Examine the proposition that the existence and prevalence of ‘Attention Deficit Hyperactive Disorder’ is ‘a matter of debate’ and its treatment, ‘medical fashion’. You should refer to published literature and research.

Emma Price, 2021

“Now this is a map of the instance that ADHD in America or prescriptions for ADHD. Don't mistake me, I don't mean to say there is no such thing as Attention Deficit Disorder. I'm not qualified to say if there is such a thing. I know that a great majority of psychologists and paediatricians think there is such a thing, but it's still a matter of debate. What I do know for a fact is it's not an epidemic. These kids are being medicated as routinely as we had our tonsils taken out. And on the same whimsical basis and for the same reason - medical fashion.” Robinson (2008) Changing Educational Paradigms, RSA Lecture.

Examine the proposition that the existence and prevalence of ‘Attention Deficit Hyperactive Disorder’ is ‘a matter of debate’ and its treatment, ‘medical fashion’. You should refer to published literature and research.

Attention deficit hyperactivity disorder (ADHD) is defined as a psychiatric disorder; one that must present itself symptomatically in childhood (NHS: 2018). Common symptoms might include: ‘often ha[ving] difficulty sustaining attention in tasks or play activities’; ‘often does not seem to listen when spoken to directly’; ‘often does not follow through on instructions and fails to finish school work, chores, or duties in the workplace’ (American Psychiatric Association: 2013). These symptoms can and are perceived as behavioural deficiencies in children and young people and ADHD is consequently documented in pupils’ Education Health and Care Plans under the category Social Emotional and Mental Health needs. Scheffler *et al* (2007) argue that it is a neurological condition grounded in ‘great clinical and strong scientific investigation’ (p. 450) not least due to its impairments impacting a broad spectrum across public health services: education, social care and family lives. In his lecture, Robinson (2008) argues that children are being educated within a system that is not fit for current purpose: it was ‘conceived for a different age’ and it has not evolved with the times. Robinson alludes to the debate around the social versus medical model of inclusion: he queries how children are streamed; he questions why ADHD diagnoses have increased in line with standardized tests; he challenges the standard of an education system that penalizes children for ‘being distracted’ yet conversely having to navigate an ‘intensely stimulating’ era (2008). This essay will explore the proposition that the existence and prevalence of ADHD is a matter of debate: it will also seek to examine how ADHD sits within wider academic and scholarly research into the perceptions of behaviour and establish how current discourses are shaped within society. It will also consider how ADHD is treated and whether there is

argument to suggest that it is treated ‘medical fashion’ (Robinson: 2008) as suggested.

In his handbook *Attention Deficit Hyperactivity Disorder* (2014*)* Russell Barkley outlines the history of ADHD and demonstrates, through references to a German text, that ADHD has a history which began in the 18th Century. However, he focuses the majority of his chapter on the 20th Century and how ‘clinical scientists strove for a clearer, more accurate understanding of the very essence of this condition’ (2014: p. 3). Barkley argues that those with a diagnosis of ADHD are a ‘heterogeneous population’ (p.3) and ADHD presents itself with ‘considerable variation’ (p.3) dependent on the individual and any comorbid diagnoses. Barkley, however, is very clear in the ‘significant problems’ (p.3) with: inattention, impulsiveness and excessive activity that those with an ADHD ‘label’ (p.3) exhibit. Within Barkley’s history he states that historically ‘poor or disrupted parenting’ (p.7) has been cited as a cause of ADHD. A theme which is also prevalent in current debate. In MacLure *et al’s* (2012) research within the early years, they cite a number of examples of teaching staff blaming the parents for a child’s behaviour which was seen as outside of the normal parameters. Barkley argues that critics of ADHD still cite poor parenting as an alternative to a medically diagnosed neurological disorder. Barkley, however, concludes that ADHD has ‘undoubtedly become a valid disorder’ (p. 37), one that has been universally accepted amongst medical and mental health professionals and despite the lack of neurological markers and criticisms as a diagnosis, Barkley asserts that it is a ‘legitimate neurodevelopmental disability’ (p.37). Barkley cites the developments in the diagnostic criteria through the modifications to the *Diagnostic Statistical Manual of Mental Disorders* (DSM) over time, as advancing the understanding of ADHD and argues that the ‘requirement for both cross-setting pervasiveness’ (p.37) which is universally acknowledged as positive.

