What parents need to know about ADHD

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*Please note: this hand-out is intended as a **supplement to** the presentation, not as a **substitute for** the presentation. It is intended to assist those who attend my workshop. This handout is NOT intended to be read separately from the presentation; it cannot "stand alone." If you would like to get a sense of the presentation but did not have the opportunity to attend, please read my second book* **Boys Adrift** *especially chapters 2, 4 and 8; and my fourth book* **The Collapse of Parenting,** *especially chapter 3. You can reach me at mcrcad@verizon.net but please also send a copy to* leonardsax@gmail.com.

ADHD

History of a diagnosis: "minimal brain dysfunction" (MBD)

Leandro Panizzon, a CIBA chemist, synthesized and tested methylphenidate in 1944. His wife Marguerite ("Rita") loved it, so he named it after her: Ritalin.
Ritalin was first marketed in 1954 as an anti-depressant. But in that era, "depression *without* melancholia" was not usually treated with medication. And Ritalin was not effective for "depression **with** melancholia."

DSM-II: In 1968, MBD was renamed "hyperkinetic reaction of childhood" and was no longer linked to the influenza pandemic of 1918-1919.
DSM-III: In 1980, MBD became "ADD" with or without hyperactivity.
DSM-IV: In 1994, ADHD with or without hyperactivity
DSM-5 (no more Roman numerals): raises the latest allowable age of onset; deletes the word "significant"

Sex differences (Sax, 2004; Rucklidge, 2010; Dupuy, Clark & Barry, 2013)

- Boys: predominantly hyperactive, onset before age 7
- Girls and women: predominantly inattentive, onset after age 10

Is ADHD in females the same disorder as ADHD in males? Possibly not.
EEG differences (I shared a slide showing the NEBA Assessment Aid, which uses EEG data to assist in the diagnosis of ADHD); skin conductance differences. These findings demonstrate a **double dissociation of substrates.** Whatever is going on neurologically in girls diagnosed with ADHD, Inattentive, is different from what is going on neurologically in boys diagnosed with ADHD, Hyperactive.

The United States is now an outlier nation with regard to diagnosis and treatment of ADHD. And: the patterns seen in the United States, with diagnosis now INCREASING as a function of age, and a male/female ratio of just 2:1 (down from 9:1 in 1979) – are also unique to the United States.

The five criteria – in DSM-IV and retained (with changes) in DSM-5:

1) Inattention and/or hyperactivity – this is the LEAST important criterion, i.e. the least helpful in distinguishing whether this kid truly has ADHD or some other reason for inattention
2) Age of onset (before age 7 in DSM-IV, before age 12 in DSM-5)
3) Multiple settings
4) Significant impairment (this criterion is changed to "impairment" in DSM-5)
5) Symptoms not due to another disorder

Other conditions which can mimic ADHD include depression; childhood anxiety (which presents quite differently from adult anxiety, especially in boys); adjustment disorder; sequelae of child abuse or neglect; giftedness.

Lack of motivation. How to distinguish a cognitive deficit such as ADHD from a deficit of motivation?

Ask: **What is your favorite SUBJECT** at school? Not "*what is your favorite thing to do at school*" but "*What is your favorite **SUBJECT**?*" If the answer is "lunch" or "recess", then this kid's problem may be motivational, not cognitive. Disliking school is a problem, certainly, but it is not a psychiatric diagnosis. Sometimes the problem is with the school, not with the child: see chapter 2 of *Boys Adrit* and chapter 5 of *Girls on the Edge.*

Of the five required criteria for ADHD in DSM-5, the two which are most important in the differential diagnosis are **onset before 12 years of age** and **no other explanation** for the deficit of attention. If a student was doing well at school in elementary school and middle school but then begins complaining of difficulties concentrating or focusing at high school, ADHD can NOT be diagnosed. You must explore other explanations, such as anxiety, depression, sleep disturbance, etc. etc.

