ADHD – WHAT IS IT?

Attention Deficit Hyperactivity Disorder

The DSM-5 defines ADHD as a pattern of inattention and/or hyperactivity-impulsivity (American Psychiatric Association, 2013).

There are **three main types** of ADHD presentations:

1. Predominantly **Inattentive**
2. Predominantly **Hyperactive-Impulsive**
3. **Combined** Presentation

Inattention consists of having trouble organising and holding attention on tasks, being distracted easily and forgetting things.

Hyperactivity/Impulsivity consists of fidgeting, talking excessively and interrupting others.

The Prevalence of ADHD

In the U.S., the 2016 National Survey of Children's Health revealed that:

1. **5.4 million children** aged 2-17 years old currently had ADHD.
2. **8.4%** of all 2-17-year olds currently had ADHD. (Danielson et al., 2018).

Associated Difficulties:

Cognitive impairments in executive functioning and verbal memory have been found in those with ADHD (Claesdotter, Cervin, Akerlund, Rastam & Lindvall, 2018).

Children with ADHD are more likely to develop **psychiatric disorders** such as conduct disorder and anxiety disorders (Cuffe et al., 2015).

They also report **poorer communication and social skills** compared to children without ADHD (Klimkeit et al., 2006).

WHAT ARE THE CURRENT DEBATES FOR ADHD?

1. Is ADHD really on the rise?

From 2003 to 2011 an estimated **2 million more U.S. children** were diagnosed with ADHD. (Visser et al., 2014). Why a sudden rise?

Schwarz (2013) discusses the **'selling of ADHD'** by drug companies through a campaign to increase awareness of ADHD and promote medication for it. The increase in ADHD diagnoses and prescriptions for ADHD medication is, at least partly, likely to be attributed to this push to 'sell' ADHD.

Rydell, Lundstrom, Gillberg, Lichenstein and Larsson (2018) found increases only in the milder cases of ADHD symptoms and not in the severe, leading to the proposition that this 'ADHD epidemic' could be explained by **changes in diagnostic practice, overdiagnosis, and better awareness of ADHD itself**. More parents may be recognizing symptoms in their children and seeking help.

Bastra et al. (2012) proposes that the DSM-IV admits to **lowering the threshold** for ADHD, which may likely have been a reason leading to the increase in diagnoses, as more children would be eligible.

With **better awareness** around ADHD, more parents can recognize the symptoms in their children. However, the diagnoses may be made on a much too **lenient basis**, therefore contributing to this increase.

2. Is there an overreliance on medication for ADHD?

With the increasing rates in diagnoses of ADHD (Visser et al., 2014), the prescription of drugs used to treat ADHD are **also on the rise**. Methylphenidate (or Ritalin) prescriptions increased from 459,600 prescriptions in 2008 to 862,639 in 2015 and this increasing trend continues year on year (The Care Quality Commission, 2018).

In 2011, **69% of U.S. children**, aged 4-17, with current ADHD were also taking medication for it (Visser et al., 2014). The debate on medicating children with ADHD arises from this increase in prescriptions and whether there may be an overreliance on these medications.

In the US, **just over 25% of children** with ADHD aged 4-5 were receiving medication treatment without any behavioural treatment while **only around half** of this cohort were receiving any behavioral treatment at all (Visser et al., 2015).

This study underlines the fact that there may be increasing **pressure on local authorities** to prescribe psychotropic drugs for ADHD due to budget constraints, meaning a lot of children are not getting access to behavioural treatments first (Dixon, 2013).

Children as young as three are being prescribed psychotropic drugs for ADHD, even though they're deemed **unsuitable for children under the age of six** indicating a potential and dangerous overreliance on medication as a treatment for ADHD (Dixon, 2013).

Schwarz (2013) states that the campaign to find and treat children with ADHD has led to those with **milder symptoms** receiving a diagnosis and consequently medication when they possibly do not need it.

