Adult ADHD as a dimensional disorder

Moncrieff & Timimi argue that there is no specific evidence to link adult attention-deficit hyperactivity disorder (ADHD) with childhood ADHD. They also question the increase in the use of stimulants for the condition and the role of the pharmaceutical industry in this. We can all lament the way in which the pharmaceutical industry has tried to increase the use of their products, yet the mere fact that they have done so does not invalidate their use.

The authors seem to ignore that most clinicians and academics see ADHD as a dimensional disorder. Just as with depression, the cut-off point for treatment is essentially arbitrary. This is the case in many psychiatric and other medical illnesses and conditions. We all recognise a patient when the illness is severe but it is less clear whether treatment is the appropriate course of action in less severe cases.

Majority opinion clearly suggests that the reason for the symptoms of ADHD is an increased density of dopamine transporter (DAT) complexes. With increasing age, there is a natural decline of these complexes, which causes a reduction of core symptoms. This leads to a change of prioritisation of core difficulties in adults, which does not represent a completely different set of symptoms as the authors suggest. The other argument the authors pursue is the high rate of comorbidity which they argue invalidates the diagnosis. However, untreated ADHD is likely to cause secondary difficulties such as conduct problems, personality disorder and substance misuse. Of course these difficulties cause some symptoms that are similar to the core symptoms of ADHD, but this hardly invalidates the primary diagnosis. More research is needed to find out whether adult treatment of ADHD mitigates the impact of acquired secondary problems. The current evidence would suggest that this is probably not the case. Therefore, the authors are certainly correct when they urge caution in the use of stimulants in adults if the main reason for the treatment would be to treat secondary diagnoses.

The authors argue that the wide variation in prevalence rates in difference studies is an argument against the validity of the concept of ADHD. However, such varieties are found in many dimensional syndromes. Depression and personality disorder are only two examples where this is the case. The American studies usually show higher prevalence rates because of their lower cut-off point for caseness of ADHD. In Europe, because the cut-off point is arbitrary and researches usually have it set higher, the prevalence figures appear different.

Moncrieff & Timimi mention a follow-up study which, they claim, shows that any beneficial effects from stimulant use are not sustained at long-term follow-up. Careful analysis of this study would have shown that the reported lack of sustained benefit had to do with the relatively high drop-out rate in the intention-to-treat analysis. This is not surprising as most psychiatric studies over 3 years have high drop-out rates. However, the subgroup of children that stayed in this study and continued with their medication actually maintained the benefits throughout the 3-year period. I fully agree with the authors that the evidence in adults is rather less clear, although on current evidence the effect sizes of stimulant drugs are certainly among the highest in medicine.

At the end of the day, the decision to treat adult ADHD with stimulants is a clinical one that should take into account the severity of symptoms, potential side-effects, and the likelihood of reasonable improvement.


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Are we missing the point in the debate on adult ADHD?

There is no doubt attention-deficit hyperactivity disorder (ADHD) in adults is a relatively new concept and as the evidence base emerges it is a good idea to critically appraise it. It has its problems being a ‘trait’ condition where the traits are distributed across the spectrum in the population. This poses a challenge to clinicians on where to set the bar for illness. One can argue to what extent this process is influenced by societal values and expectations.

The dilemma of categorising a symptom present in continuum in the population into an illness and wellness dichotomy is not unique to ADHD or even to mental health. It resonates with issues faced in setting the bar for hypertension or hyperglycaemia.

Rather than getting into a critical analysis, Moncrieff & Timimi seem to have approached the subject in a one-sided way that tends towards not accepting the condition exits rather than objectively weighing up-to-date evidence. For example, they state: ‘The evidence from randomised trials in adults and children therefore provides little basis for the sort of long-term drug treatment that is now being implemented for adults presenting with ADHD de novo, or for those with a continuation of a childhood presentation’. With regard to this statement, it is unclear who is recommending this.

