

**Martin  
Whitely**

# **Speed Up & Sit Still**

**The Controversies  
of ADHD Diagnosis  
and Treatment**



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*Medical research has made such enormous advances that there are  
hardly any healthy people left.*  
ALDOUS HUXLEY



## Introduction

### Martin's ADHD Journey

I have always been competitive and, like most boys, prone to exaggerate my achievements. It is a fair boast, however, that from kindergarten until at least age fifteen I was the least organised, most distracted and least attentive boy in my year at school. I wasn't disobedient or exceptionally disruptive but I was an under-achieving daydreamer. My school reports always contained comments like 'Martin is totally disorganised and lacks concentration. With greater effort he could achieve much better results.' It wasn't because I had no interest in things academic. For a sporty kid I had a nerdish preoccupation with politics, current affairs and chess. Things that interested me demanded my attention; things that did not, did not.

For a few brief years as a senior at high school, I became more focused and achieved good academic results, way above anything I had previously managed. But then my early years at

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university were a disaster. Until I found the right formula for me of working full time with a heavy part-time study load, I lacked the motivation, pressure and focus to succeed. In truth it was only when I felt others expected me to fail that I was motivated to prove them wrong.

Eventually I graduated with a degree in accounting and after a few false starts in my mid-twenties I worked as an accountant. Although I had no difficulty understanding the theoretical foundations, I was a hopeless accountant because of my complete lack of interest in detail. I made the transition to teaching just before I turned thirty and found the challenge of educating, motivating and entertaining students exciting. Similarly, when I moved into politics in my early forties I found the diversity and constant pressure exhilarating.

As an accountant I was a square peg in a round hole. The constant movement and colour of teaching and politics are far better suited to my personality. I still lose things, am forgetful and distracted, have difficulty waiting my turn, occasionally fidget and sometimes 'self-medicate' with an excess of alcohol. However, at age fifty I have a wonderfully happy work and home life, structured in a way that copes with my weaknesses and builds on my strengths.

I have no doubt that if I was born in 1999 and not 1959, I would be a candidate for a diagnosis of attention deficit hyperactivity disorder (ADHD). I have never considered myself diseased or disordered but I have completed internet-based self-assessment tests and been classed in the extreme ADHD range. The fact that children who behave like I once did are being classified as 'disordered' is why the focus of my political work has been advocating for distracted, impulsive, inattentive children.

## MARTIN'S ADHD JOURNEY

I first heard of ADHD in 1995 when I began teaching at a wealthy independent boys' grammar school and was struck by the number of 'medicated' students who seemed disengaged from their peers and unnaturally quiet and compliant. I had always considered that hyperactivity, impulsivity and disorganisation were part of what made boys boys. One student in particular alarmed me. Although Ted didn't appear to be a victim of bullying, he seemed to be almost completely isolated from his peers.<sup>1</sup> He was quiet and compliant, but seemed somehow 'absent'.

When set a forty-minute in-class essay Ted completed one sentence. I knew Ted had been diagnosed and medicated for ADHD and expected that, had the medication been working, he would have been able to produce more work. When I graded Ted's paper 'unsatisfactory' his parents arranged a meeting to 'educate' me about his condition. I sat quietly as Ted's father told me about Ted's biochemical brain imbalance and advised me to adjust my expectations of what Ted could achieve.

The next year as a fifteen-year-old, Ted went on a compulsory eleven-day hike with thirteen schoolmates and two female teachers. After the hike the teachers informed me that after a couple of days Ted's personality had transformed completely. He became a typically active, engaged and humorous teenage boy. These two strong-willed teachers' report on Ted's behaviour during the hike began: 'When Ted emerged from his drug-induced haze we saw a vibrant, interested, and interesting young man...' Of course the report was never sent to his parents, although they did request a meeting with the two teachers where they asked a number of questions: 'What happened on the hike? Ted can't stop talking about how wonderful it was. Were you aware that Ted forgot to take his ADHD medication

that we had packed for him?’ When the teachers suggested that the life-changing experience that Ted had on the hike may have been *because* he was medication-free, his parents disagreed, stating that Ted may have been able to function in a low-stress environment like hiking, but he could not possibly cope without medication at school.

