ADHD

Dividing and Drugging

This paper is one section of a full critique of ADHD drugging in the UK.

For the full paper please visit:

http://thenewobserver.co.uk/features/adhd/

Conclusion

In order to explain the programme of drugging a narrative is constructed about a “disease” being “treated” and “symptoms reduced”. In genome studies and MRI scan studies small statistical differences between an average value from an ADHD group and a “normal” group are used to promote the idea of the “validity” of the “disorder”. But correlations are not evidence of causality. No clinical condition is established by these studies, which simply show a range of statistical correlations to the label. Often MRI studies cannot properly distinguish between effects which may be caused by ADHD drugs themselves and intrinsic “abnormalities”. Nor do MRI studies typically consider the effects on behaviour of being labelled. Many studies compare the ADHD group not with the population average, but with a group from whom the ADHD set has been subtracted. This attenuates findings of difference. Often findings from studies are further manipulated and/or selectively reported in order to build the case for drugging.

Psychiatry responds to the challenge of the tenuousness and varied nature of the statistical correlations of ADHD studies by defining “ADHD” in such a broad way that the “disorder” can be permanently upheld. The current definition is: “The aetiology of ADHD involves the interplay of multiple genetic and environmental factors”. This is a definition which can never be disproved. Thus psychiatry ensures the safety of its “diagnostic category” and the inevitable continuance of drugging.

There is a “public debate” about “whether ADHD is a real disease”. But this “debate” misses the point. ADHD is what it is: a “diagnostic category” of psychiatry which “does not imply a medical or neurological cause”. “Diagnosis” is via a behaviour check-list. The more serious question concerns the role of psychiatry in society. How is it allowed to produce these systems of diagnosis? What role do they play in managing deviance? What is the relationship between psychiatry and its “diagnostic categories” and the pharmaceutical industry?

Drugs to “treat” ADHD are licensed in the UK by the MHRA. (Some drugs are licensed at a European level by the EMA). The MHRA specifies that in considering the merits of a drug it is necessary to consider: “Do the advantages outweigh the disadvantages of taking the medicine?” On the evidence reviewed in this paper it is quite simply hard to see how drugs such as methylphenidate and atomoxetine can have been licensed to “treat ADHD” in the UK. Once we probe behind the “symptom reduction” claim the alleged “benefits” of the drugs are difficult to ascertain. Claims tend to be somewhat folksy such as “improving the quality of life”. The only certain positive effect of stimulant drugs is a short-term increase in ability to concentrate; an effect which is the same for everyone whether or not they have an ADHD label. But the ADHD narrative concedes that this does not translate into an improvement in long-term outcomes. The actual “beneficiaries” of ADHD drugging may be those parents and schools who are glad to see a reduction in the disruptive behaviours which constitute an ADHD diagnosis. But this is not an advantage to the young person. On the other hand the harms are real and tangible and accrue to the young person. For example, methylphenidate routinely causes insomnia and stomach aches. Imagine the effect of suffering from drug induced insomnia throughout your childhood. Atomoxetine is linked to suicidal thinking and suicidal attempts. Under a heading which includes self-injurious thinking, self-injurious acts, suicidal thinking, suicidal attempts and actual suicides the MHRA's adverse event reporting scheme recorded 122 cases in under 18s between 2003 and 2013 where atomoxetine was suspected as being responsible. According to the manufacturer, the most common side-effects of atomoxetine in young people are upset stomach, decreased appetite, nausea or vomiting, dizziness, tiredness, and mood swings. The US FDA has issued a warning that post-launch adverse event reporting has associated atomoxetine with possible serious liver damage. These considerations make it hard to see how the MHRA's test for whether or not to license a drug can have been seriously applied.

NICE was asked by The Department of Health to produce a Guideline on the “diagnosis and management” of ADHD. NICE commissioned The Royal College of Psychiatrists and The British Psychological Society to produce the Guideline. This is like commissioning Procrustes to

manage your patient bed problem. Further problems exist. The MHRA licenses each drug on a case by case basis. The MHRA is not required to consider whether a non-drug behavioural intervention might be equally as “effective” as a drug intervention. This explains the astonishing state of affairs that permits drugging at all when, even on the most biased evidence, it appears that behavioural interventions can be nearly as “effective” as drugging and yet have none of the serious life-threatening or debilitating “side-effects”. There appears on the surface to be a system of “checks and balances” but, in reality, there appears to be nothing in the way of the flow of toxic drugs from US pharmaceutical companies straight into the mouths of British young people.