The over-diagnosis of adhd

A simple way to describe Attention Deficit Hyperactivity Disorder is that it is a brain based condition where there is an imbalance of the brains chemicals dopamine and noradrenaline, these chemicals being responsible for self-control and slowing down of impulses (Green and Chee, 1997: 3). Because of the slight imbalance of these important chemicals, people with ADHD will experience impulsive, hyperactive behaviour as well as inattentiveness with short term memory and in some cases, learning difficulties. Although doctors and scientists have more information about the causes and treatment of ADHD today, there is an interesting history around this disorder which had many different theories and beliefs.

Discovered over one hundred years ago, Attention Deficit Hyperactivity Disorder is not a recent medical discovery. It was first described in about 1902 by George Still, an English paediatrician, who had observed a group of patients and recognised them as being inattentive, over active and suffering from a “ lack of moral control” (Green and Chee, 1997: 10). After George Still’s discovery, many controversies followed. It was believed that ADHD was a result of brain damage, but when doctors realised that most children with ADHD had no brain damage, that idea was discarded. ADHD was then called Hyperactive Child Syndrome, where all the focus was on hyperactivity. In addition to this, Dr Ben Feingold researched a link between ones diet and hyperactivity, but this controversy was soon proven to not have much effect. Today, it is known that ADHD is strongly hereditary and is, as mentioned before, believed to be caused by the imbalance of dopamine and noradrenaline chemicals in one’s brain. This subtle difference in the brain

causes ADHD, as inattentiveness and hyperactivity, and can display itself through a number of different symptoms.

There is not one definite test for ADHD, but rather a series of steps to go through which help to make the final conclusion in diagnosing ADHD. As ADHD is a common condition, doctors need to be certain when assessing a child for ADHD. Some simple symptoms of the disorder are; disorganisation, restlessness, fidgeting, clumsiness, forgetfulness and being easily distracted. Although every person does experience at least one or more of these symptoms, it does not necessarily mean that they have ADHD. People with ADHD will experience these symptoms, but at a far greater level of severity than those without the disorder would, and with negative outcomes because of the severity (Green and Chee, 1997; 227). Therefore, focusing on the simple symptoms of ADHD is what often leads to an over diagnosis of the disorder, such as if a child has a lot of energy and doesn’t like to sit still, the child may just be an active child and will not necessarily have ADHD. As Dr Sam Goldstein says, “ just as not every sneeze is indicative of a cold, so too not every restless, impulsive and inattentive behaviour is indicative of ADHD.” (Goldstein, 2004: 7) shows how easily one can confuse normal behaviours with the simple ADHD behaviours, leading to an overdiagnosis of the disorder. When observing a child for ADHD, tests must be done and observations will be made according to the DSM-IV criteria to make a correct diagnosis of ADHD.

There are two main features of ADHD, these being inattention and hyperactivity-impulsivity. Under each feature there are diagnostic criteria which need to be addressed when assessing a child who possibly has ADHD.

These criteria are called DSM-IV, which stands for Diagnostic and Statistical Manual of Mental Disorders, fourth addition. Under the inattention feature, DSM-IV symptoms include; not paying attention to detail, difficulty focusing and keeping attention on tasks, not listening or following instructions, poor organisational skills, being easily distracted, very forgetful and often losing important items. The hyperactivity-impulsivity feature is arranged under two different subheadings but these are both very closely linked. Hyperactivity DSM-IV symptoms include fidgeting with hands and feet, often leaving ones seat, excessive running and climbing in inappropriate situations, difficulty engaging quietly in relaxing activities, always has endless energy and talks excessively. The impulsivity criteria include blurting out answers, difficulty being patient and interrupting and intruding on others. Using these criteria, further steps are then taken to make a diagnosis of ADHD.