I taught a number of other boys either on ADHD medication or for whom the pathway towards medication had been suggested. Often at the beginning of Year 11, where the academic rigour of subjects starts to see some students fall behind their peers, a checklist of ADHD behaviours would appear on my desk as part of the assessment process for a struggling student. For others, it was their cheeky demeanour and disinterest in an academic pathway that appeared to be the catalyst for an ADHD assessment. One boy diagnosed with, and medicated for, ADHD also had tics and Tourette syndrome, and frequently made involuntary and usually incomprehensible noises. At the time I thought the tics and Tourette syndrome were separate afflictions – years later I learned they were likely to have been side effects of his medication.

I was very uncomfortable with what I saw happening to these boys and frustrated at my inability to do anything about it. I remember attending a teachers professional development session at which a clinical psychologist informed us that the 5 per cent of the population who were the least attentive and most hyperactive had attention deficit hyperactivity disorder. The forty-minute presentation left me with an uneasy feeling that the science behind ADHD may not have been nearly as thorough as was made out. I thought the symptoms the psychologist identified – being disorganised, losing things and



fidgiting – were pretty normal childhood behaviours and was uncomfortable with the idea of using drugs to control them.

From that point on I read widely on the issue. When I was a candidate for an unwinnable seat in the 1998 federal election, I decided to speak publicly, about my concerns about possible misdiagnosis and over-prescription of ADHD medications in an opinion piece in a local paper.

My activism on ADHD really kicked into gear when I was elected to the Western Australian Parliament in 2001. In my inaugural speech I spoke at length about the issue, confusing dexamphetamine and Ritalin, but nonetheless identifying 'my grave concerns that ADHD misdiagnosis and the resultant over-prescription of amphetamines' is 'a threat to the health and happiness of many West Australian children'.

For several years I was tentative with the language I used, believing that the medical profession must have had a solid scientific basis for its diagnosis of ADHD for at least some children. The more stories I heard and the more I researched the topic, however, the more suspicious I became – initially about the validity of the diagnosis, and then about the safety and efficacy of the drugs prescribed. The more evidence I was exposed to, the more suspicious I became about the motivation of those driving the widespread prescription of ADHD drugs. It's plain that the long-term use of amphetamines is bad for children, and the most puzzling part of the whole ADHD debate is how holding this position can be characterised as radical.

My decade-and-a-half long journey through the ADHD debate has included many surprising twists and turns. The ADHD debate is like an onion: the more layers you peel away, the more you are inclined to cry.



## Diagnosis: Disease, Disorder or Difference?

In 1987 a subcommittee of the American Psychiatric Association (APA), the majority of whose members had ties to the pharmaceutical industry, voted to include attention deficit hyperactivity disorder (ADHD) in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) the APA's catalogue of mental illness.<sup>1</sup> Similar processes had seen ADHD's predecessors attention deficit disorder (1980) and hyperactive disorder of children (1968) included in earlier editions of the DSM.

Every claim about ADHD should be viewed in the light of the diagnostic criteria defined in DSM-IV. In layman's terms, the diagnostic criteria for ADHD in all its forms results in the labelling of children who are too active (hyperactivity), not active enough (hypoactivity) and inattentive, as ADHD. The diagnosis of ADHD is entirely based on observations of a child's

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behaviour, as ‘there are no laboratory tests, neurobiological assessments, or attentional assessments that have been established as diagnostic in the clinical assessment of Attention Deficit/Hyperactivity Disorder’.<sup>2</sup>

### Extract from DSM-IV: ADHD Diagnostic Criteria

Either (1) or (2):

1. six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

#### *Inattention*

- a. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
  - b. often has difficulty sustaining attention in tasks or play activities
  - c. often does not seem to listen when spoken to directly
  - d. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
  - e. often has difficulty organizing tasks and activities
  - f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
  - g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
  - h. is often easily distracted by extraneous stimuli
  - i. is often forgetful in daily activities
2. six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree

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that is maladaptive and inconsistent with developmental level:

### *Hyperactivity*

- a. often fidgets with hands or feet or squirms in seat
- b. often leaves seat in classroom or in other situations in which remaining seated is expected
- c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- d. often has difficulty playing or engaging in leisure activities quietly
- e. is often “on the go” or often acts as if “driven by a motor”
- f. often talks excessively

### *Impulsivity*

- g. often blurts out answers before questions have been completed
- h. often has difficulty awaiting turn
- i. often interrupts or intrudes on others (e.g., butts into conversations or games)<sup>3</sup>

The eighteen behaviours are, according to ADHD proponents, evidence of a neurobiological disorder, that is, a ‘biochemical brain imbalance’, though most children, and many adults, display them to varying degrees in homes, schools and workplaces every day. Consider, too, that children are naturally impulsive, inquisitive, active, playful and often inattentive. The diagnostic criteria reflect very narrow expectations of what constitutes normality in young children. Television current affairs programs often portray ADHD children as

violent, bad-tempered, uncontrollable brats, but the diagnostic criteria make no reference to violent or other extreme behaviours. Interrupting, talking excessively, being forgetful or not playing quietly are not extreme behaviours. They form a part of normal childhood behaviours and are not specific to ADHD. They also require that 'some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years'.<sup>4</sup> Yet how many six-year-olds, play quietly and await their turn patiently? Was childhood meant to be constrained, controlled, predictable and boring?

What is supposed to distinguish ADHD sufferers from the rest of the population is their level of behavioural impairment or dysfunction. Specifically, 'There must be clear evidence of clinically significant impairment in social, academic or occupational functioning' and 'Some impairment from the symptoms... present in two or more settings (e.g. at school or work and at home)'.<sup>5</sup> How 'often' a child 'fidgets or squirms in their seat', or 'interrupts' or 'avoids homework' or 'fails to remain seated when remaining seated is expected' or 'is distracted by external stimuli' so that they exhibit 'some impairment' is not defined in DSM-IV. Like beauty, 'impairment' is in the eye of the beholder. DSM-IV says:

Signs of the disorder may be minimal or absent when the person is receiving frequent rewards for appropriate behaviour, is under close supervision, is in a novel setting, is engaged in especially interesting activities, or is in a one-to-one situation (e.g., the clinician's office.)<sup>6</sup>

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In other words, ADHD children will behave appropriately and not display ADHD symptoms when they are rewarded, when people pay attention to them (close supervision) and when they are having new experiences. Conversely, ADHD children will be inattentive, easily distracted and display ADHD symptoms when their good behaviour goes unrewarded, no one pays any attention to them, or they are bored.

The diagnosing clinician doesn't have to observe any of the symptoms, let alone any impairment. He or she may simply base their diagnosis on third-party accounts of a child's behaviour. The child's parents and teachers usually provide these and are typically asked to fill in a questionnaire detailing if their child always, often, sometimes or never displays behaviour like avoiding homework and chores, losing toys, not listening, fidgeting, butting in, talking excessively or being easily distracted or forgetful.

Disturbingly, parents and teachers are rarely given guidance as to the crucial difference between sometimes and often. Even devoted parents, particularly first-time parents, can have unrealistic expectations of normal childhood behaviour. Nor is any guidance given to age-appropriate levels of attention or impulsivity control. The same imprecise, subjective diagnostic criteria are applied whether their child is two or seventeen.

What's of particular concern here is that parents and teachers are not routinely informed of the central role that their evidence plays in their child's diagnosis.

Many are simply fed the line that their child has a 'bio-chemical brain imbalance' – without any supporting evidence other than the observed behaviour of their child – and that this 'imbalance' is best treated with medication.

One counter argument to this is that all psychiatric disorders, many of which are also treated with medication, are diagnosed using similar behavioural criteria. Pointing out inadequacies in the diagnosis of other psychiatric conditions is a poor defence for the inadequacies of the ADHD diagnostic criteria. However, at least conditions like schizophrenia involve extreme behaviours such as delusions or catatonia.

