

## CHAPTER 6

### The Rise and Rise of ADHD

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This chapter offers an overview of the rise in diagnosing ADHD and the use of stimulants in children and is presented in the context of the cultural discourses and power hierarchies that exist in contemporary Western society.

#### **Something's happening here**

Something strange has been happening to children in Western society in the past couple of decades. The diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) has reached epidemic proportions, particularly amongst boys in North America. The diagnosis is usually made by a child psychiatrist or paediatrician with advocates of the diagnosis claiming that children who present with what they consider to be over-activity, poor concentration and impulsivity are suffering from a medical condition which needs treatment with medication. The main medications used for children with a diagnosis of ADHD are stimulants such as Ritalin, whose chemical properties are virtually indistinguishable from the street drugs, speed and cocaine. Boys are four to ten times more likely to receive the diagnosis and stimulants than girls, with children as young as two being diagnosed and prescribed stimulants in increasing numbers.<sup>1</sup>

By 1996 over 6 per cent of school-aged boys in America were taking stimulant medication<sup>2</sup> with more recent surveys showing that in some schools in the United States over 17 per cent of boys have the diagnosis and are taking stimulant medication.<sup>3</sup> In the UK prescriptions for stimulants have increased from about 6,000 in 1994 to about 345,000 in the latter half of 2003,<sup>4</sup> suggesting that we in the UK are rapidly catching up with the US. Concerned professionals and parents are increasingly vocal in their criticism of the excessive use of stimulants and

there are debates among clinicians proposing that ADHD is better regarded as a 'cultural construct' than a bona-fide medical disorder (e.g. see <sup>5 6</sup>).

Despite the assertion from ADHD industry insiders that 'ADHD' is a medical disorder,<sup>7</sup> even they have to concede that despite years and millions of dollars spent on research (it is the most thoroughly researched child psychiatric label—from a biological perspective that is) no medical test for it exists, nor has any proof been forthcoming of what the supposed physical deficit is, and so diagnosis is based on the subjective opinion of the diagnoser.<sup>8</sup> Indeed its validity as a distinct diagnostic entity is widely questioned as it cannot reliably be distinguished from other disorders in terms of aetiology, course, cultural variation, response to treatment, co-morbidity and gender distribution.<sup>9 10 11 12 13</sup> Furthermore there is no evidence that treatment with stimulants leads to any lasting improvement.<sup>14</sup> Indeed a recent meta-analysis of randomised controlled trials showed the trials were of poor quality, there was strong evidence of publication bias, short-term effects were inconsistent across different rating scales, side effects were frequent and problematic and long-term effects beyond four weeks of treatment were not demonstrated.<sup>15</sup>

In the absence of objective methods for verifying the physical basis of ADHD, we also conceptualise ADHD as primarily a culturally constructed entity. The cultural dynamics of this label cannot be understood without first understanding the cultural discourses and power hierarchies that exist in contemporary Western society. It is a very compelling and dominating story invented and perpetuated by those whose interests are served by its telling and retelling (ADHD was literally voted into existence in the 1980s by the American Psychiatric Association when drawing up the third edition and third edition-revised versions of the Diagnostic and Statistical Manual). By focusing on within-child explanations for presenting behaviours, ADHD divorces a child from their context, and real life experiences, including traumatic ones, become clinically less important. In this article we explore how ADHD manages to occupy and hold onto such a dominant position despite the growing criticism and lack of evidence supporting its alleged medical origins.

### **The claim that ADHD is a medical disorder**

To believers, ADHD is a diagnosable neuro-developmental disorder. Its identification is based on the observation of a constellation of behaviours that must be found across different settings and that are said to reveal abnormalities in children's activity levels, impulsiveness and concentration. Commonly, when a child is diagnosed the first-line treatment of choice is a stimulant such as Methylphenidate. Stimulants are portrayed as safe and effective and children that are diagnosed and treated in this way are said to show vast improvements in their behaviour, activity levels, concentration and achievements. In the real world the picture is not so straightforward.

### ADHD in practice

In practice, the diagnosis of ADHD relies on adults in varying caring relationships with the child, reporting the above behaviours to a medical diagnostician. As diagnosis is based on the observation of behaviours alone, this has led to a kind of 'open season' where anyone can 'have a go': teachers, parents, school doctors, welfare officers, and so on. As the construct becomes more widely known within any community, confidence in making provisional diagnoses grows too. What is alarming is the apparent lack of awareness of the self-fulfilling nature of this process.

