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On the efficacy of the DSM- IV- TR, in the diagnosis of children with Attention Deficit Hyperactivity Disorder (ADHD). A survey of medical practitioners' perceptions.

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A research report submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the Degrees of Master of Education (Educational Psychology).

Johannesburg 2007

Declaration

I hereby declare that this thesis is my own unaided work. it is being submitted for the degree of Master of Education (Educational Psychology) at the University of the Witwatersrand, Johannesburg. It has not been submitted for the purpose of any other degree or examination at any other University.

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Sharna Brest

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Abstract

There has been an increase of attention placed on the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), within South Africa. This has led to a number of controversies surrounding the legitimacy of ADHD diagnoses. And how effective the systems of categorising and diagnosing disorders are in aiding a number of practitioners in formulating a disorder. There is a substantial agreement within the literature that the understanding of ADHD is limited, the focus is mainly on the symptoms of disorders. This study explores the perceptions practitioners in the field, in identifying the effectiveness of the Diagnostic and Statistical Manual for Mental disorders (DSM) is for diagnosing ADHD. It became evident throughout this study that there is no consensus around the efficacy of the DSM. Furthermore, ADHD is not completely understood and therefore creates serious implications for the treatment and diagnosis of the disorder.

Key Words

Attention Deficit Hyperactivity Disorder (ADHD), Diagnostic and Statistical Manual for Mental disorders (DSM), treatment, diagnosis, controversies, classifications, comorbidity, categorisation, International Statistical Classification of Diseases (ICD), American Psychiatric Association (APA).

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Chapter 1: Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is a problematic phenomenon. Some researchers question its existence while others feel that the label captures a clearly definable condition. Where its existence is accepted there are further difficulties related to (a) the precise description of the condition, (b) explanations of the causes of the condition, (c) the methods to be used to diagnose it, and (d) the intervention strategies that should be used to deal with it. Accepting the de facto existence of ADHD, this research intends to focus specifically on difficulty (c) above by looking at the use of the Diagnostic and Statistical Manual for mental disorders (DSM) by medical practitioners in the diagnosis of ADHD.

In Schmidt's (1994) study on family practitioners, he highlights the lack of knowledge about ADHD among these practitioners as a significant feature within family practice in South Africa. Schmidt's results also indicate that there is a significant need for family practitioners to become more assertive in their understanding and management (Schmidt, 1994). Cartwright (1991, cited in Schmidt 1994) reported that no large scale epidemiological studies on the prevalence of ADHD in South Africa have been conducted, therefore it can be assumed that this particular topic needs to be tackled and the perceptions and understandings held by various practitioners needs to be identified (Schmidt, 1994, Bennet & Sherman (1983).

The occurrence and prevalence of childhood disorders has appeared to increase in today's society. It has become a serious concern among professionals and especially among parents. This concern relates to the lack of understanding people have for the disorder and why it occurs, as well as the conflicting methods of its diagnosis. The argument here is not against the existence of ADHD as a clinical phenomenon, but rather about the lack of consensus in constructing a consistent framework within which a diagnosis of ADHD can be made.

ADHD can be seen as a severe and often weakening mental disorder in children. Symptoms may often improve throughout the course of the disorder, but in an extensive amount of patients these symptoms do not improve, but persist into adulthood (Wender, 1995). When one mentions ADHD, it automatically brings to mind the idea of young children who cannot sit still or maintain concentration in class. However, what is often left out is that these children exhibit a number of

difficulties, such as deficits in academic performance, aggression, and conduct problems. Their general intelligence level may be questionable, as well as whether parents have ADHD or any other psychiatric disorder suggesting heredity. Child rearing practices could be an influence, parent- child relationships and peer relationships could determine if there was effective socialization of children with ADHD (Wicks- Nelson & Israel, 2003). These all play a significant role in an individual's normal or uncharacteristic development.

ADHD has become one of the most well known childhood disorders and one that has acquired many diagnoses and attention. Throughout this report there are a number of concerns and definitions surrounding ADHD, but the underlying idea pertains to the numerous questions asked; why has this disorder acquired so much attention and why has it become such a frequently diagnosed disorder? Are modern day living conditions in fact inducing these conditions, or is it because practitioners in all fields are far more committed to the diagnosing or labelling of these 'infrequent' behaviours. In view of the preceding questions the diagnosis of ADHD is problematic and the use of the DSM in the diagnosis may be challenged. However, it should be recognised that while the DSM- IV is not perfect it is still considered to be the best available means for diagnosing mental conditions.

With regards to these perceptions this report set out to look at and determine specific means of diagnosing ADHD namely; the Diagnostic and Statistical Manual for mental disorders (DSM), and the use of the DSM amongst a sample of practitioner's in a particular geographical area. The first section of this report is the literature review which details the nature and development of the diagnostic systems for mental disorders, followed by the characterisation, classification and controversies in the diagnosis of ADHD, and lastly research and controversies around the diagnosis of ADHD are explored.

The research method section looks at the method of sampling used in this report in detail, with particular emphasis on sample selection, procedure and data gathering. Following from this section is the discussion and presentation of results, which describes individual information pertaining to the participants in the research, as well as the themes identified throughout the report with particular reference to the responses from the participants in correlation to the literature and research dedicated to the topic. The conclusion of this report intends to identify and portray the most important aspects

discussed throughout the research process in order to determine the true efficacy of the DSM in diagnosing ADHD.

Chapter 2: Literature Review

2.1 Introduction

This chapter focuses on the debates surrounding the diagnostic systems used for mental disorders. The specific focus of this discussion is on the controversies surrounding the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). This review intends to establish how useful medical practitioners find the Diagnostic and Statistical Manual for Mental disorders (DSM) criteria for diagnosing ADHD, and whether in their own practice and experience, they believe the criteria may need to be extended in order to include additional criteria. This review identifies the nature and controversies surrounding the DSM, despite this the focus is on; the characterisation of ADHD in terms of diagnosis, research and controversies around the diagnosis of ADHD.

2.2 The nature and development of the Diagnostic systems for mental disorders

According to Schwab- Stone and Hart (1996) from the beginning of the DSM- II there have been numerous efforts to sustain a level of communication between the DSM and the International Statistical Classification of Diseases (ICD). Although there are a number of important differences that exist in the DSM and ICD approaches and classifications, specifically in the area of childhood disorders, the differing purposes of each system determines the differences in their orientation and content (Schwab- Stone & Hart, 1996). A major difference between these systems, identified by Schwab- Stone and Hart (1996), relates to the criteria to which diagnoses are operationalised or specified. As further indicated by these authors, the ICD offers a more inclusive description of the clinical concepts surrounding various disorders, followed by areas of differential diagnoses and diagnostic procedures, as well as including additional symptoms that should be present for a complete diagnosis.

