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Commentary

ADHD: radical approach is needed for a truthful outcome

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Response

We read with great interest the feature by Ophir,[1] which in keeping with our own endeavours carefully scrutinises successive DSM revisions of attention-deficit hyperactivity disorder (ADHD) and attempts to inform and shape our thinking.

This critique is particularly timely given the recent high profile public discourse on ADHD in the UK,[2] brought to the fore by a documentary that examined the diagnosis of ADHD and its contemporary management.[3] The breadth of views and the variety of perspectives held by the general public mirrors the wide-ranging discussion within academic, research and clinical circles, where there is a disagreement regarding virtually all elements of ADHD – from diagnosis to treatment. This 'perfect storm', so to speak, has been created by a complex set of factors that has drawn together and thrown into conflict parties driving towards different goals. At the centre of this controversy are the patients who have genuine attentional problems. It is important for us to reiterate what we have said repeatedly elsewhere, that our fundamental commitment is to patient care,[4,5] and to achieve this, we need to be confident that we are approaching the matter with clarity.

With this in mind, we appreciate Ophir's effort to take us further and, like his critique, have focused on the DSM criteria for ADHD. We adopted this approach because the DSM model maintains a seemingly unimpeachable dominance with respect to defining, diagnosing and researching ADHD. But if we are to correct its flawed diagnosis and imprecise clinical utility then we need to address these issues from the ground up. It is our view that the DSM-5-TR definition of ADHD has been extremely poorly constructed and that this is the fundamental problem that needs to be rectified first.

With the ambition of integrating conceptual and clinical inquiry related to attentional problems, and thereby informing reconstruction of the diagnosis of ADHD, we have recently interrogated its DSM-5-TR criteria[5] and reached a rather radical verdict. Drawing on scientific evidence in addition to examining the clinical conceptualisation of the diagnosis, we concluded that it suffers from fundamental flaws such as marked *redundancy* and unacceptable *vagueness* of criteria, along with *non-exclusiveness* from other conditions and behaviours that are commonly perceived as healthy. In addition, we strongly contested thresholds that we deemed as *arbitrary*, including the criterion of *early age of onset*. Further, we challenged fundamental aspects of the DSM-5-TR model such as the definition of *neurodevelopmental disorder*, with reference to current evidence – including that within DSM-5-TR. Remarkably, DSM-5-TR defines this term inconsistently throughout the manual – defeating the purpose of providing a definition. Thus, we feel our criticisms of DSM-5-TR are incisive, and no doubt some would regard them as harsh; however, they are based on careful analysis and are ultimately necessary and fair, given the clinical implication of flawed diagnostic criteria.

Ophir examines ADHD diagnosis from a theoretical perspective and concentrates on whether it has 'adequate construct validity', whereas we have started by focusing on its clinical usefulness, because 'clinical utility' is an important requirement for any condition to be classified as a 'mental disorder'.[6] This is significant because as per DSM-5-TR, a diagnosis 'should help clinicians to determine prognosis, treatment plans, and potential treatment outcomes for their patients';[6] however, bizarrely, it fails to meet this condition of its own making.

Numerous examples noted in Ophir's feature[1] could be used to question the clinical utility of the DSM-5-TR model of ADHD. For instance, the extreme discrepancies in ADHD prevalence between subsequent revisions of the DSM and between countries, a drastic decline in purported male-to-female ratios (from 10:1 to 2:1) across the DSM editions, an expanding range of ADHD comorbid disorders, the inclusion of an increasing number of differential diagnoses in the manual and, finally, the assigning of inattention, a defining characteristic of the disorder, preferentially to females have unnecessarily distorted the social perception of the disorder. All of this substantiates the verdict that our clinical and scientific understanding of this condition is insufficient.

Worryingly, the current approach to research in ADHD also suffers from fundamental problems. For instance, a recent scoping review of adult ADHD diagnosis in randomised controlled trials showed 'substantial variation and no consensus about the diagnostic method', with the diagnosis being made by a clinician in approximately only one-third of studies. Furthermore, a majority of the studies 'did not seem to include an assessment of general psychopathology', which is necessary for considering a differential diagnosis.[7]

These unresolved methodological problems along with the aforementioned conceptual issues illustrate a failure to meet Robins and Guze's requirements of a precise and distinctive clinical picture informed by research.[8] This, together with the successive 'broadening [of] the range of symptom presentations', expanding 'the definition of impairment' associated with ADHD and increasing the flexibility of its diagnostic criteria,[1] means that clinicians are left with unclear guidance as to how to recognise the true disorder and manage it effectively. Instead, they must rely on their clinical experience and expertise, which inevitably varies among clinicians and further increases the heterogeneity of the diagnosed population. Concerningly, once again, it is patients that pay the *price* for this chaos. Indeed, apart from the time and financial costs invested in assessments, they are at risk of the serious downstream

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consequences of misdiagnosis and mistreatment, both of which can cause lifelong physical and mental health harms.

Therefore, as per Ophir's clarion call, a radical and immediate change in how ADHD is diagnosed and treated is needed. We support the need to resolve 'conceptual tensions' surrounding the diagnosis[1] and at the same time address its poor clinical applicability but respectfully argue that, perhaps prior to either of these advances, we should strengthen the unstable foundation of ADHD. We agree with Ophir that it is 'a time to tear down and a time to build',[9] a sentiment that resonates with our ongoing efforts to deconstruct ADHD and inform how to reconstruct the diagnosis anew.

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