Aust. New Z. Journal Psychiatry June 2001 35:3; 404-407

Book Review

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Attention-deficit disorder and comorbidities in children, adolescents, and adults. Thomas E Brown, editor. Washington: American Psychiatric Press, 2000. ISBN 0-88048-711-9. 671pp. Price $124.00.

In 1937, Charles Bradley (1) first reported the beneficial effects of psychostimulants on 30 children aged between 5-14 with behavioral disorders ‘severe enough to have warranted hospitalization’. The controversial story of attempts to treat children who are very restless, impulsive and have coexisting learning difficulties or other symptoms continues to unfold. That the different threshold for prescribing medication is influenced by factors other than the clinical state of the child is well documented.

In Baltimore County, USA, the rates for prescriptions for ADD/ADHD doubled every 4-7 years from 1971 through 1987 (2, 3). From 1987-1989 the combined effects of a media blitz and a threatened lawsuit led to a 39% decline in the rates of prescriptions from 1989 to 1991.

Recently, the ADD/ADHD story has taken a dramatic new turn. Elana Hernandez, Miguel Hernandez and Heather Buttler are three parents currently suing the American Psychiatric Association (APA) and the manufacturers of Ritalin. They claim that the APA colluded with Ciba-Geigy, which began manufacturing Ritalin in 1955, ‘to create, develop, promote, and confirm the diagnosis of Attention Deficit Disorder (ADD) and (ADHD) in a highly successful effort to increase the market for its product Ritalin.’ (4). They further charge that the APA, the drug manufacturer and the citizen organization Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD) committed

fraud by providing ‘misleading, inadequate, or incorrect information about the use and efficacy of Ritalin to physicians, the public, and school personnel.’

In such a climate combined with the current practice of authors disclosing potential conflict of interests, I declare that I am not aware of owning shares in companies that manufacture drugs used in the treatment of ADHD.

Furthermore, I believe, first, that the symptoms of Attention Deficit and Hyperactivity do exist. Second, I agree with the US National Institute of Health’s ADHD (5) consensus statement that concluded: the ‘unproven’ status of the disorder (ADHD) ‘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). They do provide a caveat not to confuse *unproven* with *disproved* (5 p195). Third, I have argued that the alarming increase in the number of prescriptions for drugs used to treat ADD/ADHD is part of a ‘manufactured epidemic’. The combination of many social pressures act on the medical profession to increase the risk of misdiagnosis, over prescribing and non-rational prescribing habits (6,7). Fourth, I accept APA Medical Director Steven Mirin’s view that the DSM criteria ‘are accepted and used by mental health and medical professionals worldwide.’ (4)

However, to understand the current crisis in the ADHD story we need to look beyond the narrow debate on the DSM’s diagnostic validity to account for the increase in prescriptions for ADHD. Cohen (8) at the Child Study Centre, Yale University school of Medicine, highlighted the ‘wider forces’ that influence the choices of clinical treatment of children. He observed, there is ‘rarely a one-to-one correspondence between a categorical diagnosis and a treatment strategy in child psychiatry. Rather the following factors determine the type of treatment: first, clinician’s expertise; second, the clinician’s theoretical orientation in relation to different clinical situations and types of disorders; third, the availability of resources; fourth, the wishes of parents and other adults; fifth, the child’s willingness to participate (including his schedule and other demands on his time; and finally, *economic factors (what type of insurance the parents have, if any; the limits*

on length and intensity of treatment defined by the insurance, the family's ability to pay).' (my italics).

The question of financial incentives may create subtle or not-so-subtle forces on both parents and the medical profession to influence diagnostic and prescribing habits (9, 10, 11).

In this context, Perrin et al (12) observed that when children receive income as part of a program of disability benefit for ADHD, the diagnosis can 'reflect bias because providers tend to code conditions and procedures that are likely to be reimbursed. Thus, the diagnoses on claims may not accurately reflect the conditions that children have.' This raises a critical question: could the culture of 'cash benefits to a maximum of approximately $6000.00 per year per beneficiary' under the Supplemental Security Income in the US be a contributing factor that promotes the increase in the rate of prescriptions for drugs used to treat ADHD?