For the purpose of this research report it is imperative to take note of Schwab- Stone and Hart's (1996) comparison of the DSM and ICD systems, in that both these systems encourage recording

of all diagnoses relevant to a patient's clinical presentation; however, the ICD retains the possibility of applying a few combination categories (e.g. Hyperkinetic Conduct Disorder), in which comorbid symptom patterns are indicated as one diagnosis rather than two, as is the case in the DSM.

In the past decade or so there has been a specific need for a system of diagnosis to be created to help a variety of professionals to understand a diagnosis of mental disorders. During this time the Diagnostic and Statistical Manual of Mental Disorders (DSM) has seen a number of changes and editions. In addition to this manual a new version of the system of diagnosis used in most parts of the world has been developed and revised as well (International Classification of Diseases (ICD), World Health Organization, 1992, cited in Schwab- Stone & Hart, 1996). Schwab- Stone and Hart (1996) have noted that in order for the DSM to be revised, the appearance of a new classification demands adjustment on the part of the practitioners and researchers, and are therefore repeatedly surrounded by continuous disagreement.

To understand the nature of the DSM it is necessary to look briefly at its history as well as its relationship to the ICD. In the past, there was a strong need for mental disorders to be classified in a way that suited diagnostic criteria, however there was no consensus on what disorders should or should not be included. These debates were focused on the differing systems that existed in categorising mental disorders, in respect of the practical use in clinical, research, or even statistical settings (Levy & Hay, 2001, DSM-IV-TR, 2000). In the United States of America (USA), the primary focus for developing a classification of mental disorders was the need to gather statistical information. What may have been considered the first official attempt to gain information about mental illness in the USA was the recording of the occurrence of one category- 'idiocy/ insanity' in the 1840 survey (see DSM-IV-TR, 2000). By the 1880 survey there were seven categories that had been distinguished.

In 1917 the committee on statistics of the American Psychiatric Association (APA), along with the National Commission on Mental Hygiene, formulated a strategy that was adopted by the Bureau of the Census for gathering consistent statistics across mental hospitals (DSM-IV-TR, 2000). The American Psychiatric Association (APA) consequently collaborated with the New York Academy of Medicine to develop a nationally acceptable psychiatric classification that would be included in the first edition of the American Medical Association's Standard Classified categorisation of Disease. This

categorisation was intended to diagnose in- patients with severe psychiatric and neurological disorders. A far broader categorisation was later developed by the U.S. Army in order to incorporate the outpatient presentations of World War II servicemen and veterans (e.g., psychophysiological, personality, and acute disorders) (DSM-IV-TR, 2000). At the same time the World Health Organization (WHO) published the sixth edition of ICD which, for the first time, included a section for mental disorders. The ICD- 6 was greatly influenced by the Veterans Administration nomenclature and included 10 categories for psychoses, 9 for psychoneuroses, and 7 for disorders of character, behaviour, and intelligence.

The American Psychiatric Association Committee on categorisation and statistics developed an alternative to the ICD- 6 that was published in 1952 as the first edition of the *Diagnostic and Statistical Manual: Mental Disorders* (DSM-I) (DSM-IV-TR, 2000). The DSM- I incorporated a glossary of descriptions of the diagnostic categories and was the first official manual of mental disorders to focus on clinical effectiveness. The DSM-IV-TR (2000) shows that the use of the word 'reaction' throughout the DSM-I was influenced and reflected by Adolf Meyer's psychological view that mental disorders represents reactions of the personality to psychological, social, and biological factors. In other words, a person's mental diagnosis is a reflection of a number of interrelated aspects and not based purely on the person's state of mind.

Due to the lack of general acceptance of the mental disorder classification contained in the ICD- 6 and ICD-7, the WHO sponsored a comprehensive review of various diagnostic issues that was conducted by the British psychiatrist Stengel (DSM-IV-TR, 2000). According to DSM-IV-TR (2000), Stengel's accounts have had a great influence on recent advances in diagnostic methodology, especially the need for precise definitions as a means for promoting and influencing reliable clinical diagnoses. However, the next revision process leading up to the development of the DSM- II and ICD- 8, did not include or consider Stengel's recommendations (DSM-IV-TR, 2000). The DSM- II was similar to DSM- I but eliminated the use of the term reaction (DSM-IV-TR, 2000).

According to the DSM-IV-TR (2000) the development of the DSM- III was coincided with the development of the 9th version of the ICD, as had been done with previous editions. This edition of the ICD was published in 1975 and implemented in 1978. Work on the DSM- III began in 1974, and was published in 1980. The DSM- III introduced various significant and important methodological

innovations, which included explicit diagnostic criteria, a multiaxial system, and an expressive approach that aimed at being unbiased with respect to theories of etiology (DSM-IV-TR, 2000). The ICD- 9 version did not include diagnostic criteria nor did it include a multiaxial system, this was due to the fact that the international system was developed in order to define categories that would facilitate the collection of basic health statistics. By comparison, the DSM- III was developed with the additional goal of providing a medical categorisation for clinicians and researchers (DSM-IV-TR, 2000). The DSM-IV-TR (2000) shows that there were a number of difficulties surrounding the acceptance of the DSM- III as there were inconsistencies in the system and a variety of criteria were not clear. Therefore the American Psychiatric Association appointed a work group to revise the DSM- III, which further led to the development and publication of the DSM- III- R in 1987.

The DSM- III represented a key element in the progress of mental disorders and greatly facilitated further empirical research (DSM-IV-TR, 2000). According to DSM-IV-TR (2000), the development of the DSM- IV has benefited from the significant increase in the research on diagnosis that was greatly influenced by the DSM- III and DSM- III- R. The task force chosen to work on DSM- IV and its work groups conducted a three stage experiential process that involved comprehensive and methodical reviews of the published literature, reanalysis of already obtained data sets and widespread issue focused field trials (DSM-IV-TR, 2000).

The development of the DSM- IV cannot be discussed without identifying its relationship to the ICD-10. The tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD- 10), developed by WHO, was published in 1992 (DSM-IV-TR, 2000). The preparation of the ICD- 10 and DSM- IV saw a collaboration of efforts from researchers, resulting in mutual influence. The ICD- 10 consists of an official coding system and other associated clinical and research documents and instruments (DSM-IV-TR, 2000). According to DSM-IV-TR (2000) the codes and terms provided in the DSM- IV are compatible with both the ICD- 9- CM and ICD- 10. The clinical and research drafts were extensively reviewed by the DSM- IV work groups and recommended significant topics for DSM- IV literature reviews and data reanalysis (DSM-IV-TR, 2000). The draft versions of the ICD diagnostic criteria for further research were included as alternatives to be compared with previous versions of the DSM and additionally used as suggested DSM- IV criteria sets in field trials (DSM-IV-TR, 2000). According to DSM-IV-TR (2000) the continuous consultations between developers of the DSM- IV and ICD- 10 led toward an extremely

useful congruency and reduction in irrelevant information or differences in wording between the two systems.