Sleep deprivation can mimic ADHD of the inattentive variety. The Conners Scale and similar instruments cannot tell you WHY this kid is not paying attention, only that they are not paying attention. You must determine whether the girl or boy is sleep-deprived. No devices in the bedroom! The Conners Scales are very useful as a tool for assessing the effectiveness of your intervention over time. They are NOT useful in the diagnostic process, except as a blunt screening tool. When used as a screening tool, the Conners Scales have high sensitivity but low specificity.

I have referred to the five "required" criteria. Unfortunately, DSM-5 introduced a new diagnostic category: ADHD, Unspecified. "Unspecified" ADHD can be diagnosed in cases where "full criteria are not met". The clinician need NOT specify how many of the criteria are not met. You could fail to satisfy ALL FIVE criteria and still be diagnosed with "ADHD, Unspecified." As analyst Wayne Kondro observed, "simply being alive" now suffices for the diagnosis of "ADHD, Unspecified."
See my article for the *Wall Street Journal,* June 27 2013, " 'Unspecified Mental Disorder'? That's Crazy", online at http://on.wsj.com/1epTGIm.

See also the article published in the *Annals of Internal Medicine* by Allen Frances MD, former Chair of the DSM-IV Task Force, "The New Crisis in Confidence in Psychiatric Diagnosis," full text online at http://annals.org/article.aspx?articleid=1688399.

Here is the FULL TEXT of the criteria for ADHD Unspecified, p. 66 of DSM-5 (emphasis added):

> *This category applies to presentations in which symptoms characteristic of attention deficit / hyperactivity disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate* ***but do not meet the full criteria*** *for attention-deficit / hyperactivity disorder or any of the disorders in the neurodevelopmental disorders diagnostic class. The unspecified attention-deficit / hyperactivity disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for attention-deficit / hyperactivity disorder or for a specific neurodevelopmental disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis.*

The dangers of "an empirical trial of medication"

- "An empirical trial of medication" – may be misleading in this context: stimulants such as Adderall, Concerta, Metadate, Vyvanse etc. appear to help normal kids at least as much as they help kids with severe ADHD
- Gabrieli et al. gave Adderall to normal kids and withheld medication from kids with severe ADHD
- Amphetamine and methylphenidate appear to damage the nucleus accumbens in the developing brain (e.g. Carlezon et al. 2004; Diaz-Heijtz et al.; Gramage et al. 2013; Li and Kauer; Pardey et al. 2012, etc.); list of 14 relevant scholarly citations is online at

http://www.leonardsax.com/stimulants.html.

- Dr. Joseph Biederman at Harvard; Fred Goodwin, former chief at NIMH; Charles Nemeroff, chief at Emory; all acknowledged accepting >$1,000,000 from drug companies which they did not publicly disclose. They were functioning as paid spokespersons for the pharmaceutical industry. http://nydn.us/13co0zX

The American Neurological Association has published an official "white paper" advising physicians not to prescribe Schedule II stimulants for purposes of "neuroenhancement." The first author is William Graf MD at Yale School of Medicine. The full text is online at no charge at http://neurology.org/content/early/2013/03/13/WNL.0b013e318289703b.

If medication is necessary, Wellbutrin (bupropion) and/or Strattera (atomoxetine) and/or Intuniv (guanfacine) may be safer choices for many kids rather than the Schedule II stimulants (Adderall, Vyvanse, Concerta, Metadate, Focalin, Daytrana, Ritalin etc.). If the response to non-stimulants is good but not great, you may *add* a low dose of e.g. Adderall.

Basic idea: 40mg Strattera + 5mg Adderall is roughly as efficacious as 20mg Adderall, with lower risk. If you offer a drug holiday from Schedule II stimulants, be sure to taper, just as you would taper a patient off steroids. If you are prescribing a stimulant along with a non-stimulant, I suggest recommending that the stimulant be taken only on school days; the non-stimulant must be taken every day. By using a lower dose of the stimulant and also skipping the stimulant on weekends and holidays and vacations, you minimize the development of long-term tolerance.

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A bibliography of papers about the dangers of stimulant medication is online at http://www.leonardsax.com/stimulants.html.

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