A SYMPOSIUM ON ATTENTION DEFICIT HYPERACTIVITY DISORDER

The Changing Social Reality of ADHD

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Attention Deficit Hyperactivity Disorder (ADHD) has become a hallmark disorder of American society, especially among children. The Center for Disease Control estimates seven percent of the school-age population has the disorder and numerous studies have shown that the number of children, adolescents and now adults who are treated with medication for the disorder continues to increase. It has been the most common psychiatric diagnosis among children for several decades. The widely-used medication treatment, Ritalin, has become synonymous with the disorder (although now there are more than a dozen different medications used). Until the last decade this had been a mostly American phenomenon, with European and other countries diagnosing and treating a fraction of the numbers treated in the United States, but in recent years the diagnosis has migrated to other countries, although still at much lower rates.

Rick Mayes, Catherine Bagwell and Jennifer Erkulwater give us a thorough and thoughtful social and historical account about the emergence and expansion of the ADHD diagnosis and treatment. Their detailed history of the disorder is fascinating and well-researched, presenting a provocative analysis of the impact of policy changes on ADHD. The roots of ADHD are in the chance discovery in the 1930s of a misnamed "paradoxical effect" of stimulant medications that could reduce hyperactive and restless behavior in children, but the treatment did not become well-known until the approval of Ritalin for use with children in the 1960s. During this period we see a series of names for a disorder that Ritalin and similar medications were deemed to treat: organic drivenness, minimal brain dysfunction, hyperkinesis, hyperactive syndrome and ADHD. All of these assumed but did not demonstrate some kind of underlying biophysiological disorder. An important conceptual shift occurred when focus on the disorder shifted from disruptive behavior to attention difficulties. Reframing the problem from largely hyperactive behavior to include inability to sustain attention was a significant definitional change that widened the net of children who could be diagnosed and treated for ADHD. It also altered the gender balance, because the symptom array now included girls who spaced out as well as boys who acted up.

While the number of children diagnosed grew steadily during the 1970s and 1980s, expanding to include adolescents, it was in
the 1990s that the ADHD diagnoses skyrocketed. The prevalence went from 900,000 4–17 year old children diagnosed in 1990 to 3–4 million children diagnosed by the end of the decade. Mayes, Bagwell and Erkulwalter posit three policy changes that helped trigger the surge of ADHD in the 1990s: (1) a 1990 Supreme Court decision that engendered a change in the Supplemental Social Security (SSI) program to allow it to include low income children with disorders like ADHD, (2) in response to the lobbying of parents of ADHD children, Congress passed a law in 1991 that included ADHD as a “protected disability” under Individuals with Disability Education Act (IDEA), resulting in children with a diagnosis receiving special accommodations, (3) in the 1990s, lawmakers expanded the number of children who would be eligible for Medicaid, allowing new populations of children (mostly poor) to have access to diagnosis and treatment. In that decade, the number of prescriptions for stimulant medications increased six-fold.

According to the authors a backlash against ADHD treatment began in the later 1990s. But the roots of this are much earlier; perhaps one benchmark would be the well-publicized claims of “drugging school children” in Omaha in the 1970s. There have long been critics and skeptics of ADHD and its treatment, and while noted, they do not seem to have influenced the authors’ assumptions about ADHD. Throughout the book the authors assume ADHD is a “real disorder,” that diagnosis is generally accurate, and that stimulant treatments are safe (p. 11 and elsewhere). This is reflected in the most disappointing chapter in a book by social scientists. Chapter One presents ADHD in a thoroughly unremarkable and uncritical light, reiterating mainstream medical understandings and claims concerning ADHD. This could just as well have been written by one of the eminent ADHD medical experts (who are widely cited in the chapter). The authors accept the common medical assumption that there is an underlying biological dysfunction. Such contentions have been proposed for decades but the evidence for an organic basis for most children who are diagnosed with ADHD remains elusive, despite genetic claims and sophisticated imaging on brain scans. And even if one found some validated biophysiological differences, the sociological question remains, does difference mean disease?