It is quite clear that the most important uses of the DSM- IV has been as an educational tool (DSM-IV-TR, 2000). The interval between DSM- IV and DSM- V has been extended according to the intervals set between earlier editions. Thus the information in the text, which was prepared on the basis of literature dating from 1992, runs the risk of becoming progressively more out of date with the expansive collection of research published each year. In order to bridge the gap between the developmental process of the DSM- IV and DSM- V, a revision of DSM-IV text was undertaken(DSM-IV-TR, 2000).

The ultimate goal of this revision can be seen as involving a number of aspects namely: 1) to correct any factual errors that were identified in the DSM- IV text, 2) to review the DSM- IV text to guarantee that all of the information is up to date, 3) to create changes in the DSM- IV text that would reflect new information available since the DSM- IV literature reviews were concluded in 1992, 4) to make improvements that will aid the educational strength and worth of DSM- IV, and 5) to update those ICD- 9- CM codes that were altered since the DSM- IV 1996 coding update (DSM-IV-TR, 2000). According to DSM-IV-TR (2000) the text revision process began in 1997 with the selection of Test Revision work groups, similar to the original DSM-IV Work Group structure.

The DSM-IV was the product of 13 work groups consisting of 27 members, each of whom were responsible for a section in the manual. There was an immense amount of international involvement in developing the DSM, which enabled there to be a pool of information that would apply to a multitude of cultures (DSM-IV-TR, 2000; Schwab- Stone & Hart (1996) in systems of psychiatric classification). The task force aimed to look at issues and observable evidence early in the process to identify and rule out any potential problems and / or differences in interpretation.

Schwab- Stone and Hart (1996), discuss the revision process of the DSM in great detail. These authors identified the beginning of the process in 1988, which was seen as rather hasty. However, the DSM was revised with reciprocal input and maximal management of efforts (Schwab- Stone & Hart, 1996). According to Schwab- Stone and Hart (1996) the goal of the revision process was to develop diagnostic criteria that would make the most of identifications surrounding functionally impaired

children and adolescents, agreement among clinical diagnoses, internal consistency of symptom lists and reliability of specific diagnoses. For the purpose of this research report the reliability of the DSM on diagnosing Attention Deficit Hyperactivity Disorder (ADHD) will be discussed in a fair amount of detail.

In 1990 there was an update of the 'International classification of diseases' (ICD- 10) and in 1994 there was another update, this was an update of the 'Diagnostic and statistical manual of the American Psychiatric Association' (DSM-IV). These systems have been noted to be very similar in there categorisation (Levy & Hay, 2001). The DSM- IV-TR was created in order for practitioners in all fields to have an area of classification of mental disorders, and for there to be a collection of statistical information (DSM-IV-TR, 2000). Experience with the DSM- III revealed a number of inconsistencies within the system and various instances in which the criteria were not entirely clear. Therefore there was a need to revise the manual and correct the imperfections, which led to the publication of the DSM- III- R in 1987 (DSM-IV-TR, 2000). The development of the DSM- IV has benefited from the considerable increase in the research on diagnosis, including literature and available data sets, that were relevant to the revision of the manual (DSM-IV-TR, 2000).

Although the DSM-IV-TR 2000 provides a classification of mental disorders, no one definition is absolute and completely precise in identifying the boundaries of mental disorders, as they have been defined and classified in competing ways. In the DSM-IV, each mental disorder is conceptualised as clinically significant either as a behavioural or psychological syndrome; or as a pattern within the individual that is connected with the present distress or disability; or one with an increased sense of suffering death, pain, disability, or as an important loss of freedom (DSM-IV-TR, 2000). Regardless of the cause, according to the DSM, the cause must be considered a symptom of behavioural, psychological, or biological dysfunction within the individual. According to DSM-IV-TR (2000) it is not simply a representation of deviant behaviour, nor is it defined as conflicts between the individual and society, rather it is being classified as a mental disorder, unless this is a representation of a symptomatic dysfunction within the individual (DSM-IV-TR, 2000).

As previously discussed the ICD- 10 has also undergone a series of revisions. In the late 1950's, the area covering psychiatric diagnoses in the 7th edition was subjected to close scrutiny and it was

found to be missing a clear representation of the scope involving psychiatry (Rutter et al, 1975). The World Health Organisation (WHO) sponsored a programme which intended to develop and reconstruct a more sufficient and satisfactory classification for mental disorders, which led to the publication of the 8th edition in 1968 (Spitzer & Williams, 1980). Although this was an important achievement in the international alliance and an improvement on prior versions, the ICD- 8 classification of mental disorders presented a concession leading toward further investigation and revision (Kramer, 1968).

A 10 year research plan, initiated in the 1960's assessed case history exercises which led to extensive seminars to assess the functioning and reliability of the system in various areas concerning psychiatric diagnosis, particularly those involving child psychiatric disorders (Schwab-Stone & Hart, 1996). According to Schwab- Stone and Hart (1996), 1978 saw the publication of the ICD- 9, however there were plans for further investigation, revision and research, opening the pathway for a system that would address descriptions for clinical and research diagnoses.

The ICD- 10 incorporating the above changes is the final piece of the series to the large puzzle of the 10 year revision process. The development of this piece involved a large number of international field trials. The goals of these trials were firstly to investigate and estimate the applicability of ICD- 10 psychiatric diagnoses in a number of countries, simplify the use of the system and lastly, increase the level of interpretation agreement when the system was applied by various clinicians when making diagnoses in clinical practices or contexts (Schwab- Stone & Hart, 1996). Results from the field trial were developed and identified, and further used in the refining of the ICD- 10 draft before final publication in 1992 (Schwab- Stone & Hart, 1996).

Schwab- Stone and Hart (1996) suggest that using the ICD- 10 involves creating a bigger picture of a particular patient and allowing the clinician to puzzle together a patient's clinical presentation in order to develop an overall picture, rather than simply determining whether a sufficient number of specified symptoms are present, as identified in the DSM system since the DSM- III.

The nature and purpose of the DSM- IV is to provide a clinical, research and educational tool. It has also tried to provide communication among clinicians and researchers (DSM- IV- TR, 2000). Another aim of the DSM is to assist and improve the communication among clinicians and

researchers, as the DSM incorporates a multitude of diverse orientations. The authors have placed an enormous amount of importance on the idea of providing clinical practitioners, in all fields, with the knowledge of psychopathology (DSM- IV- TR, 2000).

Schwab- Stone and Hart (1996) have addressed concerns surrounding the environment one resides in as having a significant effect on a person's development and thus influencing certain aspects when a diagnosis is made. According to Schwab- Stone and Hart (1996) the ICD- 10 needs to remain flexible in order for it to be used as an international system, as it is used in diverse settings under a range of clinical situations or conditions.