When making the diagnosis of ADHD, there are a number of steps to follow to make sure of an accurate diagnosis. Dr Christopher Green (1997: 61) states that there are four simple steps to diagnosis; firstly to look for alarm signals – any behaviours or symptoms that could indicate ADHD. Secondly, to exclude ADHD ‘ lookalikes’- the behaviours or disorders that are often confused with ADHD. Thirdly, to use objective pointers towards the diagnosis, such as tests and questionnaires, and lastly, to take a detailed history of the child being assessed and link it to ADHD subtleties, discover if the child had any noticeable signs of ADHD growing up. The DSM-IV criteria to determine ADHD can only be used to make a diagnosis if six or more of the symptoms under each subheading (inattention, hyperactivity and impulsivity) are experienced or displayed consistently for six or more

months, and are not at an age-appropriate developmental level. From this observation, a series of tests will be done to help make the diagnosis.

Children believed to have ADHD must take a series of tests once the DSM-IV criteria have been observed appropriately, starting with the standard intelligence test. The standard intelligence test will then be followed by specialised subject tests, for example maths, reading and writing, just to name a few. These tests will be monitored by a psychologist who will observe restless or inattentive behaviour. This observation can sometimes be misleading though, as some children are able to focus in a quiet environment, but cannot focus in a noisy classroom environment (Green and Chee, 1997: 67). After ADHD has been identified from this test, children will take a test of attention and persistence to indicate the main areas of weakness caused by ADHD. This final test will help make the final diagnosis of ADHD and will help indicate the right medication to give. Although these tests are the most accurate in diagnosing ADHD, there is still some controversy around whether ADHD is in fact being overdiagnosed.

There is a common belief that ADHD is over diagnosed (Sciutto and Eisenberg, 2007: 106). For ADHD to be classified as overdiagnosed the number of false positives, people diagnosed with ADHD who should not be, must be far more than the number of false negatives, people with ADHD who are left undiagnosed and untreated. ADHD is one of the most common childhood disorders (Sciutto and Eisenberg, 2007: 106), with three to seven percent of school children meeting the ADHD criteria. A CNN online poll in 2002 showed that seventy six percent of the people who responded to the poll believed that ADHD is an over diagnosed disorder (Sciutto and

Eisenberg, 2007: 106). A recent study in 2007 (Sciutto and Eisenberg, 2007: 108, 109) focused on looking at evidence for and against the overdiagnosis of ADHD. An area of this study looked at factors that could contribute to a false diagnosis of ADHD, the first factor being comorbidity, many children diagnosed with ADHD also meet the criteria for another psychiatric disorder and these symptoms overlap with ADHD symptoms, therefore resulting in an incorrect diagnosis. Another factor is diagnostic inaccuracy. Many children are given a diagnosis of ADHD after an initial, brief assessment, but then when evaluated properly on a second occasion, only a few children are given a final and accurate diagnosis of ADHD. A reason for this diagnostic inaccuracy is that some psychologists do not follow the correct diagnostic program and only briefly take in to account the DSM-IV criteria. The other area of this study focused on factors that could contribute to false negatives in ADHD, people with ADHD who are undiagnosed and untreated for it. The key area was aimed at gender differences, which showed that girls with ADHD are more commonly under diagnosed. The reason for this is because girls with ADHD are more likely to internalize their symptoms and are less hyperactive and disruptive but struggle more with inattentiveness. The conclusion of this study showed that there is not enough evidence to claim that ADHD is overdiagnosed, so is therefore not classified as overdiagnosed. Although this is just one study, there are other controversies around if ADHD is over diagnosed or under diagnosed and this applies to both children and adults.