Ken Robinson (2008) argues that he is not ‘qualified’ to deny the existence of attention-deficit hyperactivity disorder (ADHD) but highlights that its existence is a ‘matter for debate’; post- structuralist sociologists are active participants in this debate. MacLure, Jones, Holmes and MacRae (2012) argue that childhood narratives are being shaped by a cultural discourse about what is defined as acceptable behaviour. MacLure *et al* (2012) researched four early years settings in a

qualitative study to enquire how individual children were constituted within the discourse of ‘good’ and ‘normal’ (2012: p.448) behaviour. Their research, although focused primarily within classrooms, also widened its scope, and discussed the ‘wider educational and social discourses’ (p.448) that are prevalent within education institutions, guidance and strategy. MacLure *et al* argue that children and consequently their behaviour are incorporated into a *‘discursive frame*’ (p.454) that provides meaning to a child’s behavioural conduct. Within this framing device, MacLure *et al* argues is the ‘attribution of offending behaviour to underlying physical or physiological causes’ (p.454), for example attention deficit hyperactivity disorder. MacLure *et al* suggest that this ‘*medicalisation’* frame seeks underlying causes for behaviours which sit outside the parameters of ‘normal ranges’ (p. 454). MacLure *et al* further argue that children in the early years who ‘fail to act’ (p.455) in socially acceptable normative ways are pathologized as different. An example of this ‘discursive frame’ taking shape within educational settings is an ‘Information and Guidelines for Schools’ about ‘Attention Deficit/ Hyperactivity Disorder’ leaflet published by Milton Keynes Council (2013). Within these guidelines, the council states that ‘pupils with AD/HD pose particular challenges to their teachers’ (p.8), crucially this statement follows over a page of behaviours which are identified as being outside the ‘normal’ range. The term ‘challenges’ reinforces the social discourse within which ADHD as a condition is considered and how those pupils are pathologized as different.

In researching their paper, MacLure *et al* (2012) utilised Foucauldian theory to underpin their post-structuralist stance. Foucault (1977) argued that schools copied the military method of: breaking down and reshaping humans to produce ‘docile bodies’ (p.138) that were disciplined, capable, obedient and crucially productive for a capitalist society. MacLure *et al* (2012) explore this notion and those of the ‘disciplinary…gaze’ (1977: p.173) and judgements (1977: p. 179) within their qualitative research and established that children who displayed exemplary discipline were praised: those that did not were placed within a subordinate position within the class. Foucault (1977) asserts that these dynamics within the classroom perpetuate the deployment of power and those who were perceived to be outside of the exemplary disciplinary regime were judged in relation to the norm. In the same way the NHS lists some of the symptoms of ADHD as: making careless mistakes;

appearing forgetful; having difficulty organising tasks; deviances outside of the perceived norm could lead to the *medicalisation* frame as defined by MacLure *et al.*

Harwood (2012) argues that it is the lack of thorough research into behavioural issues that are not funded by medically oriented bias which supports the pathologizing of disorderly children and supports the contention about the existence of ADHD as a mental disorder. Harwood refers to the legitimacy of the different editions of the *Diagnostic Statistical Manual of Mental Disorders* (DSM) and argues that these modifications are socially constructed rather than medically validated. Harwood points to the evolving definitions of conduct disorders in general and ADHD specifically in the DSM and that the 'validity' (2010: 3) of the diagnostic criteria for ADHD is questionable. Harwood argues that the DSM is 'an extremely powerful and influential compendium of psychopathology' (2006:20) within the diagnostic discourses of 'disorderly children' (2006: 20) due to it being used globally as a diagnostic manual. Harwood reiterates that despite alternative methods to diagnose conduct disorders being available, it is the DSM that is most 'dominant' (2006: 21). Harwood points to specific alterations between DSM- III, DSM III-R and DSM-IV (2006: 57) as having significant implications for those that were previously diagnosed, with conduct disorders, under earlier criteria under the guise and discourse of the 'scientificity' (2006: 58) of the DSM. Harwood argues that it is this very 'scientificity' that reinforces the influence of the DSM.

Harwood (2012) argues that the modifications to the DSM are culturally constructed. Harwood states that the media continues to have huge influence in DSM changes, including specific additions to the current DSM- V, published in 2013. Harwood uses the example of a popular US TV show *Hoarders* and the subsequent 'legitimacy' (2012: 2) of the introduction of 'Hoarding Disorder' to the DSM-V. Due to the 'scientificity' of the DSM Harwood argues that the evolution of the DSM as a reflection of its contemporaneous social and cultural attitudes 'can become easily concealed' (2012:5). Harwood argues that media creates the discourse which in turn leads to the disorder: inclusive within this diagnostic discourse is ADHD and its 'legitimacy'. Harwood (2012) argues that the cultural discourse surrounding behavioural issues and conduct disorders have also been shaped by the perception of protagonists within the media. It could be argued that any debate regarding diagnostic criteria is not limited to whether ADHD is in existence but whether a

thorough review of how any diagnostic criteria for mental disorders are established is needed.