2.3 Characterisation, classification and controversies in the diagnosis of ADHD

According to Selikowitz (2004), ADHD is not a new condition or phenomenon. The first description of children with this disorder was coined by an English physician, Dr George Still, in 1902. He described 20 children who exhibited impaired concentration and over-activity; however he did not give these conditions a name. This 'condition' gained further attention after an encephalitis epidemic in USA in 1917-18. This illness left a number of children with attention difficulties, over- activity and impulsivity (Selikowitz, 2004). Selikowitz (2004) has noted that since then ADHD has received much attention and has become a widely studied developmental disorder in childhood. In the 60's, attitudes toward ADHD in the UK and the USA began to diverge from the initial ideas held. It was at this time that the International Classification of Diseases (ICD) of the World Health Organisation came into being (Selikowitz, 2004). The first Diagnostic and Statistical Manual of the American Psychiatric association (DSM) followed.

It has been noted by Green (1996) and Hallowell and Ratey (1994) that many children who display symptoms such as restlessness, low frustration and tolerance and lack of a sense of control, are diagnosed as ADHD when in fact they may have an underlying intellectual disability. According to the DSM-IV-TR (2000), symptoms characteristically worsen when they are in situations that require sustained attention and mental effort or that may lack elements of inherent application. The DSM-IV-TR (2000) identifies situations in which such symptoms may be minimised or are absent and therefore indicates that the clinician needs to gain as much information as possible from a multitude of sources, to clearly identify particular behaviour patterns in particular settings.

There are a number of factors that may contribute to, or affect symptoms of the disorder such as family interactions, school expectations, and other demands that are placed on the individual child. Such demands can be seen in the current education system, where there is pressure on children to be school ready, and this pressure is initially placed on the teachers who further push the children, which is then reinforced by the parents expectations of where there children should be at. There is a lot to be said on the predisposition of the individual, for the prevalence of ADHD, as well as the family history. It is difficult to place a diagnostic classification on one individual as each person presents these symptoms in a different way, which is why it is important to know the history of a child in order to identify whether there is a pattern of the particular symptoms. Pledge (2002) points out that those symptoms may be mimicked by various emotional disorders, such as reactions to abuse, depression or anxiety.

In order to provide a comprehensive understanding of ADHD, one needs to focus on the processes involved in the diagnosis of the disorder. In gaining information on the categorisation of ADHD, one needs to tap into, and explore the Diagnostic and statistical manual of mental disorders (DSM- IV). The DSM- IV-TR (2000) defines the essential features of ADHD as, a constant pattern of inattention and/or hyperactivity- impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development (Criterion A).

ADHD has been characterised by inattention, impulsivity and/or hyperactivity, these being the general characteristics of the disorder. With the continuous changes and reviews of the diagnostic manuals, the diagnostic criteria have continuously revised ADHD classification. The DSM- III provided a model of the disorder which includes symptoms involving inattention, motor hyperactivity, and impulsivity which reflects three separate dimensions to the disorder. According to the DSM-III, a child was considered to display attention deficit disorder with hyperactivity (ADD/H) if he or she demonstrated significant difficulties in the inattention, motor hyperactivity, and impulsivity symptom areas. A diagnosis of attention deficit disorder without hyperactivity (ADD/WO) was appropriate when the child exhibited difficulties in sustained concentration or attention and impulsivity but did not have motor hyperactivity (Schwab- Stone & Hart, 1996).

According to Schwab- Stone and Hart (1996) this distinction changed considerably over time (from the DSM-III to the DSM- III- R) to include a unidimensional definition according to which diagnostic criteria involved a child exhibiting at least 8 of the 14 symptoms listed relating to difficulties in attention, impulsivity and motor hyperactivity. The DSM- III-R further raised a number of concerns as the definition may result in the identification of a heterogeneous population, including some children who may also meet the DSM- III criteria for ADD/WO. In preparation for the revision of the DSM- IV, reviews of the extensive literature were conducted, such as that by Lahey et al (1988, cited in Schwab- Stone & Hart, 1996) who recommended that the symptoms of attention deficit disorder would best be described using a two dimensional model. The first dimension comprising of symptoms representing inattention and disorganisation, and the second dimension comprising of symptoms involving motor hyperactivity and impulsive behaviour. This model was consistent with factor- analytic literature, indicating that symptoms of inattention are more strongly correlated with one another than with symptoms of hyperactivity- impulsivity and vice versa (Bauermeister et al, 1992, Lahey et al, 1988 & Pelham et al, 1992, cited in Schwab- Stone & Hart, 1996).

There are a number of controversies surrounding the use of the DSM. Maniacci (2002) believes that due to the diverse population and various complicated issues when seeking help, assistance and guidance, clinicians need to make accurate and informed diagnoses. Maniacci (2002) proposes that the manual is not perfect, but it is probably the best attempt yet to catalogue such disorders. Although the DSM aims to iron out any problems in application, Holmes and Stalling (2001), Tramonte (1997), and Beamish (2001), have identified various cultural, traditional and ethical dilemmas regarding the use of the DSM.

There are various limitations in the categorisation process in the DSM- IV, as there is no unified diagnosis for all people and therefore trying to categorise those that are on the boundaries of diagnosis, may be difficult. Therefore it is important to emphasise that when using the manual the clinician should be aware that individuals sharing a diagnosis are likely to be varied even with regard to the defining features of the diagnosis. According to the DSM-IV-TR (2000), a categorical approach to classification works best when all members of a particular diagnostic class are homogenous, when there are apparent boundaries between certain classes, and when the different classes are mutually exclusive.

On the strength of the available literature, the two dimensional model was adopted for use in the DSM- IV and this led to the further development of three types of ADHD diagnoses; firstly those with clinically significant numbers of inattention symptoms only (predominantly inattentive type), secondly those with significant levels of hyperactivity- impulsivity only (predominantly hyperactive-impulsive type), and lastly those with a combination of inattention and hyperactivity- impulsivity symptoms into a combined type (Schwab- Stone & Hart,1996). According to Schwab- Stone and Hart (1996) these subtypes result in the reduction of issues surrounding heterogeneity, previously mentioned in the DSM- III- R.

The DSM- IV has been said to include a greater specification of criteria for a diagnosis to be made, including impairment, pervasiveness, and age of onset, it also adds the specific requirement of clinically significant impairment in social, academic or occupational functioning (Schwab- Stone & Hart, 1996). In order to further conceptualise the true criterion surrounding a diagnosis of ADHD, a brief description of the ICD- 10 requirements for diagnosing Hyperkinetic Disorder follows.

