

Correspondence

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.¹ 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.^{2,3} 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 of 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 researchers 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.⁴ 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 & Timimi¹ seem to have approached the subject in a one-sided way that tends towards not accepting the condition exists 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.²

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.³ 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 personality disorders), front-line adult clinicians face a major challenge. Emotional instability is increasingly recognised in adults with ADHD.⁴

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 withheld 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.woorb.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