### Co-morbidity

DSM-IV makes no reference to a biochemical imbalance being the cause of ADHD, although it is treated as if it does have a single biochemical cause by the claim that, in the majority of cases, it is co-morbid – meaning that it co-exists with a range of other diseases and disorders.<sup>7</sup> Typically it's argued that the co-morbid conditions require separate but complementary treatments; in practice this means ADHD-specific drugs for ADHD and other drugs for co-morbid conditions. It is common for children to be on a range of drugs for bipolar disorder, depression, anxiety and ADHD simultaneously. South Australian psychiatrist Jon Jureidini rejects the concept of multiple co-morbid disorders: 'When you have got a kid with ADHD and oppositional defiance disorder and depression and anxiety disorder...what this says is not that he has got four disorders, but that there is something wrong with the kid and people haven't properly understood what it is yet.'<sup>8</sup>

Poor diet, sight, hearing, parenting, teaching, physical, sexual or psychological abuse or trauma, sedentary lifestyle, neurotoxin exposure, underlying medical conditions and even



boredom can lead to a child failing to pay attention and/or acting in an impulsive or hyperactive manner. Most of these causes have little to do with 'brain chemistry'. Occasionally, however, neurotoxins may cause a biochemical imbalance in the brain and, if so, the source of the neurotoxins should be identified and removed. The use of drugs to address a biochemical brain imbalance caused by toxins simply introduces yet another toxin.

Jon Jureidini believes the rise in ADHD prescribing is caused in part by doctors who jump too quickly to unwarranted conclusions, stating: 'If you are going to be a good psychiatrist or a good mental [health] professional you have to be able to tolerate that [vast] level of uncertainty and not go grasping for the prescription pad or the MRI scan or whatever the latest fad is to deal with that complicated issue.'<sup>9</sup>

Jureidini also believes that in some cases abuse or neglect may be 100 per cent responsible for children's errant behaviour while other cases parenting has very little to do with it. The diagnosis of ADHD and subsequent medicating of children can hide serious child abuse. It's obvious, for example, that children who have been sexually or physically abused are highly likely to be inattentive and behave inappropriately. I recall a phone call from a woman whose nine-year-old grand-daughter had been a victim of sustained sexual abuse by a family member. She was distraught that her daughter had allowed the young girl to be medicated for ADHD. On dexamphetamine (a psychostimulant) her grand-daughter had become quiet and withdrawn, which apparently pleased her mother, but exasperated the grandmother who believed her real issues were being masked by medication. Severely traumatised children are likely to avoid homework, be

easily distracted, lose things, fidget and squirm. Victorian child psychiatrist Dr George Halasz believes medicating an abused child further damages that child's self-esteem: 'If a child victim of abuse is diagnosed with ADHD and medicated, it will break all their trust in relationships. They perceive themselves as damaged goods.'<sup>10</sup>

## The History of ADHD

In 1902 Dr Fredric Still documented cases involving impulsiveness, labelling it a 'defect of moral control'. It was later renamed 'minimal brain damage'. In 1922 the symptoms were further defined and given the name 'post encephalitic behaviour disorder'.

The use of stimulants to modify behaviour did not begin until 1937 when American doctor Charles Bradley was the first to recommend stimulants to treat hyperactive children. Dr Bradley

observed the 'calming' effect of stimulants on children when he gave Benzedrine (trademark for amphetamine) to a group of 30 children in order to treat headaches that resulted from spinal taps they were given. The Benzedrine did not do anything for the headaches, but it did make the children less active and more compliant, in a fashion he called 'spectacular'.<sup>11</sup>

Bradley had identified the effects of amphetamines on 'normal' children but proposed amphetamines as a treatment for

hyperactive children. In 1950 Dr Bradley undertook a study of 275 hyperactive children given amphetamines. He reported 'between 60 per cent and 70 per cent to be much improved while on the drugs'.<sup>12</sup>

And in 1956 the stimulant Ritalin made its first appearance in the treatment of these hyperactive children. Despite these early origins it was not until well into the 1960s that the use of stimulant medication to treat hyperactive children became common, and not until the 1990s that, facilitated by the loosening of the DSM-IV diagnostic criteria, prescribing rates exploded in North America and Australia.<sup>13</sup>

Except for Still's 'defects of moral control', early emphasis was on aetiology-based (cause) descriptions of the disorder. This is despite the fact that the cause or causes had never been established. The term 'minimal brain dysfunction' used in the early 1960s was altered in the late 1970s to 'hyperactive disorder of childhood'. This name change drastically altered public perception of the disorder. No one wanted to have a brain-damaged child – having a hyperactive child was far more acceptable.