Rutter (1989, cited in Schwab- Stone & Hart, 1996) identified the categories for Hyperkinetic disorder in the ICD- 10, as a group of disorders characterised by overactive, poorly modulated behaviours in combination with inattentiveness and lack of persistence. According to Rutter (1989, cited in Schwab-Stone & Hart, 1996) this collection of symptoms is required to be early in onset, in other words before 6 years old, constant across various situations and continual over time.

Furthermore, due to long standing differences in the conceptualising of the disorder, it has been more narrowly conceptualised in the ICD- 10 than in the DSM-IV. However Schwab- Stone and Hart (1996) argue that a diagnosis cannot be made solely on the basis of symptoms of inattention and therefore state that attention deficit disorder is not used because it "implies a knowledge of psychological processes that is not yet available, and it suggests the inclusion of anxious, preoccupied, or 'dreamy' apathetic children whose problems are probably different" (WHO, 1992, p.262, cited in Schwab- Stone & Hart, 1996). It can therefore be concluded that there are a number of differences that remain between the two systems in this particular area of mental diagnosis, therefore one should consider such difference when a diagnosis is needed and further acknowledge the differences that exist when clinicians diagnose and consider what system they employ in the diagnosis, if any.

Considering the fact that ADHD is commonly diagnosed, as shown in the research, for example Schwab- Stone and Hart (1996), Rutter (1989) and Maniacci (2002), there has been no previous research showing the integrated clinical use of the DSM to make a diagnosis of ADHD, and if the DSM is being used, how critical the clinicians are of the criteria used in the diagnosis of ADHD. The researcher will critically analyse the clinician's reliance on the medical model and pharmacological interventions, and will critically engage in the findings, in the same way as Illich (1976) attacks the medical position.

2.4 Research and controversies around the diagnosis of ADHD

In this section the focus is on the difficulties and controversies surrounding the diagnosis of ADHD found in the literature devoted to the issue. It is of great importance and interest that the teething problems surrounding the classification of this disorder be discussed in order to gain a clearer understanding of the dynamics surrounding such a disorder. Schwab- Stone and Hart (1996) mention that the added requirements have tended to make the criteria more precise and allow for the minimisation of over diagnosing ADHD. The purpose of this research report is to further determine whether this statement does in fact hold true when clinicians make diagnoses of ADHD.

According to Weiss (1996) there are a number of controversies related to the syndrome of ADHD, which were generated by the many changes in the terminology of the disorder as well as changes that reflected historical trends in conceptualising either a range of etiologies or fundamental features of the syndrome. In addition Still (1902, cited in Weiss, 1996) provided an articulate description that sounds similar to present day definitions. Still described these children as being hyperactive, incapable of concentrating, and as having difficulties with learning and conduct problems. He termed the children as having "morbid defects of moral control" (Weiss, 1996, p 544).

According to Jacobs (1998), mild cases of Hyperkinetic disorder are rarely seen, and therefore there are particular complications in addition to severity. He further suggests that for some of these children there has been a question surrounding the accuracy and quality of the diagnosis. For other cases there have been further difficulties with the medication given, which needs to be solved in a controlled setting (Jacobs, 1998). This author delves into the complications of medication given to these children, and discusses the importance of addressing issues children may face with such a

diagnosis and the medication given. One such area of concern is the effect this has on the child's social skills or the treatment of a comorbid disorders such as anxiety or aggression associated with conduct disorders or oppositional defiant disorder.

Jacobs (1998) further states that there may be a question regarding parental attitudes with high levels of expressed emotion and critical commenting on the child's behaviour, which has proven to be detrimental to the child's outcome in hyperactivity. Jacobs (1998) and Weiss (1996) discuss the implications of medication and intervention in great detail, including areas of neurological difficulties, comorbid psychiatric difficulties, behavioural approaches and parental influence regarding the diagnosis. For the purpose of this report these areas will not be discussed but they have been useful in gaining a more comprehensive understanding of the diagnosis and its associated difficulties. The next section of this discussion will be devoted to issues in child and adolescent psychiatry, regarding classification of childhood disorders.

> At the present time in child and adolescent psychiatry, classification systems have their greatest role in facilitating communication for both clinical and research purposes; their role in prediction is somewhat more limited, and their explanatory value is often quite limited (Volkmar, 1996, p 417).

As mentioned previously, Volkmar (1996) proposed that the goals of classification were to include facilitation of communication among professionals regarding mental health, providing information about given disorders and relevant treatment and/ or prevention for these disorders, as well as to provide useful information for further research in order to understand the pathogenesis of disorders. This author further states that the need for classification alludes to the importance of differentiating disorders from one another, according to their associated features and developmental course. Furthermore, classification systems should be applicable over the range of development and must be comprehensive and logically significant (Volkmar, 1996).

According to Volkmar (1996) classification of disorders implies that various clinically significant patterns of symptoms and behaviours are observed in individuals and are therefore a source of significant distress or impairment. This author further indicates the importance of mental

disorders being assumed to have a biological basis, however, this need not be the case; for example, maladaptive, enduring personality patterns can readily be classified as disorders. It is interesting to note that a diagnosis based on biological attributes is not sufficient and therefore collateral information is needed for a complete and thorough diagnosis. In the next chapter this is an area that will be explored and discussed in detail.

Volkmar (1996) highlights various issues in the classification of disorders. According to this author the developmental considerations assume major importance in the provision of a classification system for children and adolescents, as well as for adults. In addition, Volkmar (1996) suggests that at times the child's overall development may have a major impact on the way in which other disorders can or will be expressed, for example a child with Autism may also exhibit conduct problems.

Volkmar (1996) includes the role of theory in his discussion on classification and further states that classification schemes that are determined by theory are limited in important respects. Furthermore, he contends that theory classification schemes are, by there nature, based on a set of assumptions and hypotheses that are not mutually shared. Although this is true of theory, its importance cannot be excluded when defining various disorders, however, care needs to be taken when using theory in understanding various disorders to the point of excluding collateral information. "If theoretical laden descriptions are used for classification, communication regarding the same basic clinical phenomena becomes complicated" (Volkmar, 1996, p418).

According to Volkmar (1996) the phenomenological approach to classification has been a dynamic force in the various 'official' diagnostic systems. This approach has been described by Volkmar (1996) as a source of great frustration to clinicians and is often incorrectly taken to propose or infer that matters such as history, course, outcome and etiology are irrelevant to classification. Although official diagnostic schemes tend to be atheoretical, it does not mean that theory is insignificant or irrelevant, but should be used with caution (Volkmar, 1996).

For the purpose of this report it is important to emphasise that there is no single system waiting to be discovered and, according to Volkmar (1996), etiology need not essentially be included in classification systems. Furthermore he states that aspects of intervention may be more directly

related to the clinical condition than to etiology. This once again highlights the importance of considering collateral information in diagnosing various disorders, especially childhood disorders such as ADHD.