While the authors are persuasive about the impact of policy changes, especially on poor children, they skirt the role of the pharmaceutical industry in the ADHD story. Although they acknowledge that many physicians who were involved in creating the influential DSM-III diagnostic definitions of ADHD had financial ties to drug companies and give brief mention of the rise of direct to consumer advertising, they don’t examine the role of the pharmaceutical industry in promoting ADHD and its stimulant treatment. It seems reasonable to ask what role did the pharmaceutical industry have in the expansion of ADHD diagnosis and treatment, especially in shifting the targets and thresholds for treatment. This is a significant piece of the puzzle that is given short shrift here.

Sami Timimi and Jonathan Leo have compiled a collection that is profoundly critical of the medical and educational conceptualization and treatment of ADHD. The contributors include authors who are well known for their professional critiques, skeptical physicians and practitioners, and promoters of esoteric solutions. The chapters are virtually all critical of the current medical perspective and treatment of ADHD and range from the analytical to the prescriptive. While contributions to such volumes can be notoriously uneven, I was particularly impressed with a couple of the more analytical chapters. Lydia Furman, an academic pediatrician, provides an excellent review of the physiological evidence for ADHD and concludes that a “review of the supporting literature for ADHD reveals no clear evidence for a discrete disease or condition” (p. 43). The core symptoms of inattention, impulsivity and hyperactivity can result from numerous other conditions, and the screening tools for ADHD have not been validated. In other words, contrary to Mayes and his colleagues, most authors in this volume question whether ADHD is a valid disorder and if the regular stimulant treatment is warranted or safe. Psychologist Jay Joseph presents a critical view of genetic ADHD research, especially
twin and adoption studies, concluding that the search for ADHD genes is fruitless. Sociologists Nicky Hart and Louba Benassaya provide a provocative argument for a social class analysis of ADHD diagnosis and treatment, but regretfully the data are not yet there. Reading the chapters on globalization of ADHD reinforced my impression that ADHD diagnosis and treatment are spreading from the United States to distant parts of the world. Some of the other chapters were strong on criticism but weak on data or analysis; it is incumbent on critics to be as rigorous as are the advocates of ADHD, and a number of these chapters fall short. But books like this are important, written by outsiders who do not share the assumptions of the medical paradigm and, indeed, are often deeply skeptical of it. Authors here ask hard questions about the validity of diagnosis, the source of the disorder, the efficacy and safety of treatment, and offer some alternative interpretations and practices. Books like this can provide a challenge to accepted mainstream assumptions.

After decades of diagnosing and treating children for ADHD, we are seeing some interesting changes that should be grist for the sociological mill. This classic case of the medicalization of deviance is undergoing some significant changes. As noted, ADHD is going global; both the influence of the American psychiatric profession (and its "bible" DSM-IV) as well as opportunistic drug companies are helping to spread the gospel of ADHD stimulant medication treatment to places where it hardly existed previously. Furthermore, ADHD used to be considered a disorder of children and adolescents, but with the emergence of adult ADHD it is seen increasingly as a lifetime disorder. This opens new populations for treatment. In recent years we have heard about diversion of ADHD medications to students in high school and college who want to take the stimulants as a kind of cognitive enhancement. This has led to a grey market in schools, where students can trade or purchase drugs like Ritalin. While we don’t have much data, there have been reports of youngsters actually seeking an ADHD diagnosis for the social benefits (e.g., un timed tests) or as ready access to the stimulant medications. As a news magazine cover once stated, ADHD: Not just for children anymore.

The Case for Demedicalizing ADHD

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It is not initially apparent why a book co-edited by a psychiatrist and a neuroanatomist would be important for sociologists to read and consider thoughtfully. Sami Timimi and Jonathan Leo suggest this book is "an antidote" to the often one-sided mainstream framing of ADHD as medical disorder. The articles in Rethinking ADHD provide a detailed history and challenge to the dramatic rise of the medicalization of a seemingly new disorder. Although it is somewhat uneven in the quality of the articles and there are some articles that some sociologists may gloss over, this collection is important for us as scholars, teachers and parents of a generation of students (especially boys) who have been diagnosed as having substantial learning disorders. Perhaps the strongest part of the collection is the diversity of the contributors and professional perspectives presented in the volume. The case for demedicalization of ADHD is not just an issue of professional conflict between health and mental health clinicians. The contributors represent psychiatrists, psychologists, educators, social workers and even one sociologist.