The paper repeatedly quotes secondary research and uses qualitative remarks without systematically analysing data. Rather than looking into evidence base for current pharmacological treatment, the authors mention the National Institute for Health and Clinical Excellence guidance and focus on three randomised controlled trials quoted in that document. The recent Cochrane review on the matter found seven studies.
The authors raise the issue of lack of genetic overlap between ADHD in children and adults referring to the European consensus statement on diagnosis and treatment of adult ADHD. The study does mention that ‘to date several publications highlight potential associations with ADHD in adults, some but not all of which are shared with genetic association findings in children’, which is again a conclusion they draw from five other pieces of research. This information gets subtly presented in the paper as: there are ‘some’ similar genes between adult and child ADHD but ‘many are different’. Further, the authors state that ‘there have been many challenges to the validity of the childhood disorder’. They support this statement with three references, two of which are their own publications.

The debate to be had in the clinical world of adult ADHD in the UK is the issue of false positives. Due to the relative lack of stigma of the condition (which is not necessarily a bad thing!) and the issue of diagnostic overlap (particularly with emotionally unstable or borderline personality disorder), front-line adult clinicians face a major challenge. Emotional instability is increasingly recognised in adults with ADHD. With these commonalities in impulsivity and emotional dysregulation the difference between ADHD and emotionally unstable or borderline personality disorder gets blurred in adults (particularly with inclusion of attenuated varieties in DSM-IV) and hinge almost exclusively on ‘inattentiveness’. In my opinion, the authors let us down in not exploring in depth these and other real diagnostic and prescribing challenges surrounding adult ADHD.


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Adult ADHD: problems and pitfalls

The controversy surrounding adult attention-deficit hyperactivity disorder (ADHD) is intellectually interesting in terms of what it says about the distinction between pathology and normality and our moral response to this. However, the role of psychiatrists is to provide impartial advice to patients about what intervention is likely to be more useful than harmful. The individual then decides whether the intervention is useful for them or not. This applies to any intervention, not only pharmacological.

Considering data may help to inform the debate. I have run a National Health Service adult ADHD clinic for the past 3.5 years, during which time we have received 350 referrals, about half for adults who believe they may have ADHD, but who have not been assessed for this before. Of those who were ultimately identified as having significant ADHD traits and offered pharmacological intervention: (a) 70% were unemployed or had dropped out of education, (b) 15% had been in trouble with the police previously, (c) 72% had had previous contact with mental health services (and no consideration given to the possibility of ADHD), (d) 30% had two other mental health problems apart from ADHD, (e) 70% of those prescribed medication (stimulant on non-stimulant) returned to work or education.

It is the last finding that is most telling. These are individuals who are, and have always been, struggling significantly. Medication can help them to successfully complete ordinary but important tasks like hold down a job, stick to a course or maintain personal relationships. It is not a cure, but a powerful tool that can empower the individual.

The psychiatrist has a critical role in diagnosing and prescribing a substance that can have such profound effects (both positive and negative). Perhaps we should focus more on trying to identify who would benefit from intervention, and less on the intellectual exercise involved in ‘pathologising normality’.

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Authors’ response

We are glad our article provoked some discussion and we agree with Dr Shah about the need to provide impartial advice and to determine an individual’s preferences. Although the outcomes of the adult attention-deficit hyperactivity disorder (ADHD) service he describes are impressive, we do not know that these are attributable to medication alone, rather than other aspects of the care received in a specialist service. Only randomised controlled trials can establish whether medication has specific efficacy, after which effectiveness in real clinical practice and cost:benefit ratios have to be considered. Since we published our paper, the Medicines and Healthcare products Regulatory Agency (MHRA) has witheld approval for methylphenidate hydrochloride for adult ADHD on the basis that differences from placebo are small and do not outweigh documented adverse effects (http://news.woob.com/959215/adhd-drug-concerta-disapproved-for-adults-in-europe).