There are various contextual factors to consider when dealing with children and diagnosing a variety of problems or disorders they may be exhibiting. These factors are discussed in detail by Volkmar (1996) and Taylor (1994), in certain situations and populations, contextual variables or situational factors such as family, school, or cultural settings create major complications and difficulties for the application of diagnostic systems. According to Weiss (1996) evidence of possible biological determinants has been presented. In addition there have been reports by Campbell (1990, cited in Weiss, 1996) of the relationship between family stress and aspects of lower socio- economic status with higher ratings and rigorous complaints of behaviour in referred 3 year old hyperactive preschoolers. Adding to this, a negative mother child relationship predicted persistence of such problems identified at this young age (Weiss, 1996).

Weiss (1996) further suggests that family factors contribute to the severity of the disorder as well as duration. All the above mentioned holds true within a South African context, where there is limited access to mental health care facilities for the majority of the population, therefore creating a lack in the conceptualisation of the dynamics around such a disorder. This would be an interesting area for further research; however for the purpose of this report this area will not be pursued further.

Levin (1938, cited in Taylor, 1994) conducted a clinical study of more than 200 restless children, comparing them with normally active controls. He discovered that severe restlessness was linked with lesions of the brain. Furthermore, milder degrees of restlessness were associated rather with parenting problems. Bradley's (1937, cited in Taylor, 1994) observation of the unforeseen effect of amphetamine on hyperactivity and other behavioural problems provided a significant and important practical reason for making a physically based diagnosis. Strauss's (1947, cited in Taylor, 1994) research in the 1940's expanded this idea further, by postulating that hyperactivity, in the absence of a family history of sub normality, can be regarded as sufficient and relevant evidence for a diagnosis of brain damage. According to Taylor (1994) the influential writings of Laufer et al (1957, cited in Taylor, 1994) ensured a recurrent and growing

diagnostic practice among paediatricians in the U.S, together with the diagnosis of attention deficit disorders and prescription of sympathomimetic central nervous stimulants became extremely common, especially during the 1960's and 1970's.

> The 1970's and 1980's saw the arrival of explicit diagnostic criteria and a rapid growth of research. Intensive biological, experimental, psychological and psychopharmacological investigations made attention deficit the childhood condition most written about and most cited in *Index Medicus.* … An increasing appreciation of the heterogeneity of the problems subsumed within the diagnosis has led to reappraisal of the components of the disorder (Taylor, 1994, p285).

According to Taylor (1994) cultural differences remain and the history of thinking and gaining knowledge about these behaviours in the past still affects the range of therapeutic efforts in the present.

> The attentional problems of a child whose difficulties arise only as a result of an inappropriate school placement would not, for example, merit a diagnosis of attention deficit disorder (Volkmar, 1996, p418).

According to Volkmar (1996) appropriate variables probably assume their greatest importance in the attempt to define and study disorders of infancy and early childhood. In addition, this is an area of immense interest, as it may provide clarity on the controversies surrounding adult ADHD and its diagnosis. An infant's environment allows for the development of reactions and change, thereby causing the infant to react in a number of ways (Volkmar, 1996). Volkmar (1996) additionally indicates that cultural differences may in fact affect diagnostic concepts, criteria and practice.

It is of great importance that one takes into consideration what occurs when disorders are classified, specifically when such classifications become labels for certain individuals. Volkmar (1996) states that it is vital that clinicians and researchers alike keep in mind that disorders, rather than children, are classified. There are a number of concerns regarding the possible effects surrounding the labelling of children and to some degree these concerns are considered valid (Volkmar, 1996). This concern filters into the lives of the lay person and thus has a ripple effect leading to a situation of "labelling libelling",

where children in various settings and circumstances are affected. "The 'label- libel' gambit… you libel by label…find the right label for some process, and you know about it" (Postman & Weingartner, 1971, p36). Even though such a label may be useful in understanding or determining what a child's needs are, according to Volkmar (1996), a diagnosis of ADHD or a learning disability may not only be associated to earlier social stigma or other problematic effects, but it may also be linked to more realistic expectations on the part of parents and teachers. This may however be a prerequisite for further treatment or intervention. In addition to labelling, Weiss (1996), also discusses the notion of a child diagnosed with ADHD as being more likely to become a scapegoat for parental or teacher frustrations.

Due to the social stigma attached to mental illness, behavioural and developmental problems, Volkmar (1996) suggests that one place significance on the child's disorder, rather than placing importance on the child as the disorder.

> The term *diagnosis* refers both to the notion of assigning a label to a given problem and to the act of evaluation. In important respects it is the diagnostic process (Cohen et al, 1988) that is the most important of the two. Although diagnostic labels have considerable value, they do not provide information about the individual, which is unique and uniquely related to intervention. Diagnostic categories will, and should, change, and children may exhibit a disorder for variable periods of time. The needs of individuals will vary depending on the individual and not simply as a function of whatever disorder(s) he or she has (Volkmar, 1996, p418- 419).

According to Hechtman (1996) one cannot discuss the developmental aspects of symptoms such as hyperactivity, impulsivity, and inattention without an appreciation of the role one's temperament plays in these particular behavioural features. Furthermore, Hechtman (1996) believes that individual variability of temperamental features may have a number of different and complicated origins, such as; heredity factors and psychosocial factors. Hechtman (1996) further discusses the aspects relating to the presenting symptoms of hyperactivity, impulsivity and inattention as being identified as early as infancy, whereby the child exhibits behaviours such as sleep disturbances, feeding problems, increased fidgetiness, extreme irritability and crying. Although these symptoms may occur in infancy, they continue throughout a child's

development; however they may be expressed and exhibited in different ways and degrees of behaviours (Hechtman, 1996). Active freeplay, unpredictable behaviour, very disruptive and often dangerous behaviours; frequently shifting activities, restlessness and distractibility have been identified by Hechtman (1996), during toddler years. During adolescence, behaviours such as running around excessively, engaging in dangerous impulsive acts, easily and severely distractible are frequently exhibited (Hechtman, 1996).

From the following discussion it will be evident that there is a strong need for a concise and direct explanation for symptoms of ADHD, in order to comprehend the dynamics behind the disorder and to further our knowledge in determining a suitable and viable diagnosis. This is a common concern throughout this report and is further supported by Weiss (1996) who discusses the growth of knowledge around definitions and understanding of ADHD as well as extended issues surrounding its nature and development. Furthermore, Weiss (1996) states that most symptoms of the syndrome are at times, manifested by all children however, there is one major and significant difference: in children with ADHD symptoms are rigorous and persistent. The symptoms come together to form a syndrome and are present for many years, they are not momentary reactions to a stressful event or life change. According to Weiss (1996) in the DSM-IV (1994) terminology remained the same, *Attention Deficit Hyperactivity Disorder,* and this disorder was once again described under disruptive behaviours.