In Australia, the current events program '60 Minutes' recently (29 October 2000) broadcast a follow-up of children who started treatment with Ritalin about 8 years ago. While one adolescent claimed that the drug helped him, the mother of another child had since learnt that her son was incorrectly diagnosed. She was told he needed Ritalin for his ADHD. He was later diagnosed with Asperger's Syndrome. The ADHD story is complex and controversial.

Thomas E Brown, PhD, Associate Director, Yale Clinic for Attention and Related Disorders contributes an important book to this contentious area. His publishers, American Psychiatric Press, provide the disclaimer that the book 'represents the views and opinions of the individual authors and do not necessarily represent the policies and opinions of the Press or the American Psychiatric Association.' Those authors are 'outstanding researcher-clinicians' mostly from centres of excellence in America with a few Canadian and Swedish contributions. This book carries the hallmark of medical authority.

Dr Brown described the birth of the idea for his book, in 1992, as he and his colleagues struggled to find 'pure' ADHD cases while they confronted the clinical reality that most children, adolescents and adults with ADHD presented with pictures complicated by 'multiple comorbidities' (xv). Thus, the book emerged to map the terrain of *comorbidity* i.e. other psychiatric disorders that impair the sufferer of ADHD.

The book's 20 chapters are divided into two Sections. Section one has 14 chapters that deal with the emerging understanding of Attention-Deficit Disorders/ADD, its genetics, and the clusters of comorbidity: mood disorders; anxiety disorders; learning disorders; oppositional defiant, conduct, and aggressive disorders; obsessive-compulsive disorders; sleep disorders; substance abuse and substance use disorders; tic disorders; and developmental coordination disorders. I wondered why PTSD was omitted, but more of that later. Section two contains 6 chapters dealing with assessment and interventions ranging from pharmacotherapy, cognitive therapy to psychosocial and educational interventions.

The book has some strong points. Admirably it does ask the core question: 'What difference does comorbidity make?' (p28) and offers important guidelines. For example, that the clinical course and outcomes of ADD 'are generally poorer in the presence of comorbid conditions than when there is no comorbidity, whether measured by parent-child interactions, poor school performance, automobile driving behaviors, or risks for later substance abuse and antisocial personality disorder.' (p29).

I found reassuring the observation that to fulfill the diagnostic judgments demanded by the DSM IV in a determination of whether any individual's symptoms qualify for ADHD requires 'clear evidence of clinically significant impairment in social, academic, or occupational functioning'. This requires empathic perception, effective communication with the patient, an appreciation of the wide breadth of 'normality' and a firm grasp of the multiple varieties in which psychopathology may be manifest' (p25). However, on

balance, I found the book disappointing especially given that its contributors work on the 'cutting edge of current research in this field' (xix).

Since Luhrmann's (13) sociological analysis of American psychiatry located the deep split between biological and psycho-social paradigms as part of our profession's ailment, we can readily identify those members of the profession who pay 'lip service' to the bio-psycho-social paradigm of ADD/ADHD. The book does at least acknowledge some aspects of the psychosocial dimension of ADHD/ADD. But the paradigm offered, to my mind, has both inconsistencies as well as fatal conceptual and logical flaws.

My concerns are on two levels. First, the combination of inconsistencies and conceptual and logical flaws; second, the lack of balance and the tone of the book which reflects precisely Jensen's (5) concern of 'researchers and clinicians who may have reified ADHD as a 'thing' or a 'true entity' (rather than a working hypothesis…).

Turning first to the inconsistencies that start with the book's title and content. As explained, the title of the book accommodates the editor's view of multiple forms of the condition of Attention-Deficit Disorders, hence the plural form of the word 'disorders'. Next, reflecting the centrality of inattentiveness in the 'spectrum' of disorders, Brown uncouples 'hyperactivity' in the ADD paradigm to return to a variation of the old DSM III ADD nosology.

Having excluded 'hyperactivity' as a defining feature in the book's title, most of the chapters persist to provide overviews of ADHD-based research that, by definition, nevertheless *do* include 'hyperactivity'. This fundamental confusion pervades the book leading to fatal conceptual and logical flaws, most evident in the discussion of the genetics of ADHD (not ADD).