The 1970's marked the introduction of parent, teacher and, where appropriate, child rating scales to support the diagnosis of ADHD: rating scales that have henceforth proven contentious. Barkley (2015), however, argues that the rating scales provided clinicians with an opportunity to gather quantitative data that could 'assist in determining developmental patterns and deviance from the norms' (p.17) for the first time. Barkley also suggests that the introduction of the rating scales meant that there was a move away from mere 'clinical impression' and towards 'some structured, semiobjective, and quantitative measure of behavioural deviance' (p.17). Keith Conner's (1969) developed the eponymous rating scale which is still commonly used in ADHD diagnosis. The rating scale has four subjective quantifying judgements: not at all; just a little; pretty much; very much (Conners, 2008) and then a number of statements for the person completing the questionnaire to respond to, for example, 'excitable', 'daydreams', 'cries easily or often' with no accompanying definitions. Within the questionnaire there are no quantifying statements to indicate to parents how frequently 'just a little' might occur; we might argue therefore that the rating scale is at best a 'semiobjective' tool, but more significantly a subjective measure of behavioural 'deviance'. The rating scale itself stipulates that it 'should not be… used as the sole criterion for clinical diagnosis or intervention' (Conners: 2008: 2). However, Harwood (2006) cites an example of a parent questionnaire being completed and within 40 minutes a conclusive diagnosis of ADHD being reached; a clear breach of the guidelines. The Conners rating scale professes to be 'reliable and valid' (Conners: 2008: 23), however as ADHD is defined as 'behavioural deviance' there is always going to be a subjective gaze from the person completing the rating scale. We could, therefore, argue its introduction has somewhat problematised the diagnosis of ADHD further.

Official health guidance stipulates that the symptoms of ADHD are noticed at an early age within childhood, notably between the ages of 6- 12 years old. (NHS, 2018). This stipulation excludes the majority of the population: adults. The diagnosis of ADHD within adulthood is contentious. NHS guidance problematises adulthood diagnosis as the symptoms 'are difficult to define' (2018). The NHS also professes that 'it's believed it cannot develop in adults without it first appearing during

childhood' (2018). These stipulations support Harwood *et al's* (2014) argument that an ADHD diagnosis is centred within the discourse of a 'diagnostic gaze' (p.1) prevalent during childhood and as the NHS states when a child 'starts school' (2018).

Robinson, in his lecture, asserts that there is not an ADHD 'epidemic' (2008), implying derisively that it is not something that can be caught; there is, however, much debate amongst scholars about the reasons for the prevalence of ADHD as a diagnosis. Barkley (2014) states that in the United States, ADHD is one of the 'most prevalent childhood psychiatric disorders' (p.3) and consequently, one of the most widely contested neurological diagnoses. Lahey et al (1990) posit that whilst the fundamental characteristics of the DSM criteria have maintained the same, the boundaries of the diagnostic definitions were changed substantially in the DSM- III-R modifications, and it is these changes which have 'result[ed] in sizeable changes in the prevalence of the disorders' (p.52). Barkley (2014) also explores this notion and offers the explanation that from the 1980's you could be diagnosed with or without hyperactivity, broadening the scope of the disorder. Harwood (2006) argues that the only sufficient term that 'captures the breadth of influence of this new and worrisome cultural form' is that of a 'phenomenon' (p.1). To consider this debate further we need to explore worldwide prevalence and statistics; how the prevalence has changed over time and what influences the changes to prevalence.