However, the MTA Cooperative study (1999) does provide support for the effectiveness of medication management in ADHD alongside Carlson, Pelham, Swanson and Wagner (1991) who showed the beneficial effects of methylphenidate on arithmetic performance in children.

DIAGNOSTIC LABELS- DO WE NEED THEM?

The Difficulties and Negative Implications in School:

A study by Batzle, Weyandt, Janusis and DeVietti (2010) highlighted the potential stereotyping effects of diagnostic labels on the individual. They found that teachers gave students, with an ADHD label, **lower ratings on behaviour, IQ and personality** than children with no labels.

The potential negative attitudes of teachers could create a **self-fulfilling prophecy** (Merton, 1948) in the child with ADHD; this may lead them to underperform or misbehave in school if they start to believe the teachers views that they're disruptive and naughty or unable to learn, for example.

Labelling can lead to **over-generalisation**; teachers and parents may start to see the label before the child and attribute behaviour to the diagnosis instead of to the environment (Woodcock, 2009).

Over-generalisation could lead to a **lack of change** in school systems. For example, if a child with ADHD found a certain task particularly difficult and started to react with disruptive behaviours, it would be easy to attribute this behaviour to their ADHD label instead of a difficulty they're having; in this way, diagnoses can have **masking effects** (Woodcock, 2009).

The Benefits of Diagnostic Labels and Positive Implications in School:

Most importantly, a diagnosis can lead to often well-needed **support and treatment** as well as access to special education services at school (Bastra et al., 2012) which can provide children with a more positive experience at school as they have access to the support they need.

A diagnosis may provide **relief for parents** as they can acknowledge a likely cause of their child's behaviour which is at no fault of their own (Harborne, Wolpert & Clare, 2004).

Solvang (2007) notes the boost in **self-esteem and confidence** which can accompany diagnoses due to the potential de-stigmatising effects. They may feel more confident in school if they can attribute some difficulties externally and gain understanding from others.

Crawshaw, MacFadyen and Dodd (1992) also highlight **the benefits of classification** in research which can help other patients. If we didn't have labels with which to classify disorders such as ADHD, how would further research using those individuals be conducted?

THE 2 YEAR WAIT:

In her article, Boseley (2018) addresses the issue that in the UK, children are having to wait up to **2 years** for a diagnosis of ADHD. The increase in diagnoses of ADHD has unsurprisingly also led to this **increase in waiting times.**

Boseley (2018) quotes Jo Platt, MP, who mentions **the impact on the children and their families** waiting for the diagnoses, as without it they may be just seen as disruptive and naughty.

Children all over the UK are waiting for a diagnosis for ADHD, just to get the support they desperately need- meanwhile they are face negative views from others.

Boseley (2018)

EDUCATIONAL PSYCHOLOGISTS (EP)- HOW CAN THEY HELP?

The role of an EP and the levels at which they work:

EPs can work at **four main levels** and be involved with a range of problems and challenges amongst these levels.

Inclusive practice serves to bend the system to make sure that all children can thrive in a school environment and this is what EPs strive towards.

At an **individual** level, EPs are trained in how to work individually with children to be able to create change and find solutions to the problems they're having; they can use a range of problem-solving strategies to do this.

Working at a **group** level, EPs can involve individuals within group consultations and discussions to engage them in problem-solving strategies as a group instead of individually.

At the level of **organisation**, EPs can put things in place for children to feel more comfortable in their school environment. EPs can make schools aware of a child's difficulties and make sure teachers and staff working within the school are educated in how to help the child and understand when things may be going wrong and how to tackle those situations.

At an even higher level, EPs can work at a **systemic** level to train other professionals such as teachers, GPs and other EPs in working with young people and educate them further in the practice.

An **EHCP** (Educational health care plan) can also be requested by schools and parents in which EPs give their opinions on the matter in question. EHCPs can provide funding for schools allowing them to provide extra support for those individuals who need it.

Sargeant (2018)

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