> For several reasons DSM-IV, as a diagnostic instrument, results in a larger number of patients receiving a diagnosis of ADHD, and these patients are potential candidates for stimulant therapy. We have seen an increasing number of girls in elementary school and both male and female adolescents who are not hyperactive-impulsive or disruptive, but who present with severe underachievement because of inattention and who fit criteria for ADHD- inattentive type. This together with making the terminology suitable also for the diagnosis of adults, has resulted in an increase in the number of patients given the diagnosis and for whom stimulants may be prescribed. It has been estimated that DSM- IV has increased the diagnosis of ADHD by 24% (Lahey, 1994), even without counting adults thus far (Weiss, 1996, p545).

2.5 Conclusion

This review was intended to identify the relevant debates and controversies surrounding the diagnostic systems used for mental disorders. Specific focus of this discussion was based on the controversies surrounding the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). This review identified the nature and controversies surrounding the Diagnostic and Statistical Manual for Mental Disorders, despite this the focus has been on the characterisation of ADHD in terms of diagnosis, research and controversies.

It would be of great interest to determine the use of the ICD- 10 within a South African context as it involves various external factors as having a significant impact on a diagnosis. As well as comparing the use of the ICD- 10 and DSM- IV in diagnosing certain disorders, specifically when looking at ADHD. Such aspects would be helpful when used in a South African context, where placing the emphasis on a person's environment plays a vital role in the development of individuals, especially in the delicate development of children. The reliability of the diagnostic systems in diagnosing ADHD has become a relevant concern within the realm of this research report. This may be due to the continuous changes and updates that the DSM has seen and is continually experiencing. Another area of interest is the growth and development of the ICD- 10 and the process that this system has undergone to have reached a point where the last publication was in 1992 and no reviews have been mentioned to date. As mentioned by Schwab- Stone and Hart (1996) the ICD- 10 involves creating a bigger picture of a particular patient and allowing the clinician to puzzle together a patient's clinical presentation in order to develop an overall picture, rather than simply determining whether a sufficient number of specified symptoms are present, as identified in the DSM system since the DSM- III.

The DSM- IV was aimed at providing a form of communication between clinicians and other professionals within a medical realm. It has created a place for research on specific mental disorders, and has constructed an elaborated sense of knowledge regarding psychopathology. However one questions whether it has been helpful when one intends to make a diagnosis for specific disorders, for the purpose of this report specifically for ADHD diagnosis.

One cannot merely base a person's diagnosis on theory, therefore creating a need for alternative means to gaining information. This is further backed up by Schwab- Stone and Hart (1996) as they specifically address concerns surrounding the environment one resides in as having a significant effect on a person's development and thus influencing certain aspects when a diagnosis is made. According to these authors the ICD- 10 needs to remain flexible in order for it to be used as an international system, as it is used in diverse settings under a range of clinical situations or conditions. This would particularly benefit South Africa in a multitude of ways due to the cultural diversity within the country. However, this would be an interesting area for further research and not intended to be explored within the context of this report.

It is evident that there are a variety of limitations in the categorisation process of the DSM- IV, as there is no unified diagnosis for all people and therefore trying to categorise those that are on the boundaries of diagnosis, may be difficult and may lead to an element of labelling a person rather than the disorder. It seems that a patient's symptoms are constructed in such a way as to fit within the boundaries of a classification so that there can be a diagnosis and a name for their condition.

Problems that arise in understanding ADHD may be described in terms of attribution, in this instance Rosenthal and Jacobson (1968) highlight how attribution leads to the question of whether a teacher's expectation of her pupil's intellectual competence can come to serve as an educational self- fulfilling prophecy. This idea that a label might affect an individual's competence is equally applicable to this clinical domain, where clinicians using the DSM often categorise children's ability in terms of a label of a criteria which may lead to a self fulfilling diagnosis. According to Volkmar (1996), the attention problems of a child whose difficulties arise only as a result of an inappropriate school placement would not, for example, merit a diagnosis of attention deficit disorder (Volkmar, 1996, p418).

Throughout this review there have been a number of references to literature that have been based on statistics gained in the United States of America and the United Kingdom. Socio- economic and cultural differences raises questions of contextual validity of diagnostic instruments developed in more homogenous first world countries such as USA. This further raises questions about the relevance of such systems when used in another country such as South Africa. Themes identified from the extensive literature reviewed for the purpose of this report have continuously lead the

researcher toward the question of how one actually comes up with, or creates a clear and concise diagnosis when using only the DSM- IV system, as there are so many categories and aspects relating to every disorder that one comes across. The ICD- 10 has been described as combining disorders to form one diagnosis, in other words one name that involves different symptoms, whereby the DSM- IV has many types of disorders creating many categories for people to fall into. Therefore if one looks hard enough for specific symptoms within the DSM- IV one would probably find a disorder relating to an entire population.

Given all the contestation of controversies around the diagnosis of ADHD a number of questions arise for example; how does one diagnose ADHD? what is it? what is its genesis? do we have a clear sense of how to diagnose?. Such questions, as well as those relating to the usefulness of the diagnostic systems have consequently led to the next chapter and will be explored further. From the extensive literature explored throughout this section, it would seem that if one were to base a diagnosis solely on the DSM, one would be able to diagnose and categorise every individual in our society. This leads to other questions regarding the limited interest or insight into the diagnostic reliability and efficiency of the ICD- 10; however for the purpose of this report the ICD- 10 will not be explored.

Chapter Three: Research Method

3.1. Introduction

In view of the literature reviewed in the previous chapter it is clear that there are numerous controversies surrounding the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). To establish the extent of these controversies within a South African context the researcher set out to survey a number of clinician's, namely General Practitioners, Psychiatrists and Neurologists, views on the diagnosis of ADHD. The researcher specifically intended to establish the prevalence of ADHD cases each clinician is exposed to, how one goes about diagnosing ADHD, and how useful the Diagnostic and Statistical Manual for Mental Disorders (DSM) is in terms of diagnosing the disorder. Related to this the researcher intended to determine whether these clinicians believe the DSM is an efficacious means of diagnosing ADHD.

This research was qualitative in nature and in qualitative research the aim is to gather the richest data possible (Creswell, 1994). For the purpose of this report, an open-ended questionnaire was deemed sufficient to answer the research question posed. It is important to note that while the terms "reliability" and "validity" are essential criteria for quality in quantitative research, in qualitative research the terms credibility, confirmability, dependability and transferability are the essential criteria for quality (Golafshani, 2003). In qualitative research validity is likened to trustworthiness, that is, whether or not the result of the research is credible or defensible.

In order to achieve trustworthiness for this particular project, the goal was to ensure that those participating in the research would at all times feel that the research itself is credible. In this way, it was intended that open and honest information would be given by the participants.

