all go wrong?' I keep in mind a number of factors before I respond. I tell them that from all that we know about the condition, the diagnosis of ADHD is problematic.

All clinicians who deal with children's problem behaviours are aware of their complex causes, wide variety of available interventions and treatments. All approaches depend on some assessment based on a concept of the condition. Our current culture's medical super-specialization in mental health struggles to define the boundaries that demarcate the wide range of normal behaviours, kids-just-being-kids, against the increasing number of categories in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (2).

Over the last 50 years the DSM criteria for Attention Deficit Hyperactivity Disorder (ADHD) reflect changes in our professional thinking that translates into how we conceptualise the condition. Decade by decade, since the initial DSM I (1952), each revision changed the criteria for this condition from the initial 'motoric disinhibition', to DSM II (1968) hyperkinetic reaction, DSM III and DSM III-R (1980, 1987) attention deficit disorder (ADD) and inattention and hyperactivity and DSM IV and DSM IV-TR (1994, 2000) as attention deficit/hyperactivity disorder, (ADHD). The next revision, DSM V, is due to be published in 2011.

Beyond the changes in criteria for and conceptualizing of ADHD, how

professionals perceive the condition is influenced by other cultural, social and economic factors. The public and professional debate centered on these issues at times questions the basic assumptions on nature of this vexing condition. The current NH & MRC 'terms of reference' first point, the conceptualizing of ADHD, reflects this concern.

Some professionals reify ADHD as a disease which enjoys a perception of a medical (neuropsychological) condition with a genetic cause. Opponents view the behaviours as a syndrome, the complex symptoms shared by a number of conditions with different causes. Such divergent perspectives (3) are addressed in the recently published Psychodynamic Diagnostic Manual (4) which offers the mental health profession a fresh approach to ADHD.

The PDM is a collaborative effort by 6 international and American psychoanalytic, psychodynamic associations, which includes the American Psychological Association's Division of Psychoanalysis (39). The DPM Task Force comprises 40 distinguished mental health professionals, including Reiner Dahlbender (Germany), Hector Ferrari (Argentina), Peter Fonagy (England), Stuart Shanker (Ontario) and Daniel Widlocher (France).

Over the years, the DSM has attracted both praise and criticism, but the most recent argument, from the 'inside', is from a key architect of DSM III, Robert Spitzer. In the past he espoused above all else the need for scientific precision in psychiatric diagnosis. Now years later in a recent book, (5) he acknowledged the DSM's limitations, offering a lack of context and developmental perspective:

> *'Many critiques of the DSM have come from the 'outside' in that they have been suspicious of the very notion of a mental disorder…In contrast, Horowitz and Wakefield recognize the DSM's contribution …Ironically, it is by taking seriously the DSM's claim to be a manual of mental disorders (and thus to fall within the scope of medicine) that the authors are able to mount a devastating critique of the way the DSM operationalizes the diagnosis of depression (and by implication, the other diagnostic categories as well) with inadequate attention to context. Because their analysis is anchored in psychiatry's own assumptions, it will be hard for those now constructing the DSM-V (expected publication in 2011) to ignore.' (viii-xi).*

Turning to the specific concerns with the DSM and childhood conditions, Allen J Frances and Helen Link Egger, the former as chairman of the DSM taskforce of 27 members concluded that the DSM as a descriptive system was necessary but not sufficient:

'*The absence of a developmentally sensitive interactive or longitudinal perspective in the DSM system of classification limits the useful (sic)*

of the categories for both research and clinical assessment and treatment of children and adolescents'. (6, p164)

One possible reason why these concerns have not been articulated in scientifically informed guidelines based on evidence was the absence of an alternative classification system to the DSM. That was the last half century. However, the PDM has the potential to create a new culture in psychiatric diagnosis. In contrast to the DSM's strategy of narrowing of the mental health field's focus on simple symptom clusters, the PDM authors note that such an approach was possibly 'misguided'. (p3) They add:

> *'scientific evidence includes and often begins with sound descriptions, such as case studies…Insufficient attention to this foundation of scientific knowledge, under the pressure of a narrow definition of what constitutes evidence (in the service of rapid quantification and replication) would tend to repeat rather than ameliorate the problem.' (p3).*

The PDM's approach to clinical cases values and repeatedly emphasizes the need to attend to complexity and subtlety which is achieved through its 3 Axis structure. Applied to adults and young people, the PDM's approach addresses precisely those issues that the architects of the DSM noted.