Barkley (2014) argues that the current prevalence of ADHD diagnosis is due to the improved quality and quantity of knowledge that both medical professionals and laymen have access to. He suggests that there is now an 'international recognition' (p. 36) of ADHD in comparison to the 1970s when there were 'sizeable discrepanc[ies] between North American and European views of the disorder' (p.19). Whilst North Americans recognised the disorder more openly, Europeans considered 'attention deficit…uncommon' (p.19) and attributed the overactivity to brain damage. Barkley asserts that it is the growth in global knowledge and information sharing that has led to the 'recognition' (p.36). One of the primary reasons for this growth is that people can access the internet, which in turn has led to: the development of 'parent support groups' (p.36)- both at a local and international level and the increasing numbers of scholarly texts and research available on ADHD for consideration. Barkley concludes that as everyone now has access to the same information,

research and data, any previous differences between countries 'understandings of ADHD' (p.36) are no longer apparent. This stance, however, disregards the difference in prevalence data dependent on which diagnostic criteria is being used: that of the DSM IV or the *International Classification of Diseases- 10 (ICD-10).* Harwood (2006) reports that data from the UK in 1999 survey found, 9.5% of children have a conduct disorder under the DSM- IV criteria versus 5% prevalence using the ICD-10 criteria. These discrepancies highlight the need for more objective, standardised diagnostic criteria for all psychiatric disorders, including that of ADHD.

Harwood (2010) argues that if ADHD was a genuine neurological disorder there would not be a disparity in the rates of diagnosis across social groups. Harwood asserts that diagnosis data from Australia, the United States, and England show that there are 'disproportionately higher numbers..,from disadvantaged backgrounds' (p.2). Harwood defines disadvantage not simply under socio-economic terms but under pluralist terms. Harwood (2010) cites the work of Wolff and De-Shalit (2007) who, in their own research investigated the nuances of disadvantage and propose that people need opportunities to secure six functionings to do well in life. Wolff *et al* propositioned that it is the absence of those functionings that lead to disadvantage. The US Center for Disease Control and Prevention (2016) report that over time there has been a significant increase in the numbers of children diagnosed with ADHD, for example in 2003 just over 4 million children had a diagnosis, however, this figure has increased to over 6 million by 2016- nearly 10% of the population, supporting the notion of a 'phenomenon' (Harwood: 2006: p.1). Harwood (2010) argues that the ADHD 'phenomenon' is not due to children beset with neurological deficiencies but a socially constructed 'epidemic' (Robinson, 2008) that is interwoven with politics. Harwood suggests that by refocusing the lens of 'social disadvantage' towards 'psychiatric disorder' it 'becomes politically acceptable to not address the root causes of social problems' (p.3). Harwood's research leads her to conclude that young people from disadvantaged backgrounds, in pluralist terms, are caught up in the 'medicalisation of behaviour' (2010, p.2) and the consequences of pathologizing behavioural differences are that children continue to be viewed under a 'diagnostic gaze' (Harwood *et al's*: 2014: p.1). This gaze leads to the prioritisation of diagnosis over education- a fundamental institution in supporting young people and their families achieve their secure functionings.

Harwood (2006) does support Barkley's notion that it is increased information sharing that has created a prevalence of ADHD diagnosis. Harwood, however, states that the scope of an ADHD diagnosis is now operating within a dual clinic, that of a formal and an informal one. Harwood (2010), in her research, explored the notion of the informal clinic, which she attributes as having emerged due to the 'disconnection' (p.10) and 'loss of affiliation' (p.10) that exists between institutions, such as health centres and schools, and families 'marked by social and economic disadvantage' (p.9). Harwood cites the statistic that, of the children most frequently excluded from school, they are perceived to have 'behavioural difficulties' (p.1). These rates of exclusion within this area of educational need creates, what Foucault (2006) described as a 'magic circle' (p.5); the power of cultural attitudes and discourse to create a powerful stigma associated with behavioural difficulties, are perpetuated within these figures. They in turn lead to what Harwood describes as 'fearsome creatures' (2010, p.3) living in disadvantage not least due to their exclusion from their schooling institution. Harwood cites an example of a home visit between a New South Wales youth professional and an eighteen-year-old mother, who lived with her sister. Within the visit it was disclosed that her sister's son 'who's ADHD' (p.10) had been trained to sit and watch TV as he had too much 'energy' (p.10). This exchange revealed that the family had self-diagnosed a 2-year-old with ADHD. Harwood argues that this example mirrors social exclusion from 'wider parenting' (p. 11) support networks and dilutes the power of ADHD as a diagnosis. It is arguable that this social exclusion further perpetuates disadvantage in securing the other functionings (Sen, 2000) for wellbeing.

