Attention deficit hyperactivity disorder: time to rethink

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The time has arrived to sort out the decades-long ADHD debate

The Royal Australasian College of Physicians is currently revising the 1997 National Health and Medical Research Council (NHMRC) guidelines on attention deficit hyperactivity disorder (ADHD).[1] Also, the American Psychiatric Association is working towards the fifth edition of the *Diagnostic and statistical manual of mental disorders* (DSM), with an expected publication date of 2012. These are valuable opportunities to review existing diagnostic criteria for ADHD and consider alternatives.

Recent refinements in psychiatric classification and advances in neuroscience research have jointly contributed to a clearer understanding of some childhood psychiatric disorders. Paradoxically, these developments also raise doubts about the diagnostic validity of ADHD — the most common psychiatric clinical presentation in childhood.

These doubts arise from difficulties in conceptualising ADHD as a "disorder". They also exemplify the growing turmoil that is part of the larger disillusionment with psychiatry,[2] reflecting fundamental changes both within and beyond the profession in many Western countries, including Australia. A central concern is the increasing tendency of psychiatry to transform what many regard as normal emotional responses to life's stresses and traumas into psychiatric disorders.

The nosological conundrum of ADHD was highlighted in the United States National Institutes of Health's ADHD consensus statement; it concluded that there is evidence supporting the validity of the disorder, but did not provide a consensus regarding which ADHD patients should be treated with psychostimulants.[3] A response to the statement noted that:

> … [the] "unproven" status of the disorder should give pause to both researchers and clinicians who may have reified ADHD as a "thing" or "true entity" (rather than a *working hypothesis* that serves scientific, communication, and clinical decision-making purposes).[4]

In addition, it has been noted that discussion of the diagnostic validity of ADHD is far from stale or easily dismissed, and that a renewed sense of urgency arises when a:

> … diagnostic concept is listed in an official nomenclature and provided with a precise, complex definition [which] tends to encourage … insidious reification.[5]

Such unintentional reification by DSM-IV[6] — where so-called core symptoms of ADHD (poor impulse control and lack of sustained attention) are construed as a disorder — is illustrated by tracing the DSM's successive revisions of ADHD as a diagnostic entity. Antecedents for ADHD range from "motoric disinhibition" in DSM-II (categorised as hyperkinetic reaction) and "inattention" in DSM-III (categorised as attention deficit disorder) to attention deficit hyperactivity disorder (ADHD) in both DSM-III-R and DSM-IV.[7]

The fact that such conceptual changes are part of the DSM's stated aim (ie, to identify clinical conditions that can be considered as genuine medical disorders and to distinguish them from problems of living) results in a catch-22 error that has been noted in relation to major depressive disorder.[8] This flaw in logic also applies to ADHD. Beyond this flawed logic, Russell Barkley — a respected American authority on ADHD — reviewed the criteria for ADHD and concluded that "what is clear is that the current DSM-IV approach has little clinical or research merit".[9]

Further disenchantment with the disease entity assumptions of the DSM revisions has arisen from the serial increase in numbers of diagnostic categories: from 60 in 1952 (DSM) to 145 in 1968 (DSM-II) and 410 in 1994 (DSM-III). This led one author to comment:

> … particularly badly affected by this constantly creeping diagnostic expansion have been children, whose least oddity or not quite normal (frequently confused with average) quirk is now assigned to some syndrome or other and treated with behaviour therapy and drugs. The ethics of all this is rarely called into question.[10]

At the ideological level, some see a process of "psychotherapeutic revisionism" in mental health care in the US.[11] I have discussed how such a revisionist ideology views ADHD in detail elsewhere.[12] In summary, it fails to distinguish between psychology as "science" and as "scientism". As a consequence, the former holds that ADHD symptoms arise from the interaction of genetic and developmental influences during pregnancy through childhood, whereas the latter focuses on symptoms as utilitarian targets for treatment. The DSM's atheoretical approach, which perpetuates the continuing absence of a "developmentally sensitive, interactive or longitudinal perspective in the DSM system",[13] sits within such revisionist ideology. These contrasting conceptual and ideological views have resulted in divergent perspectives on the conceptualisation of ADHD, reliability and validity of ADHD diagnosis, and treatment options for behaviour labelled as ADHD.[14,15]

Ethical dimensions and other subjects for consideration in the ADHD debate include:

- diagnostic decision making;
- inappropriate (over- or under-) medication;
- "performance enhancement" arguments;
- the relationship between the psychiatric profession and the pharmaceutical industry, raising possible conflicts of interest;
- third-party reimbursement for ADHD as a disability;
- the lack of childhood safety and efficacy data leading children to be termed "therapeutic orphans"; and
- purported aetiologies based on genetics versus "toxic environments".[16]

Importantly, these purported aetiologies have been recast into integrative models that include both genetics and environmental factors,[17] a new direction that has immediate implications for clinicians and researchers.

Global expenditure on drugs to treat ADHD rose ninefold to US$2.4 billion in the decade to 2003.[18] It would be naïve to think that market pressure does not influence evidence-based protocols in resource-starved health services. The revised practice parameters from the American Psychiatric Association relied on the

DSM-IV text revision definition of ADHD. The limitations of their recommendations were explicit:

> These parameters are not intended to define the standard of care, nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results.[19]

Let us hope that the committee created by the Royal Australasian College of Physicians to define and describe the current conceptualisation of ADHD will have the scientific rigour, maturity and wisdom as they undertake the revision of the 1997 NHMRC guidelines on ADHD[1] to emphasise the distinction between ADHD as a set of symptoms and a disease concept.

As we approach the critical crossroads between the fourth and fifth revisions of the DSM's ADHD criteria, a glimmer of hope has emerged, signalling that the time has arrived to sort out the decades-long ADHD debate. The *Psychodynamic diagnostic manual* (PDM)[7] offers an alternative to the DSM construct of ADHD — a relief to what I believe to be shortcomings of the current DSM.[9] The PDM's inclusive approach to diagnosis integrates the subjective experiences of patients with their neuropsychological capacities for regulation of relationships, intimacy and emotional experiences, as well as attention and behaviour. Ideally, such an approach will enable the next generation of children to be spared prescription medications in the current quantities and combinations, based on dubious diagnostic criteria for behaviour labelled ADHD.

Competing interests

None identified.

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