This self-fulfilling process occurs at many levels. For example, when a parent and child meet a specialist medical practitioner, the meeting is likely to be organised to elicit the type of information needed to fulfill predetermined diagnostic criteria. The relationship between the people's beliefs, expectations and subjective reporting will shape and inform the questions asked, responses given, and of course the child's behaviour in the room. Basically, some observable behaviours in children (such as inattention and hyperactivity) change in status from behaviours containing no more or less information (in isolation) than the inattention or hyperactivity as described by an observer, to becoming the basis of a primary diagnosis. The biomedical template is applied and the behaviours are interpreted as a sign of a physical disorder. This leaves out several layers of experience and context that could contribute to any observed behaviour as well as alternative meanings that could be given to that behaviour. This also denies the participant observers an opportunity to witness the child demonstrating exceptional behaviours.

This medical explanatory model has enormous cultural power. Naturally, most of the population will assume that once doctors have named these behaviours as a disorder, such a categorisation must have a natural and scientific basis. This leads to the huge differences in the experiences of children with the label being interpreted as of lesser importance when compared to the assumed similarities children with a disorder are felt to possess.

Behaviour rating scales have become a key part of the diagnostic process and are presented as an objective tool. Critics point out that agreeing a cut-off point for the behaviours in question is a culturally and subjectively driven process which is reflected in the fact that epidemiological studies (using rating scales) have produced very different prevalence rates for ADHD (in its various forms), ranging from about 0.5 per cent of school age children to 26 per cent of school age children.<sup>8</sup> The criteria used for rating behaviours are based on Likert-type frequency descriptors (for example, often, seldom, never, and so on), thus reliable diagnoses depend on how consistently raters share a common understanding of the behaviours to be rated. Despite attempts at standardising criteria and assessment tools in cross-cultural studies, major and significant differences between raters from different countries,<sup>16</sup> as well as between raters from different ethnic minority backgrounds,<sup>17</sup> continue to be apparent.

If trained professionals cannot agree on how to rate behaviours relative to some sort of agreed (all be it arbitrary) 'norm', it is not surprising that non-professional observers and informants have different thresholds. For example, Reid et al.<sup>11</sup> cite several studies reporting that specialist teachers tend to be more tolerant of misbehaviour and judge students' behaviours as less deviant than general class teachers.

ADHD is thus ideally placed as a convenient diagnostic 'dumping ground' allowing all of us (parents, teachers, doctors, politicians) to avoid the messy business of understanding human relationships and institutions and their difficulties, and our common responsibility for nurturing and raising well-behaved children. Loose, subjective diagnostic criteria with no established medical basis lend themselves to the 'elastic band' effect of ever stretching boundaries as the drug companies help themselves and the medical professions develop new markets. This has resulted in stimulants being prescribed for their perceived performance enhancing properties and with more children in classrooms taking stimulants many parents end up feeling their child is at a disadvantage if they do not.<sup>18</sup> Stimulants are also being prescribed to children without them even fulfilling broad diagnostic criteria. This trend has now become so established that in some areas of the United States, less than half the children prescribed stimulants reach even the broad formal criteria for making a diagnosis of ADHD.<sup>19 20</sup> In the UK you can now get a diagnosis via a 25-minute telephone consultation, without the child concerned being seen.<sup>21 22</sup>

### **So why such a strong belief in ADHD?**

ADHD exists as a concept because it has been positioned within the empiricist tradition of medical and psychological research. Writing on schizophrenia, Boyle<sup>23</sup> draws attention to some of the devices that psychiatry uses to create the impression of a brain disorder despite the absence of supporting evidence. Firstly, she points out that by using their powerful status doctors can simply assert that it is a medical disorder, in such a way as to minimise opposition. In the case of ADHD, the Barkley et al.<sup>7</sup> consensus statement would be a good example of such rhetoric. Here a group of eminent psychiatrists and psychologists produced a consensus statement to forestall debate on the merits of the widespread diagnosis and drug treatment of ADHD. Secondly, to support the assertion of a medical disorder, apparently meaningful associations with biological processes are created. For example, funding research that supports claims of biological or genetic causes (whether this delivers results or not), leads to the construct implicitly being regarded as if it is part of a larger field (in the case of ADHD, neuro-developmental psychiatry). Thirdly, the medical discourse prevails by ignoring or rejecting other non-biological accounts of (in this case, children's) behaviour, or by co-opting them as peripheral or consequential rather than antecedent.