Robinson (2008) suggests children are being medicated for ADHD 'whimsical[ly]' and there is strong evidence to suggest that the primary treatment for ADHD is (psychostimulant) medication. The United States Center for Control and Prevention of Diseases (2016) reports that 62% of children with an ADHD diagnosis are medicated; a staggering 18% of those children are aged between 2-5 years old. This is a damning indictment on the diagnosis process and strong evidence to support Harwood's assertions that there is a widespread ADHD 'phenomenon' (Harwood: 2006 p.1). Interestingly, of the 62% that are medicated, 30% of those children or young people receive no behavioural intervention or support, this is ethically debatable. In their *Challenging behaviour: a unified approach* updated report (2016),

the Royal College of Psychiatrists argue that any use of ‘antipsychotic medication’ (p.10) should be coupled with alternative therapy. They also suggest that the usage of such medication should only be used with individuals where there is severe perceived risk to that individual or towards others. We could argue that this is contrary to the reality of the statistics presented from the United States; echoed by Robinson’s morally dubious concern in his 2008 lecture.

Scheffler *et al* (2007) carried out an investigation into the global usage of medication for the treatment of ADHD and considered the ten-year period between 1993 – 2003 for their analysis. In their evaluation they established that the number of countries using ADHD medication rose from thirty-one to fifty-five whilst the overall usage worldwide had increased by 274%, including increases in usage within both developed and developing countries. Scheffler *et al* (2007) conclude that the prevalence of the ADHD diagnosis combined with the global usage of medication could lead to ADHD being the ‘leading childhood disorder treated with medications across the globe’ (p.456). Scheffler *et al’*s study goes a long way to support Robinson’s assertion that ADHD medication is handed out ‘whimisical[ly]’ (2008).

Harwood (2006) also supports the assertion that children and young people are being over medicated as a ‘quick fix’ (p.3) remedy to societal disadvantage. Harwood *et al* (2014) argue that a large societal concern within special educational needs, is the prevailing shift towards the medical rather than social model brought about by capitalist forces influencing public services. Harwood (2006) suggested that a school had ‘been accused of forcing parents into medicating their children’ (p.93) and in her 2010 research Harwood asserted that societal disadvantage is allowed to prevail within society’s current medical model as parents are not taught the ‘soft skills’ that are needed to navigate the ‘medical interventions’ that they are ‘compelled to pursue’ (2010: p.13) thus creating a power imbalance between institutions and families. These ‘medical interventions’, which are difficult for parents to challenge conclusively lead to young people being segregated from mainstream teaching and considered as ‘prescription junkie[s]’ (2006: p. 106). Harwood (2010) argues that these perceptions have been generated by the ‘pathological discourse’ in which medication has become ‘*the* normal remedy for behaviour problems’ (p.15). Ekins (2015) also

guards against viewing special educational needs through ‘medical approaches’ (p.174) and suggests that no reform of the educational system can be successful unless we consider the ways that children are ‘identified and categorised’ (p.174). The Royal College of Psychiatrists (2016) support the assertion that a social model is the most appropriate recourse of treatment, outlining that treatment can only be truly inclusive if ‘new, creative and flexible’ (p.4) approaches are adapted. Harwood, Ekins and The Royal College of Psychiatrists all advocate for an alternative model of treatment for those with ADHD: one that ensures a positive, enabling, capable and inclusive environment for all and a medical remedy that is not considered the norm.

Robinson’s assertion that the existence and prevalence of ADHD is a ‘matter of debate’ (2008) is true. Post- structuralist sociologists have argued, quite fervently, that ADHD sits within a wider social discourse of behavioural perceptions. The Royal College of Psychiatrists (2016) themselves argue that challenging behaviour is a socially constructed concept (p.8). However, we don’t know to what extent denying the existence of ADHD could damage those diagnosed with the condition, to ignore social, emotional and mental health needs could adversely affect those students whose needs cannot presently be met within their educational settings. The statistics for the treatment of ADHD indicate that a large proportion of those diagnosed with ADHD are medicated. Barkley states that stimulant medications continue to the be the ‘treatment of choice…for ADHD’ (p.8) because they decrease impairments. What is not known, however, is the long-term effect that taking drugs, like Ritalin, have on those who have been diagnosed within the current medical model of education. Robinson (2008) and Ekins (2015) are aligned in their views that the present educational model does not reflect the generational needs of our students and perhaps an educational review is the starting point for bigger societal change. I would suggest, that for now, rather than refute the existence of ADHD more research and clarity are needed. More research into how ADHD can present itself in adolescence and adulthood and more clarity over an improved objective criteria for ADHD diagnosis. This coupled with longitudinal studies covering the impact of taking stimulant medications over the course of childhood would give us greater insight into ADHD as a neurological disorder.

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