During the 1970s, further symptoms such as a lack of focus and daydreaming were added to the diagnostic list. Impulsiveness was also expanded at this time to include verbal, cognitive and motor impulsiveness. In 1980 the APA voted to change the name of the disorder to 'attention deficit disorder' (ADD) and its definition was again expanded. The new definition was based on the assumption that attention difficulties are sometimes independent of impulse problems and hyperactivity – the disorder was redefined as primarily a problem of inattention, rather than of hyperactivity. In keeping with this approach, two subtypes of ADD were presented in DSM-III: ADD/H, with hyperactivity,

and ADD/VO, without hyperactivity or passive ADD. The recognition of passive ADD has been the subject of debate ever since.

### *Passive ADHD*

When the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) was revised in 1987, the name of the condition was changed to the one we use today, attention deficit hyperactivity disorder (ADHD), and the symptoms were again merged into a single disorder without any subtypes. Specifically, DSM-III-R required a child to display six of nine inattentive behaviours *and* six of nine impulsive/hyperactive behaviours. This diagnostic requirement did away with the possibility that an individual could have the disorder without being hyperactive. A child had to display both inattentive and hyperactive/impulsive behaviours.

Subsequent to the release of DSM-III-R a number of studies were published justifying the existence of passive or inattentive ADD without the hyperactivity element. In response to this backlash, the definition was changed yet again in the fourth edition of the manual published in 1994 (DSM-IV). The criteria was broadened so that a child needed to display six of nine inattentive *or* six of nine hyperactive/impulsive behaviours. The APA did not change the name ADHD, but the symptoms were divided into two categories: inattentive and hyperactive/impulsive. Three subtypes of the disorder were also defined: 'ADHD – Primarily Inattentive', 'ADHD – Primarily Hyperactive/Impulsive', and 'ADHD – Combined Type (both

inattentive and impulsive)’. Not surprisingly, this created some confusion. (Sometimes when the term ‘attention deficit disorder’ (ADD) is used today it is used in its original generic sense – interchangeably with ADHD. On other occasions it is a specific descriptor of passive ADHD.)

ADHD now applies to a whole spectrum of child behaviour. Both children who are too active and children who are too inactive are included. In addition to the ADHD hyperactive and inattentive subtypes, DSM-IVTR, the updated version of DSM-IV contains yet another category, ‘Attention Deficit/Hyperactivity Disorder – Not otherwise specified’, which further broadens the criteria to include ‘individuals whose symptom pattern does not meet the full criteria for the disorder’.

Fred Baughman American neurologist and author of *The ADHD Fraud* believes this broadening of diagnostic criteria is contrary to the process of defining legitimate diseases. In 2006 Baughman wrote:

Normally, as a condition is studied and more is learned about it, the diagnostic signs (signs=objective abnormalities) are narrowed down to a specific set of objective criteria that can be reliably applied. With ADHD the opposite happened...<sup>14</sup>

With the benefit of hindsight, Dr Allen Frances, who was the chief of psychiatry at the Duke University Medical Center and led the effort to update DSM-IV in 1994, regretted broadening the diagnostic criteria and warned of problems with the drafting of the next edition, DSM-V, due for final release in 2012. Frances believes:

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We learned some very, very, painful lessons in doing DSM IV...we thought we were being really careful about everything we did and we wanted to discourage changes. But inadvertently, I think we helped to trigger three false epidemics. One for autistic disorder...another for the childhood diagnosis of Bi-Polar disorder and the third for the wild over-diagnosis of Attention Deficit Disorder.<sup>15</sup>

Significant effort has been put into promoting and normalising passive ADHD in the public realm, much of it centred on the argument that girls were being underdiagnosed as they were more likely to have passive ADHD than exhibit hyperactivity. Typical of this is the following extract published in the *West Australian*, 16 April 2003.