In earlier years, research shows that ADHD was mostly found in children but more recent studies show that adults can suffer from the disorder too. One of

the most common statements made about ADHD is that children with ADHD will outgrow the disorder by the time they reach adulthood. But most children do not outgrow their ADHD (Marsh and Wolfe, 2007/2010: 136). Although the symptoms and signs may be worse as young children and then lessen with age, they do not disappear completely (Green and Chee, 1997: 192). In some cases noticeable signs of ADHD may be present during infancy, however one cannot be certain as there are no valid methods of identifying ADHD before the age of about three years old. Symptoms often become more evident as children move into preschool, at about three or four years old. These include acting without thinking, working and moving fast, roaming around and disrupting other children. If children display these symptoms for one or more years then they will more than likely continue with these difficulties as they grow older. When children move into higher grades at school, inattentive symptoms will start to become more evident. The early grades of junior school are the most common years in which diagnosis of ADHD occurs. The hyperactive behaviours experienced in preschool normally continue for a few years but gradually lessen. As previously mentioned most children with ADHD do not outgrow this disorder, about fifty percent of children display ADHD characteristics into adolescence (Marsh and Wolfe, 2007/2010: 136). In some cases, the problems as a result of ADHD get worse, and most ADHD teenagers present problems in emotional, behavioural and social spheres of development. These problems are often carried on to adulthood and present problems later on in life.

The impairments in developmental areas during childhood and adolescence present themselves as problems in adulthood life. Some children can grow

out of ADHD, although the majority do not and therefore learn to cope with it as they become older. Some symptoms of ADHD in adults include; restlessness, being easily bored, constantly seeking exhilaration, may experience work difficulties, depression, low self-esteem, substance abuse and personality disorders (Marsh and Wolfe, 2007/2010: 136). Many adults who have ADHD have never been diagnosed with the disorder and consequently feel there is something wrong with them, leading to frustration and additional problems mentioned above. If undiagnosed or left untreated, adults with ADHD will more than likely have negative health and mental problems, work and financial problems and relationship stability problems (Smith and Segal, 2012). There is still on-going research around the controversy about ADHD in adults. There are a number of ways for people with ADHD, both adults and children, to help deal with the disorder, which leads to the next controversy – how to treat ADHD.

There is no cure for ADHD; however there are various approaches to treating people with the disorder which enables them to live an easier life (Mash and Wolfe, 2010: 149). Although highly controversial, stimulant medication proves to be the most common way of treating ADHD (Robinson, Smith, Segal and Ramsey, 2012) and as it was the first type of medication to treat children with ADHD, it is the most trusted (Barlow and Durand, 2012: 490). Two stimulants are proven to be the most common and effective, one being Methylphenidate, for example Ritalin and Concerta, and the other being Dexamphetamine. Stimulants, otherwise known as ‘ psychostimulant drugs’, are effective because they regulate the slight imbalance of dopamine and noradrenaline in an ADHD child’s brain. This therefore allows the children to

be able to focus on tasks that they could not focus on when untreated and shut out distractions as well as thinking before acting (Green and Chee, 1997: 125). Another positive about stimulants is that they can be used on children and adults of any age, but should only be used on very young children if extremely necessary (Green and Chee, 1997: 161). Although the proven short term benefits of using psychostimulant drugs are positive such as reducing restlessness and allowing children to listen better, which evidently show the reasons for using these drugs, there are arguments against using the drugs which, for example, arise from the negative side effects which are likely to be experienced when taking the medication.

There are many controversies around using psychostimulant drugs to treat ADHD but one of the most understandable reasons for any controversy around using these drugs is because of the negative side effects. These side effects are explained by Eric Mash and David Wolfe as “ reduced appetite, weight loss, slowing of expected gains in height or weight, increase in heart rate and blood pressure, or problems falling asleep.” (Mash and Wolfe, 2010: 144). Comprehending that these are only the proven short term side effects of the drugs, the other controversies arise because there are unknown long term side effects that could be a consequence of using these psychostimulant drugs. A common area of concern for parents and another of the controversies surrounding the use of stimulant medication is the possibility of children becoming addicted to the drugs. Dr Christopher Green and Dr Kit Chee responded to this concern by saying that “ when a stimulant is effective it brings the child into harsh reality. No one ever got addicted to reality.” (Green and Chee, 1997: 160). This quote gives one an

understanding that the possibility of becoming addicted to the stimulant medication is unlikely, but this only refers to the people who are actually prescribed by a doctor to the medication. However these stimulant drugs are becoming increasingly available to the public for anyone to purchase, and in this regard are being used and abused by many adolescents and young adults who do not need the medication, as they help enhance academic performance. In this case, where medication is used when not needed, the topic of addiction becomes a reality (McCarthy, 2010). Even with the negative aspects, psychostimulant drugs still remain the most popular in treating ADHD today. The other medication to take into account when looking at treatments for ADHD is the non-stimulant medication.