Dr Bhattacharya and Dr Lepping point out that ADHD is conceived as a dimensional rather than a categorical condition, but this does not change the arguments against it. The proposed trait is still defined by ‘symptoms’ that are universal experiences and diagnosis involves subjective judgements about impairment and what the impairment is caused by. The idea that the symptoms represent a unitary underlying condition that represents an evolution of a childhood disorder is simply an assumption, which is not currently supported by evidence.

Dr Bhattacharya accuses us of being one-sided and not being objective, but we would point out that no one is truly objective and everyone has their own perspective. We would suggest that we are being more objective than others by not...
Disclosure of psychiatric records

The article by Thompson contains many errors and misleading statements. To begin with, Thompson says that requests from courts for medical records ‘are issued by letter’. Courts do not issue requests; they make orders (sometimes referred to as directions). Such orders are never couched in the form of a letter. An order requiring the production of medical records is normally addressed to one of the parties to the proceedings. Such an order would be likely to be addressed to a hospital, National Health Service trust or other such body, or to an individual doctor only when that hospital, trust, other body or doctor had previously failed to disclose the records sought.

The author says that a psychiatrist has the duty to ‘seek legal advice from the trust if it appears that clinical information is being requested that is not relevant to the legal issue at stake’. The psychiatrist has no such duty and would be well advised to refrain from expressing any opinion as to whether the records sought are relevant to the issues in the case, and still more so from acting on any such opinion. The psychiatrist is unlikely to have a full appreciation of the legal issues involved. Whether or not he has a correct understanding of the issues, to refuse to release medical records whose disclosure has been directed, on the ground that they are considered not to be relevant to the case clearly defies the authority of the court and is certain to arouse the ire of the judge. An unsympathetic judge might consider it to be contempt of court.

Thompson states that when medical records are released in compliance with a court order, ‘third-party information must be removed from case notes’. This is not the case. Section 35 of the Data Protection Act 1998 provides, *inter alia*: ‘(1) Personal data are exempt from the non-disclosure provisions where the disclosure is required by or under any enactment, by any rule of law or by the order of a court’. Accordingly, when medical records are released in response to an order of a court they must be disclosed in their entirety, as stipulated in the order. No items should be omitted.

Thompson further says that the psychiatrist’s duty of confidentiality ‘is not automatically waived by a request from court’. She suggests that a patient could complain to the General Medical Council (GMC) of a breach of confidentiality and that the Council would investigate the complaint. The GMC’s guidance on confidentiality states, at paragraph 21: ‘You must disclose information if ordered to do so by a judge or presiding officer of a court’. This, of course, does no more than state the law of the land. However, it is clear that no

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For the full list of references to this letter, please email the authors.

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starting from the presumption that adult ADHD is a useful and valid category. There are numerous articles that provide an opposing point of view. With regard to the randomised trials of drug treatment, since National Institute for Health and Clinical Excellence guidelines are so influential and have endorsed the validity and drug treatment of adult ADHD, it is important to point out the evidence on which these conclusions were reached. We also refer to a meta-analysis of trials of methylphenidate, which found no significant difference in parallel group randomised trials, and the Cochrane review of amphetamines quoted by Dr Bhattacharya also found a lack of evidence of long-term benefit and a high risk of bias.

We do not see that our presentation of the genetic data differs substantially from the way it is presented by Kooij et al, also quoted in Dr Bhattacharya’s letter. In any case, we know that most molecular genetic findings are not replicated. The references we used to support the idea that there have been challenges to the concept of childhood ADHD include a book by one of us that was referred to because it reviews the literature in this area, and an article challenging the consensus statement on ADHD that was authored by 32 authors, as well as ourselves.

Dr Bhattacharya and Dr Lepping highlight the problem of comorbidity. The idea that the frequent comorbid conditions are distinct problems, or secondary to ADHD symptoms, rather than competing ways of conceptualising the same problems, is simply an assumption that follows from accepting the diagnosis of adult ADHD. Inattentiveness is too vague a concept to be used to clarify the diagnosis and, given the inclusive nature of inattentiveness ‘symptoms’, is likely to be identified by most people with mental health problems, as well as many without.