Privileged social groups, who hold important and influential positions, have

a powerful effect on our common cultural beliefs, attitudes and practices. Child Psychiatry in the UK does appear to have re-invented itself in the last ten years. Having struggled with a crisis of identity about being doctors, influential child psychiatrists successfully influenced the UK's professional discourse convincing it that there were more personal rewards for the profession by it adopting a more medicalised American style approach (e.g. see <sup>24</sup>). ADHD has, along with a string of other so-called disorders, helped construct the field of neuro-developmental psychiatry, which the public, trusting such high status opinions, has come to view as real.

The development of diagnostic categories such as ADHD is of course of huge interest to the pharmaceutical industry. Indeed some argue that ADHD has been conceived and promoted by the pharmaceutical industry in order for there to be an entity for which stimulants could be prescribed.<sup>25 26</sup> It is after all a multi-million dollar industry, with the US National Institute of Mental Health<sup>27</sup> and the US Department of Education and the Food and Drug Administration<sup>28</sup> all having been involved in funding and promoting treatment which calls for medicating children with behavioural problems. The situation with drug companies controlling the agenda of scientific debate has become so prevalent that it is virtually impossible to climb up the career ladder without promotional support from drug companies. Most senior academics have long-standing financial links with drug companies inevitably compromising the impartiality of their opinions.<sup>29</sup>

Similarly the impartiality of patient support organisations has to be questioned. In recent years it has become apparent that drug companies are using such consumer lobbying groups to their advantage not only by (often secretly) generous donations, but also on occasion by setting up patient groups themselves.<sup>30</sup> The main pro-medication pro-ADHD consumer support group in North America is CHADD, which receives substantial amounts from drug companies, receiving an estimated \$500,000 in 2002.<sup>31</sup> There are other support groups: for example, in the United Kingdom the parent support group 'Overload' have been campaigning for prescribing doctors to provide more information to parents about the cardiovascular and neurological side effects of stimulants, believing that many more parents would be likely to reject such medication if they were being properly informed about it by the medical profession. However, without the financial support of the multinational giants, their message rarely gets heard.

ADHD is now also firmly entrenched in the cultural expectations of our education system. The defining of a disability requiring special needs help at school is now shaped by the disciplines of medicine and psychology.<sup>32</sup> The adherence of these two fields to measuring physical and mental competence in order to determine normality inevitably conveys assumptions about deviance and failure and these labels then become attached to both individuals and groups who have failed to measure up or conform. Special needs practice in schools rests on within-child explanations.<sup>33</sup> Psychiatric diagnoses have thus become an acceptable device for raising funds to meet children's perceived special needs. Increasing experience of children rendered less troublesome (to a school) by taking a

stimulant, when coupled with a belief that these children's non-compliant behaviours were caused by a medical condition has also increased demand from teachers for children to be diagnosed and medicated.

### **Effects of this new category of childhood**

What are the effects of embracing practices that impose descriptions such as ADHD onto children's behaviour? Children quickly become objects of such descriptions. Their creativity, capacity for 'exceptional behaviours' and diversity go unnoticed. ADHD pushes teachers, parents and medical practitioners into self-doubt about their capacity to teach and care for children. The opportunities for developing reflexive, appreciative child management practices and skills are lost.

In mental health settings, the chance to build a repertoire of therapeutic skills and practices that might facilitate people to talk about their experience in ways that can create more empowering meanings that build on their own knowledge is also lost. Instead children are persuaded to take highly addictive and potentially brain disabling drugs for many years and may well be cultured into the attitude of 'a pill for life's problems'. Children and their carers risk developing 'tunnel vision' about their problems rendering them unnecessarily 'disabled' and dependent on 'experts'. The effect this has not only on the physical health of our children in the West, but also on our ways of viewing childhood is incalculable. Behind the rise in diagnoses and the liberal prescription of such dangerous medicines lurks a deep malaise that is infecting Western culture—hostility to children—for in our modernist, hyperactive, individualistic lifestyles children 'get in the way'.

### **Endnotes**

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