

ATTENTION DEFICIT DISORDER MIMICS OTHER PROBLEMS

As a psychoanalyst, as well as a psychologist, I have a different point of view about attention deficit disorder than many other clinicians. I believe that, in general, professionals of all disciplines are these days enormously and, I think, dangerously glib about diagnosing ADD.

I have often heard from a parent this scenario: "I went to see Dr. So-and-So about my son and I told him that Sonny doesn't stay in his chair at school, he doesn't finish his work, he can't keep his mind on what he is supposed to, he has trouble with organization, forgets his assignments. Dr. So-and-So told me, "Your son has ADD."

What's wrong with this picture? What's really wrong is that this reply has *no explanatory power*. In other words, it's merely a rephrasing of what the parent already said to the doctor about her son. The reply sheds no light on the problem. It explains nothing. It adds nothing to our understanding of the symptoms. And unless everyone involved with the ADD patient--especially the patient himself--comes away from an evaluation with a clear and more comprehensible understanding of the meaning--not necessarily the cause, but the meaning--of this *particular* patient's symptom picture, then we're not doing our best job. And what especially concerns me is that we are likely to miss other conflicts and problems if we base our evaluation essentially on the outward behavioral symptoms of ADD.

This risk of misdiagnosing is just as high--maybe even higher--if the clinician adds to his diagnostic inventory the usual--or even unusual, flashy and high-tech--instruments: computer aids, rating scales, I.Q. subtests, teacher checklists, etc. In fact, misdiagnosing, under-diagnosing or over-diagnosing is then even more likely, I think, because, well you know how the *omniscient tests* can lull and seduce one into a false sense of security; "the *tests* said it--it must be true," especially if it's a computer test!

And let's face it: Most teachers, pediatricians and therapists do, in fact, base their diagnosis of ADD entirely on behavior alone. What's wrong with this approach is the fact that *all* ADD symptoms may be part and parcel of other forms of psychopathology or normality!

There are few behaviors which are not forced to fit into the procrustean bed of ADD in order to support what is so often, in my experience, a pre-determined diagnosis. I most certainly *do* believe there is such a thing as "true," biologically-based ADD. But I think I could probably count on two hands the number of such cases I have personally evaluated in the last fifteen years. Naturally, that low number in part reflects my own bias, although we are all biased in certain ways which affects our work.

But as Donald Rosenblitt, M.D., Medical Director of the Lucy Daniels Center for Early Childhood, has pointed out, teachers from inner cities, suburbs and towns across the nation are encountering a six to ten-fold increase, compared to a generation ago, in the number of children with impulsive, distractible and over-active behaviors. Almost all

these children meet the standard criteria for ADD. Are we to understand then that ADD, presumably a brain disorder that the child was born with, has increased in less than one generation by a factor of six or a factor of ten? How and why should this be?

And how can we understand this puzzle: The National Institute of Mental Health has officially declared that about 6-7% of school-aged children have ADD and it is generally accepted that the ratio of affected boys to girls is about 7 to 1. If we combine the 6-7% incidence with the 7 to 1 ratio, then the incidence of the disorder in girls is 2% or 1 in 50, and the incidence in boys about 1 in 8. Why should a biologically-based brain disorder manifest such a spectacular gender difference?

U. S. News & World Report recounted recently how the U.S. consumes 80% of the world's Ritalin. And consider this fact: The reputed incidence of ADD in Great Britain, by some estimates, is only 10% of the incidence in the United States. The British require higher scores on ADD questionnaires for diagnosis. Are they missing the diagnosis 9 out of 10 times, or we over-diagnosing ten-fold?

What is the practical implication of this cautionary tale? For me, it is this: I no longer perform ADD evaluations per se. When you evaluate a child for ADD, you're really asking and trying to answer the wrong question. Essentially, you are asking: "Does this child have ADD or not?" The appropriate question to pose is, instead, "What's going on with this child?" Of course, one can say the same thing about virtually any presenting problem which brings children and their parents to seek professional help,

whether it's anxiety, depression, learning problems or behavior disorders. It's just that so very many children are being officially and unofficially labeled ADD these days. It's gotten so that it is a rarity when a mother calls me and says that she (or the teacher or the pediatrician) wants help because her child is depressed, or anxious, or worried, or unhappy. Nowadays, most of my evaluation referrals are specifically for ADD. What's going on?

I'm sure I hold the minority opinion, but this is what I think is going on: The dominant contemporary way of approaching child psychopathology--diagnostically and therapeutically--represents the triumph of behaviorism and biology among psychologists, educators and psychiatrists. And we have seen, particularly in the past decade or two, a sweeping retreat from real, in-depth clinical work--psychotherapy, as well as in-depth, thorough--which means "lengthy"--evaluations and treatment.

Managed care also is part of the problem. When you have only a few sessions at an unreasonably low fee, you are apt to take shortcuts. Child psychiatrist, Stanley Greenspan, recently commented: "In many situations, a child is being prescribed and diagnosed in one, half-hour meeting. Insurance coverage does not support the kind of assessment you need."

Above all, I want to convey how important it is for the clinician evaluating a child to maintain an inquiring, open, skeptical and independent attitude. This goes for ADD or any other disorder. Rather than really throwing Ritalin at the problem, doctors need to

take their time and make careful, thorough diagnoses. Remember H. L. Mencken's acerbic remark: "For every complicated problem, there's always an easy answer. And it's always the wrong one."

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