Conceptualization of ADHD

Against this background, the current revision of the 1997 NH& MRC guidelines on ADHD provides the perfect opportunity, under its 'terms of reference' point 1 to attend to the problems associated with ADHD's definition and current conceptualization. Additionally, points 3 & 4 include the need to synthesise and interpret the current state of knowledge on ADHD…and 'update the available resources.'

For these terms of reference to be seriously reflected in the NH & MRC guidelines, I would suggest that an inclusion of the developments in conceptualization of ADHD offered by the PDM's approach underlines how its power clarifies the complexity of childhood behavioural symptoms seen in ADHD, beyond the DSM's 'checklist' approach. Notwithstanding the acceptance and use by mental health professionals and medical professionals worldwide of the DSM, it is time to question its most basic assumptions in its approach to ADHD.

The PDM classification system offers a viable alternative conceptualization of DSM precisely because it attends to those perspectives that the DSM Taskforce chairman Frances observed to be lacking in the DSM. These include the interactive sensitivity, based on developmentally based formulations, key relationships and the subjective experiences of the child.

The PDM provides a developmentally sensitive longitudinal perspective, rather than the DSM's cross-sectional conceptualization. Thus the PDM offers an alternative conceptualization of ADHD that addresses the previous limitations that the DSM imposed as it highlights characteristic affective and somatic states, thoughts and fantasies in the child's relationships (p270-2; 675-9). ADHD as a condition with attention deficit and hyperactivity as the two primary constellation of symptoms, from a PDM perspective these symptoms can be understood in a developmental context of a developing capacity for attention from infancy onwards.

Thus, the PDM's conceptualization questions the limits imposed by our reliance on the DSM's perception of ADHD. As a child psychiatrist the PDM approach 'rings true' for me in my clinical practice as I explain to parents their children's constellation of symptoms.

The proposed NH & MRC guidelines on ADHD can reflect the advance in the conceptualization of ADHD by giving due consideration to the PDM approach. That approach in conceptualization can assist clinicians, educators, carers and consumers in the evaluation of this most common childhood condition. It would be incumbent on the NH & MRC guidelines to avoid perpetuating the perception that the only valid conceptualization of ADHD is based on the DSM approach.

In this context, the final question on the nature of the condition of ADHD is 'what is it" and 'what is it not? On the available scientific evidence, since the publication of the PDM, the answer must be approached with caution. The era of the DSM monopoly on psychiatric diagnosis has evolved to see ADHD as a set of complex symptoms, not to be reified as a 'mental disorder'.

Summary

In this submission, I have outlined how each new revision of the DSM has resulted in a new conceptualization of the condition known as ADHD. As the NH & MRC revises the 1997 version to formulates a new guideline for ADHD, it is mindful not only of the criticisms and limitations of the current DSM criteria, but also of the new look offered by the PDM.

To ignore these exciting developments, the guideline runs the risk of being seen not only old-fashioned. More seriously, if the past patterns are a guide, the current DSM criteria for ADHD are likely to be replaced with the next DSM revision. In this culture of constantly changing conceptualization of ADHD within the DSM criteria, how ethical would it be to spend taxpayers' money on a new guideline for ADHD that ignores the PDM's approach?

I would respectfully suggest for the new NH & MRC guideline development on ADHD for mental health practitioners living and working in the 21st century, that serious consideration is afforded to clarify the basis of the long standing debate on what ADHD is, and what it is not (7). This approach demands that the NH & MRC guideline address the developments in conceptualization of ADHD as found in the PDM.

References

1 Bradley C. The behavior of children receiving benzedrine. *American Journal of Psychiatry* 1937; 94: 577-585.

2 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. (4th ed., text rev.) Washington, DC: Author, 2000.

3 Halasz G., Vance LA. Attention deficit hyperactivity disorder in children: moving forward with divergent perspectives. *Medical Journal of Australia.* 177:554-557, 2002.

4 PDM Task Force. *Psychodynamic Diagnostic Manual*. Silver Spring, MD: Alliance of Psychoanalytic Organizations, 2006.

5 Horowitz A V., Wakefield J C. *The Loss of Sadness. How Psychiatry Transformed Normal Sorrow into Depressive Disorder.* Oxford University 2007.

6 Frances A J Egger H L. Whither psychiatric diagnosis. *Aust. N.Z. J. Psych.* 1999; 33:161-165.

7 Green S A., Bloch S. *An Anthology of Psychiatric Ethics*. Oxford University, 2006. p 185.