### Quiet Children Slip ADHD Net

Children with attention deficit disorders who are not naughty and disruptive are falling through the medical net, resulting in learning difficulties and social problems, according to a WA expert. Curtin University psychology professor, David Hay, who specialises in attention deficit hyperactivity disorder, said children with a form of the disorder that makes them dreamy and inattentive were often not diagnosed until their teens if at all. Girls were most likely to slip through the net. The form of ADHD most widely known – when children are noisy and difficult – was more common in boys but both boys and girls were equally likely to have ‘quiet’ ADHD.

‘ADHD is meant to be diagnosed by the age of seven but with a lot of girls, it only comes to the fore when they get to high school,’ Professor Hay said. ‘It becomes obvious in high school

because they are no longer in just one class, they have to move classes all the time and be organised, so all the organisational problems with ADHD suddenly come to the fore. When we did surveys in schools, about 4 per cent to 5 per cent of kids have this inattentive type (of ADHD) but because they are quiet kids no one really picks it up...<sup>16</sup>

### *Adult ADHD*

Many parents take the advice that ADHD is inheritable at face value and become suspicious that they may share the 'lifelong affliction' with their child. The subsequent diagnosis of adult ADHD is in their minds confirmed when they become temporarily more focused after taking medication. DSM-IV says: 'Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.' Despite this and the fact that the diagnostic criteria are defined in terms most applicable to children in a classroom setting, in recent years considerable energy has been put into promoting 'Adult ADHD'.

The Western Australian ADHD support group, the Learning and Attentional Disorders Society (LADS) (see chapter 3), attributes a variety of adult problems from car crashes to divorce and even bad manners to undiagnosed Adult ADHD:

The symptoms of ADHD can cause severe disruptions in the lives of adults: Concentration difficulties may result in people becoming procrastinators, and earning a reputation for laziness and a lack of motivation. They may be embarrassed in social situations as their

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concentration drifts during conversations. They may have a tendency to interrupt others or to make tactless comments. Physically, they may engage in high-risk activities. People with ADHD receive more traffic infringements and licence suspensions, particularly for speeding. They are involved in more motor vehicle accidents. Intimate relationships may be more difficult to sustain, with higher rates of separation and divorce occurring in this group. Educational and professional under-achievement is common, and causes great frustration. Adults with ADHD often find it difficult to manage their ADHD children...Dexamphetamine and Methylphenidate improve symptoms in up to 78 per cent of adults with ADHD.<sup>17</sup>

Even criminality and drug abuse are attributed to undiagnosed, and therefore un-medicated, ADHD. An example is the following verbal evidence given on behalf of LADS to the 2004 Western Australian parliamentary inquiry into ADHD:

The research shows that people with ADHD are six times more likely to develop a substance abuse problem. However, if they are treated with stimulant medication, the risk is reduced to the same as someone without ADHD...Some excellent work has been done by Dr Tony Mastrioni on the New South Wales prison system. He estimates that 30 per cent of the prison population in NSW has ADHD, either diagnosed or undiagnosed.<sup>18</sup>



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The effect of this association with extreme dysfunctional behaviour is to create a sense of crisis that extreme consequences will result from ADHD going untreated which really means un-medicated.

Criminal and drug-taking behaviour are in themselves dysfunctional and most often impulsive acts. How many drug addicts aren't forgetful, distracted or disorganised? It is self-evident that many criminals and drug addicts tend to demonstrate ADHD behaviours and certainly live dysfunctional lives, therefore qualifying for a diagnosis of adult ADHD. Yet to argue that ADHD, when left un-medicated, causes criminal behaviour or drug abuse is to confuse cause and effect. It involves identifying dysfunction in what is already identified as a dysfunctional population. This is the equivalent of being able to bet on a horse after the race has finished.

### *Consensus as a Substitute for Science*

Consensus rather than science has driven the expansion of the definition of ADHD. In 2002, an 'independent consortium' of eighty-four 'leading scientists' signed the 'International Consensus Statement on ADHD'. The first signatory was the world's high profile ADHD advocate, American psychologist Dr Russell Barkley.

