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# Countering the ADHD epidemic: a question of ethics?

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## Abstract

Recently in Australia, another media skirmish has erupted over the problem we currently call "Attention Deficit Hyperactivity Disorder". This particular event was precipitated by the comments of a respected District Court judge. His claim that doctors are creating a generation of violent juvenile offenders by prescribing Ritalin to young children created a great deal of excitement, attracting the attention of election-conscious politicians who appear blissfully unaware of the role played by educational policy in creating and maintaining the problem. Given the short (election-driven) attention span of government policymakers, I bypass government to question what those at the front line can do to circumvent the questionable practice of diagnosing and medicating young children for difficulties they experience in schools and with learning.

## Introduction

Attention Deficit Hyperactivity Disorder, or ADHD as it is now commonly known, seldom lacks attention in the Australian media. The most recent frenzy to dominate arose when a NSW District Court judge, Paul Conlon accused doctors of creating a generation of violent children now coming before the courts (Fife-Yeomans, 2007). He argued that their knee-jerk response to challenging or "naughty" behaviour was to prescribe Ritalin, the long-term effects of which are still unknown – although, Conlon stated that his own research indicates that children medicated with Ritalin mature into violent young people predisposed to drug addiction. In response, the Vice-President for the Australian Medical Association argued that we should blame the disorder for violent young offenders, not the treatment. Claiming that, "ADHD is associated with significant issues, including problems with the law and delinquency, drug use, family breakdown and school failure," Dr Choong-Siew Yong said that we should not "blame Ritalin or any ADHD medications, because these are actually improving the situation" (McLean, 2007, p. 1).

Curiously, unlike psychiatrist Michael Glicksman (1997), Yong seems oblivious to the chicken and egg scenario often associated with Attention Deficit Hyperactivity Disorder; ie., is ADHD the cause of these problems or do social problems manifest in behaviours that come to be diagnosed as ADHD? Leaving questions of chickens, eggs and causality aside, I wish to concentrate on where this current media storm leaves us. Despite Yong's statement in defence of doctors, national news reports questioning whether ADHD is over-diagnosed proliferated, the NSW Labor Government called for whistleblowers with information relating to over-diagnosis to step forward, and the Federal Labor Party called for updated Federal

Government prescription guidelines for doctors and a national inquiry into prescription rates. The latter is a good idea but I would suggest that we are all looking in the wrong direction and, in any case, recent history demonstrates that without appropriate terms of reference inquiries don't achieve very much.

Unless taken to the next level, all Judge Conlon's comments will succeed in doing is to create yet another media stir. The accusation that doctors are creating violent young offenders by prescribing psychostimulant medication is guaranteed to get the media's attention, which - unless one happens to be Paris Hilton - can be very difficult for the rest of to do. But what does that actually achieve and does "slamming" doctors help anyone in the long run? Actually, it doesn't. What it does do is prematurely foreclose the debate. Here I would like to try and ram a hole through that closure in two ways. First, I will explain how media frenzies such as the one I describe simply (re)invent and (re)secure the medical construct. Secondly, and perhaps more importantly, I consider what the rest of us - especially those of us who work and live with children who can be described in these ways - can do to circumvent this.

### **(Re)inventing ADHD**

Media storms kick up a lot of dust but fail to ask the right questions. In the end, we are no further towards a solution for the kids, parents and teachers at the centre of all the fuss. Indeed, the popular response to Judge Conlon's comments have so far been the same as every other media storm: ie., Is ADHD over-diagnosed? Are we over-prescribing Ritalin? Are doctors to blame? If critically analysed however, Judge Conlon's comments could lead us to ask more important questions, like: Is the current approach to children who can be described in these ways, the best that we can do? But first, I wish to argue that the question "Is ADHD over-diagnosed?" obscures a more important question; that is, what exactly *is* ADHD?

"Attention Deficit Hyperactivity Disorder" is a *label* (one of many, including Minimal Brain Damage and Hyperkinetic Reaction of Childhood) that the medical domain has coined to both group and describe certain challenging behaviours exhibited by children and young people. I am not disputing the existence of these behaviours nor the ability of doctors (or anyone else) to observe them. My contention is that the problem with "ADHD" occurs once these behaviours have been observed and the medical label assigned. The path that opens up to children who have been diagnosed with ADHD is a highly medicalised one where the child, their family and their teachers are encouraged to view them as defective - as not completely whole or incompletely formed. Stimulant medication is viewed as a medical prosthesis that can band-aid that gap, until such time as the child either matures or "learns" the correct ways to behave. However, given that 6% of young children aged between 0-4 years in care have been prescribed stimulant medications (CCYPCG, 2006), is it not fair to ask whether the fault lies with our expectations and that perhaps these should be subject to inquiry?

Getting back to the perennial question: "Is ADHD *over*-diagnosed?" my objection to this is that when it is being asked, two assumptions have already been made. The first is that an accurate diagnosis of something is possible, despite the co-location of ADHD on a grey diagnostic continuum with a myriad of other similar "disorders". The second is that the medical model (ie. that certain behaviours could/should be grouped in a certain way, assigned

a label and treated medically with stimulant medication) is the only and best response available. When we make these assumptions, as a general community, we then fail to ask questions like: Should certain childhood behaviours be “diagnosed” at all? What else can we do? More fundamentally: Is it time to review the way we respond to fidgety, distractible, impulsive children? And finally, has the medical model failed these children? Judge Conlon’s comments suggest that it has.