Dr Hudziak's basic premise is that 'The value of identifying genes that influence the development of attention-deficit/hyperactivity disorder (ADHD) is immense.' (p57) He continues that family, twin and adoption studies combined with molecular genetic

findings would be the reasonable approach. Fine. But, his claim that ‘Perhaps molecular genetic findings will help us solve the perplexing problems of interpreting DSM comorbidity’ (p70), in my opinion, is untenable.

At this point, I was reminded of DSM IV taskforce chairman Allen Frances’ (14) observation that the DSM approach perpetuates the continuing absence of ‘developmentally sensitive, interactive or longitudinal perspective in the DSM system of classification (and thus) limits the useful (sic) of the categories for both research and clinical assessment and treatment of children and adolescents.’ (14, p164). I take this to include ADHD and ADD.

Before we spend precious research dollars on the genetics of ADHD should we not pay closer attention to the authentic bio-psycho-social factors contributing to the ADD/ADHD symptoms? Taking the ‘psycho-social’ factors seriously, we are permitted to wonder if schools and families might reasonably exert pressure on the medical profession to diagnose their child with ADHD in order to become eligible to claim up to $6000.00 in disability payments. This psycho-social factor should at least be considered as constituting a part of the ‘wider forces’ that influence the complex epidemiology, prevalence rates and psychopathology that lead to the difficulties in the diagnosis and treatment of the ADHD syndrome.

My second concern centers on a lack of balance and tone. The premise of the book is articulated clearly: the ‘recognition of the validity of ADHD (not ADD, the title of the book) and the effectiveness of its treatment was supported by a recent report from the American Medical Association (AMA)… [and its conclusion] ADHD is one of the best-researched disorders in medicine and the overall data on its validity are far more compelling than for most mental disorders and even for many medical conditions’ (p4-5).

Such a tone of certainty can easily engender a belief that ADHD exists as a proven disorder. Such a false claim may lead the naïve reader to conclude that any arguments

questioning the existence and validity of ADHD (and presumably ADD) can only be entertained by crackpots.

Furthermore, I shared with McFarlane and van der Kolk (15) a major concern: the fact that the 'need to ignore the reality of trauma in people's lives also pervades medical school departments of psychiatry, where the response to increasing levels of traumatization in society has generally been to ignore it' (15, p30). This is an especially critical fact given that ADHD 'has a high degree of comorbidity with PTSD'. (15, p31) and the book under review does not include PTSD as a comorbid condition with ADD/ADHD.

Placing the book in a wider social context, a reader could be forgiven for believing that the ADHD phenomenon exists in splendid isolation from the medical culture that defined it. That a book published in 2000 dealing with the 'cutting edge' of ADD/ADHD should fail to acknowledge the current clinical reality of child psychiatry in the US with its restrictions of adequate time for clinicians to assess children is perhaps the book's most serious flaw.

Schaefer (16) observed that according to current guidelines, with the need for clinicians to justify requests for authorization for developmental assessment from managed care companies, it is much easier to meet the criteria approving the authorization for medication than developmental assessments. Children who have been exposed to risk factors such as a 'history of parental loss, *exposure to a traumatic event*, placement in foster care, lead exposure, or abuse or neglect *do not in and of themselves warrant comprehensive developmental assessment*. (my italics).

It is precisely in such clinical contexts, where developmental assessment is unauthorized that doctors find themselves under pressure to 'do something'. Under these circumstances, the option to prescribe drugs is often seen as a first option for children with behavioural disorders like ADD/ADHD. Where will this lead?

In the extreme, the complex task of assessment of children in need of psychological understanding could be reduced to a single session (17). Before that reality becomes widespread, we should keep in mind that children respond to physical and behavioural treatments, but as Taylor (18) points out, also psychotherapy, or treatment by understanding. If as a profession we neglect the child's right to be understood, we will discover, too late, that the generation of children raised on the 'magic pill' solution to life's problems will be bereft of self-understanding and risk having impaired abilities to cope with life's challenges. As I have observed before, such a generation will learn, too late, that the cost of being a winner on drugs is expensive in more ways than economically (6, 7).

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