**Extract from the 'International Consensus  
Statement on ADHD'**

This is the first consensus statement issued by an independent consortium of leading scientists concerning the status of the disorder. Among scientists who have devoted years, if not entire careers, to the study of this disorder there is no controversy regarding its existence...We cannot over emphasize the point that, as a matter of science, the notion that ADHD does not exist is simply wrong...the occasional coverage of the disorder casts the story in the form of a sporting event with evenly matched competitors. The views of a handful of non-expert doctors that ADHD does not exist are contrasted against mainstream scientific views that it does, as if both views had equal merit. Such attempts at balance give the public the impression that there is substantial scientific disagreement over whether ADHD is a real medical condition. In fact, there is no such disagreement – at least no more so than there is over whether smoking causes cancer, for example, or whether a virus causes HIV/AIDS...To publish stories that ADHD is a fictitious disorder or merely a conflict between today's Huckleberry Finns and their caregivers is tantamount to declaring the earth flat, the laws of gravity debatable, and the periodic table in chemistry a fraud...All of the major medical associations and government health agencies recognize ADHD as a genuine disorder because the scientific evidence indicating it is so is overwhelming.<sup>19</sup>

The claim that the signatories were an 'independent consortium' is questionable on a number of levels. First, there is the obvious investment in validating the authenticity of a controversial disorder for those 'who have devoted years, if not entire careers'

to its study. In addition, many of the self-appointed consortium of 'leading scientists' earn their incomes either through diagnosing and prescribing for ADHD or conducting drug-company funded research into the disorder.

It is the widespread acceptance of ADHD by 'the major medical associations and government health agencies' that is the most alarming part of the whole debate. Here, hypothesis is stated as fact and in the minds of many ADHD is so big it *must* be real. Few people in the medical and political establishment are motivated enough to examine the quality of the research or brave enough to question the validity of the diagnosis.

British psychiatrist Sami Timimi believes the Consensus Statement was a response to the authors being 'shaken by criticism' of ADHD diagnosing and prescribing.<sup>20</sup> Timimi is highly critical of the Consensus Statement and sees it as an attempt to shut down debate:

Not only is it completely counter to the spirit and practice of science to cease questioning the validity of ADHD as proposed by the consensus statement, there is an ethical and moral responsibility to do so. It is regrettable that they wish to close down debate prematurely and in a way not becoming of academics. The evidence shows that the debate is far from over.<sup>21</sup>

The authors of the Consensus Statement, according to Timimi, 'are well-known advocates of drug treatment for children with ADHD' who in the statement did 'not declare their financial interests and/or their links with pharmaceutical companies'.<sup>22</sup>

The International Consensus Statement is an attempt by its authors to present the legitimacy of ADHD as an indisputable truth. Documents such as this have the effect of dumbing down debate by substituting prejudice for science. Despite the fundamentalist fervour of the authors, the fact is that ADHD is no more than a very loosely defined set of symptoms for which self-appointed 'leading scientists' identify no cure.

### *The Question of Difference*

Most of the research undertaken by proponents of ADHD, including the signatories of the International Consensus Statement, is designed to show that ADHD medication works or that children diagnosed with ADHD are different from other children. The many claims of new research purporting to prove this difference, however, have been shown to be false. Many of the studies that claim to show differences compared brains that had never been medicated to brains that had been exposed to psychostimulants. Psychostimulants 'routinely cause gross malfunctions in the brain of the child' and 'can cause shrinkage (atrophy) or other permanent physical abnormalities'.<sup>23</sup> Most of the supposed breakthroughs relate to brain-imaging using PET scanners or MRI technology. None of the claims, however, have been sustained and all mainstream medical authorities recognise that the technologies have no role in the diagnosis of ADHD. Even the more optimistic of assessments recognise brain-imaging technologies as having no diagnostic value, merely unfulfilled potential.<sup>24</sup> Neuro-imaging can do little more than assess the shape and size of the brain.<sup>25</sup> Queensland psychologist Bob

Jacobs believes:

even if researchers found a consistent difference between children who act a certain way ('ADHD') and children who don't, and even if they could somehow prove that the difference caused the behaviours, there is no reason to believe there is any 'disorder'. There may be physiological differences between people who are right-handed and left-handed, or people who prefer the colour red over the colour blue. But it doesn't make either group 'sick'. We know that people have individual physical differences, but it is dangerous ground to say that those differences are a 'disorder', just because they are in the minority, or because the cause problems with fitting into society's rigid structures (like school).<sup>26</sup>

As Jacobs points out, the search for differences in ADHD brains, which has so far proven fruitless, is also futile. For even if the search was eventually successful all it could demonstrate is difference, not disease.