Stating that he was "...starting to lose count of (the number of) offenders coming before the courts who were diagnosed at a very young age with ADHD for which they were 'medicated'," (AAP, 2007, p. 1) Judge Conlon is actually raising a very important point – one that has been missed in the media furore. His observations suggest that the current approach doesn’t work - although I realise that one has to specify what the aim is to determine whether something works. If the aim is to get a very active child to sit still in a classroom or an impulsive child to remember to put their hand up, then one could argue that the medical response and stimulant medication does the job. If the aim is to get a child from Kindergarten to Year 12 with their dignity and enthusiasm for life and learning intact, then I think it is fair to say that Judge Conlon is witnessing the failure of the medical model to achieve this for a growing number of young people.

In the moment a child is labelled with ADHD, some paths close down and others open up. Despite media claims that a diagnosis of ADHD is an medical excuse for bad behaviour (Shanahan, 2004; Devine, 2006), the ADHD road is not what some might believe it to be. A diagnosis of Attention Deficit Hyperactivity Disorder does not result in compassion and understanding. More often than not, children who are diagnosed with ADHD (and their parents) meet attitudes tainted by suspicion and contempt (Carpenter & Austin, 2007). Furthermore, they often experience institutional discrimination and social rejection (see Neophytou, 2004). Recent research in education shows just how debilitating these early years experiences can be to children’s self-esteem and self-worth (Exley, 2005) but also that these are not mediated by medication – indeed, the child’s “need” for medication serves to reinforce to the child that they are defective and “bad”. And so the spiral begins... but this is also when and where it can be circumvented.

### **Circumventing ADHD**

Attention Deficit Hyperactivity Disorder is characterised by controversy. Indeed, the most enduring question in relation to ADHD is: does it exist? This is highly problematic because the doubt surrounding the ADHD diagnostic category functions as a red herring forestalling any real progress for the children involved. The question of legitimacy hanging over ADHD also means that state educational departments around Australia can get away with not providing additional support funding for children diagnosed with Attention Deficit Hyperactivity Disorder, whereas they do for “recognised” disabilities, such as Autistic Spectrum Disorder (Graham, 2007b).

What this means from an educational perspective is that for teachers dealing with children who can be described in these ways there is little support available – other than a diagnosis of ADHD and a prescription for stimulant medication. Research shows however that these are the kind of students that teachers feel most ill-equipped to teach inclusively (Fields, 2006). Public schools and teachers are critically over-stretched and the result, in

Queensland at least, is that children who present a problem to the system end up in paediatrician's offices.<sup>1</sup> Whether they come out with a diagnosis of Attention Deficit Hyperactivity Disorder or Autistic Spectrum Disorder (ASD) can have huge impact on the child's experiences at school, influencing how the child is perceived and the ways in which they are supported (or not, as the case may be).

Describing a child's behaviour as hyperactive, impulsive and distractible (or those popular terms we've all heard before, like fidgety, feral and hyper!) can actually precipitate their journey down the ADHD road - precluding other, perhaps more beneficial, avenues. Disturbingly, greater numbers of very young children are becoming medicated and treated for ADHD. How these children become characterised by their teachers in the early years has enormous influence on how these children are perceived by subsequent teachers and the professionals they encounter along the way. The mere suggestion of "attentional" difficulties is enough to raise the ADHD spectre and once certain words are written in a child's file, those words will continue to colour how that child's abilities and difficulties are viewed (Graham, 2007a).

One thing that teachers and parents can do to change course is resist categorising children in behavioural terms, as such terms link directly to the diagnostic triad for Attention Deficit Hyperactivity Disorder and other disruptive behaviour disorder categories. Instead of using behavioural characteristics to describe problems in the schooling context, educators can make an ethical choice and switch the lens we apply by (re)focusing on pedagogical needs. For example, rather than describing a child as "distractible" and leaving it there, educators and administrators have an ethical responsibility to: (1) acknowledge that this particular student needs redirection more often than other students; (2) make adjustments to their teaching programs in response to that need; while (3) also advocating at the school and district level for adequate resourcing to enable individual class teachers to achieve this.

## **Conclusion**

Many children who end up with a diagnosis of ADHD and stimulant medication have significant learning difficulties for which there are only educational answers. But if we keep describing these difficulties in behavioural terms, these children are unlikely to get the support they require and educational departments can continue to deny that these children have a legitimate claim to meaningful educational support structures. Using pedagogical descriptors switches the focus away from individual deficit towards teaching and learning and forces educational systems to respond to the needs of challenging students *and* those of the teachers trying to teach them.

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<sup>1</sup> Queensland is the only state in Australia that requires a medical diagnosis of impairment for disability support eligibility. The incidental effect of this particular policy is a direction towards the medical model. This bears influence on how particular behaviours are viewed.

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