Although not as commonly used as the psychostimulant drugs are, non-stimulant medication can also be considered for the treatment of ADHD. Often non-stimulant medication is only considered when the stimulant drugs are not effective (Green and Chee, 1997: 125). Atomoxetine, with the brand name Strattera, is the first non-stimulant ADHD treatment drug to be FDA (Food and Drug Administration) approved (Low, 2009). The reasons why many people believe that the non-stimulant medication is better than using psychostimulant medication is because Atomoxetine does have any indications of becoming addictive, whilst many believe that stimulant medication has the characteristic of becoming addictive. It is also believed to have a longer lasting effect than stimulant medication (Low, 2009). The other non-stimulant drug which is commonly used is the tricyclic antidepressant, Tofranil. This medication may be used when the person being treated does not react well to stimulant medication, or has signs of

depression combined with ADHD. This non-stimulant medication may take longer to take effect on the patient, but also has a longer lasting effect than stimulant medication does (Low, 2009). Both of these non-stimulant medications have similar side effects, but debatably not as severe as the side effects of stimulant medication. For the majority of people affected with ADHD, non-stimulant medication does not work and they therefore resort to using psychostimulant drugs. Using these psychostimulant drugs, combined with behaviour development, is possibly the most helpful treatment of all.

This combined treatment of stimulant medication and behaviour development is known as ‘ multimodal’ treatment. It is believed that before medication is prescribed, therapy and help should be given to the areas in which children with ADHD are struggling. After the weaknesses are found, the family should be educated about ADHD so that they are aware with what they are exposed to and how to deal with tough situations as a result of their child having ADHD when faced with them, such as helping their child work through a task that they are struggling with. Once the ADHD child is getting the help he or she needs, then medication will be prescribed in order to help the child focus (Green and Chee, 1997: 230). The one negative aspect about this progress of treatment is that it is quite expensive and therefore not everyone will be able to benefit from it. With all of the possibilities of treatment taken into account, it is evident to conclude that although highly controversial, psychostimulant drugs remain the most efficient medication to use when treating children and adults for ADHD.

Taking into account all of the controversies surrounding Attention Deficit Hyperactivity Disorder it is clear that there are definite sides to arguments in

the areas of diagnostic criteria and whether ADHD is underdiagnosed or overdiagnosed, ADHD in children as well as adults, and the treatment of the disorder. Looking at the diagnostic criteria and studies around overdiagnosis, research confirms my opinion that ADHD is not overdiagnosed, but in some cases it is misdiagnosed as many other psychiatric disorders share the same symptoms as ADHD which leads many people into believing it is overdiagnosed. Researching the occurrence of ADHD in adults as well as children concludes that ADHD in adults is very common, but is not recognised as much as ADHD is in children. Regarding the treatment of ADHD, my side taken in the debate leans towards the use of multimodal treatment, therefore supporting the use of psychostimulant drugs. Research in the area of psychostimulant drugs has shown that they have the most effect with helping children and adults focus on tasks and to restrain hyperactive behaviour, without endangering the patient’s life. Personal experience with psychostimulant drugs also accounts for my reasoning in supporting these drugs for the treatment of ADHD. The controversies surrounding ADHD all have valid points, and each individual has motives to stand behind their belief in a side of an argument. I have looked at all debates around each controversy and made a decision of where I stand based on my views around each controversy, which have been explained above.