## Prevalence Rates

Prevalence rates are estimates of the percentage of a population with a disease or disorder. A prevalence rate is different from a diagnosis rate, which is the percentage of the population diagnosed with a condition. For diseases like asthma, haemophilia, or leukaemia – with science-based diagnoses, real and indisputable

negative consequences, and medically valid treatments – parents, policymakers and clinicians need to be concerned if prevalence rates exceed diagnosis rates because it means that real disease is going undiagnosed and therefore untreated. For a subjective, ill-defined diagnosis like ADHD, estimates of prevalence rates are virtually meaningless. Even if levels of inattention, hyperactivity and impulsivity could be objectively measured so children could be reliably placed on a continuum of ADHD behaviours, that would not make it a legitimate disorder.

In spite of this inability to objectively measure an ultimately meaningless statistic, estimates of prevalence rates are frequently quoted. They are used to defend allegations that ADHD is over-diagnosed and over-medicated with the claim that prevalence rates exceed diagnosis and prescribing rates and that ADHD is in fact *under*-diagnosed and *under*-medicated. There have been numerous studies to determine prevalence rates for ADHD. Not surprisingly estimates of ADHD prevalence vary widely. An American study conducted in 1998 found that prevalence estimates vary between 1.7 per cent and 16 per cent.<sup>27</sup> Estimates of prevalence rates also vary across cultures, presumably influenced by cultural norms with the highest reported (29 per cent) being in India.<sup>28</sup> The huge range is undoubtedly a consequence of relying on subjective and ill-defined diagnostic criteria.

### *11.2 per cent NHMRC Prevalence Estimate*

The National Health and Medical Research Council (NHMRC) is an independent statutory agency funded by the Commonwealth government to develop recommendations for

best health policy and practice. In 2000, research outsourced by the NHMRC estimated that 11.2 per cent of Australian children had ADHD.<sup>29</sup> The methodology used in the study was fundamentally flawed. It involved the parents of 2737 children completing a checklist on the behaviour of their child,<sup>30</sup> not an effort to ensure the children being tested met the full criteria for a diagnosis of ADHD. There was no measure for impairment or any attempt to establish that the child displayed the behaviours in at least two settings, nor were other explanations for the ADHD type behaviours explored.

As a result the 11.2 per cent estimate was a gross overestimate of the number of Australian children who would qualify for a thorough application of the DSM-IV criteria. A prevalence of 11.2 per cent equates to one in nine Australian children. It is widely accepted that ADHD is far more common in boys than in girls at a ratio of approximately three to one.<sup>31</sup> Given that ratio and assuming a prevalence rate of 11.2 per cent, one in six boys, and one in eighteen girls would have ADHD medication. A stunning and frightening prospect. Nonetheless, this study has been frequently used to support the argument that ADHD is under-diagnosed and under-medicated. One of many examples of this abuse of statistics was by former president of the Western Australian AMA Dr Bernard Pearn-Rowe, who in 2002 was quoted as saying, '[in Western Australia] local specialists were leading the way in diagnosing and treating the condition...a 1999 review by the National Health and Medical Research Council found 11 per cent of the population aged 4 to 17 years had ADHD, but that less than 2 per cent of cases were treated'.<sup>32</sup> The fact that a state leader of the AMA unquestioningly accepted this advice is evidence of a deficit of common

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sense at the highest levels of the Western Australian medical fraternity.

Of much greater concern is that in November 2009, nearly a decade after the flawed estimate was produced, federal health minister Nicola Roxon, the Royal Australasian College of Physicians and the NHMRC, used the 11.2 per cent estimate, in a joint press release, to claim there were over 350,000 Australian children and adolescents with ADHD.<sup>33</sup> It is extremely worrying that old, specious, discredited research can be recycled by the highest levels of government and the medical profession.