In response to Dr Lepping, studies on levels of the dopamine transporter in ADHD are contradictory, despite the consensus.1 Stimulants have well-documented psychoactive effects, and so it is not surprising that they change behaviour in the short term, producing large effects sizes. What is at stake is whether or not they help people in the long term. Evidence in children is not convincing. The Multimodal Treatment Study of Children with ADHD (the MTA study), which has been criticised on many grounds, found only marginal benefits of a ‘medication management’ package over behavioural therapy alone or routine community treatment (often including stimulants) at 14 months.2 At 3 years there was no difference between the groups, and there was no effect of compliance.3 At 8-year follow-up, analysis according to randomised group and actual medication used failed to show any advantage for medication.4 Other naturalistic follow-up studies have also failed to demonstrate any advantage for long-term medication in children5 and, as we describe in our paper, the evidence in adults is even weaker. Without evidence of long-term benefits, we suggest there is no justification for prescribing medication.
Perspective of a foundation year 2 doctor on psychiatry in the foundation programme

As a foundation year 2 (F2) doctor currently rotating through a pilot post in psychiatry in the Northern Deanery, I read ‘Improving psychiatry training in the Foundation Programme’ with great interest. I am in broad agreement with the authors that psychiatry placement in the foundation programme is of great benefit both to the new doctor in terms of experience and to the profession as a whole, boosting awareness of the specialty and recruitment. However, based on my experience so far in psychiatry I have become aware of several possible detrimental effects of psychiatry as an early foundation placement for F1 doctors.

In their article, Welch et al stated that there may be ‘difficulties maintaining medical skills’ and ‘acquiring acute medical competences’. A newly qualified F1 doctor working in a medical or surgical job experiences an extremely steep learning curve as they develop skills in grappling with acute medical problems and basic everyday tasks such as prescribing medications and fluids, phlebotomy, cannulation and traditional ward rounds. Although some of these experiences are common to psychiatry, the role of the foundation doctor in the mental health multidisciplinary team is quite different and unique. Often the mental health multidisciplinary team looks on the foundation doctor for medical advice and management of patients with physical health problems. I perceive two problems with a newly qualified F1 doctor rotating through psychiatry during their first or even second placements. First, the F1 doctor is unlikely to be able to complete the steep learning curve for practical tasks at the beginning of their year; when general hospitals offer more support and are often more lenient as the new doctor develops basic skills. This could leave the F1 doctor with feelings of incompetence and possibly lead to them being viewed so by peers, seniors and ward teams when commencing a medical or surgical job later in their first year. Second, without a good grounding in dealing with common medical problems with supervision from a medical team in a general hospital, the F1 doctor is likely to lack skills and confidence in the management of physical health problems on a psychiatric ward. Therefore the benefit for the mental health multidisciplinary team of having a foundation doctor with some competence in managing physical problems is lost and the doctor may feel out of depth. Doing medical on-call work may help to minimise these effects, but infrequent duties may exacerbate lack of confidence and F1 doctors may feel thrown in at the deep end during out-of-hours work compared with peers working daily in medical jobs. I feel it is the daily work of an F1 doctor on medical or surgical wards that allows for these skills to be developed and consolidated.

Therefore, it is my opinion that F1 doctors should not be rotating through 3- to 4-month psychiatry placements for the first 8 months of their training year, but that a placement would be beneficial for the trainee in the later months once a firm medical foundation is in place. This would allow the trainee to approach their psychiatry placement with more confidence and therefore value the experience more, while not being detrimental to their initial medical training as a whole. However, given that experience in psychiatry is important in terms of recruitment and allowing foundation trainees to experience the specialty as a graduate, in addition to longer
placements at the end of F1 and through F2, perhaps shorter 1-month tasters as suggested could be considered at any stage in foundation training. This is especially pertinent given that applications for core training are submitted early in the F2 year.


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