3.2. Research methods

a) Sample selection

There is no easily accessible record of the number of clinicians within the Gauteng region, therefore the aim was to contact as many clinicians as possible, those that may be residents of clinics and hospitals within the area and those that may be in private practice.

The researcher set out to survey as many practitioners as possible in the Johannesburg area. This was not an easy task as clinicians would have to take the time out of their practice to complete the forms as well as return them to the researcher. Only 9 responded. Consequently, the researcher ended up with a limited sample which was ultimately not random. Given the qualitative nature of the intended research this number of respondents was deemed to be sufficient to provide the researcher with a fair indication of the views held by clinicians in this geographic area.

The researcher targeted a particular group in full knowledge that this group does not represent the wider population; it simply represents itself. According to Cohen and Manion (2000) this is often the case in small scale research where no attempt to generalise is needed. Furthermore, small scale research often uses non probability samples because, regardless of the disadvantages that may arise from their non- representativeness, they are frequently less complicated to set up and significantly less expensive. As such, according to Cohen and Manion (2000), a small sample can prove perfectly sufficient when researchers do not intend to generalise findings beyond the sample in question.

The eventual sample that was obtained consisted of two General Practitioners, three Neurologists and four Psychiatrists. For the purpose of this report the main interest shared among the individuals in the sample pertained to the clinical presentation of ADHD in their practice.

When employing sampling methods one must also take into consideration the ethical implications that may occur. According to Cohen and Manion (2000) ethical concerns encountered in educational research in particular can be exceptionally multifaceted and delicate and often place researchers in moral predicaments which may at times appear rather unresolvable. One such predicament involves the researcher trying to create a balance between the demands of being professionals in search for

truth, and their subject's rights and values potentially being threatened by the research (Cohen & Manion, 2000). It is therefore of great importance that the subjects or participants in this report remain anonymous and confidentiality be strictly adhered to. Participants were aware of the extent of their involvement as volunteers within the research process; this was emphasised by the researcher in the form of a thorough explanation of the research beforehand. This allowed the researcher to gain informed consent, which further ensured that the subjects involved have the right to participate and withdraw at any point in the research process.

b) Procedure and Data gathering

(i) Nature of Instrument:

An appropriate data gathering instrument was not found within the literature reviewed in the previous chapter. Consequently the researcher devised a questionnaire to elicit relevant information to answer the research question. The questionnaire was fairly short and consisted of two sections. Section A comprised of specific questions relating to practitioner's qualifications, area of practice or specialisation, extent of time in practice, average number of patients seen a week, and ages of patients seen in their practices. In this section, the clinicians were provided with a limited choice of questions.

Section B consisted of 21 closed and open ended questions, which according to Cohen and Manion (2000) is a more attractive tool for smaller scale research or for those sections of the questionnaire that encourage an honest or personal comment from the respondents in addition to ticking numbers and boxes. The questions were answered by the practitioners him/herself in their own time. Clinicians were given the opportunity to voice their opinions about ADHD, the prevalence of cases of ADHD, its nature and diagnosis, as well as the usefulness of the DSM in diagnosing the disorder. To encourage honest and reliable answers, respondents were not required to identify themselves or give any information that would identify them. Due to the problems surrounding interviewing the particular sample group, the researcher depended on a questionnaire in order to gather data on the efficacy of the DSM in diagnosing ADHD. In addition a questionnaire is extensively used and valuable when collecting survey information, providing structured, sometimes statistical data, being able to be administered without the attendance of the researcher, and often moderately straight forward to analyse (Wilson & McLean, 1994, cited in Cohen & Manion, 2000).

Constructing a questionnaire is not an easy task and the researcher needed to balance the time taken to construct the questionnaire, guide and improve the questionnaire as well as determine the effectiveness of the questionnaire with the outcome of the research process. For the purpose of this research report the suitability of the questionnaire was constructed in such a way to ensure sufficient data collection. Notwithstanding the fact that a questionnaire is a difficult form of analysis, it is a more objective means of collecting data without imposing one's own feelings and views on the topic of investigation. However ethical consideration is of the utmost importance and should be stringently adhered to when constructing research questions.

The questionnaire was less structured, more open-ended and word- based. This form of questioning allowed for the researcher to capture the specificity of the particular situation. The intention of the questions in section B was therefore to gain a sense of genuineness, honesty and openness, which according to Cohen and Manion (2000) are the hallmarks of qualitative data.

Although there are a number of positives when using open- ended questions as a form of data gathering, there are a number of difficulties. If an authentically open- ended question is being asked it may be unlikely that the response would bear similarity to each other enabling them to be compared too closely (Cohen & Manion, 2000). The open- ended questions used in the questionnaire of this report may have made it rather difficult for the researcher to make comparisons between respondents as there may be little to compare. Such questions have a number of limitations; to complete an open-ended questionnaire takes longer than merely ticking a box therefore creating time constraints, particularly with the time taken for respondents to divulge their knowledge and placing it on paper (Cohen & Manion, 2000).

(ii) Distribution of questionnaire:

Due to a number of difficulties in reaching various professionals required for the study the researcher acquired a convenient sample which was self selected. Given that the sample was self selected, it is obvious that they have a vested interest in the topic of investigation and consequently the nature of their responses should be seen in this context. This type of sampling method is referred to as purposive sampling and is described by Cohen and Manion (2000) as involving the researcher

handpicking cases or participants to be included in the sample on the basis of their judgement of their typicality or area of specialisation. In this way the researcher builds up the sample that is acceptable for the specific needs of the research (Cohen & Manion, 2000). As its name suggests the sample has been chosen for a specific purpose (Cohen & Manion, 2000).

The researcher gained the assistance of four respondents when accompanying a child from the researcher's internship site for a neurological assessment. After the doctor had completed the assessment the researcher enquired whether the doctor would be interested in participating in the research. The researcher briefly explained the nature of the intended research and asked whether the doctor would be willing to fill in a short questionnaire that had been developed by the researcher, regarding the topic of ADHD. Once the doctor had agreed, the doctor suggested that the researcher contact three other colleagues who may be interested in the topic as well. The researcher contacted the three doctors and when an agreement was made the researcher personally delivered a detailed description of the research as well as the questionnaire to them.

The doctors that were identified were easily accessible for the researcher and were willing to participate in the study. Questionnaires were completed and returned to the researcher within a week. Given that the initial attempt to find participants was difficult, the researcher was eventually aided by her therapy supervisor who helped her to gain access to clinicians interested in the topic of study. The researcher contacted each of these clinicians telephonically and once an agreement was reached an explanation of the intended research, accompanied by the questionnaire, was faxed or emailed to each respondent. Within a week the clinicians had faxed and emailed the questionnaire back to the researcher's personal fax and email address. The researcher had seven respondents and was not sure whether there was a chance of gaining anymore. Therefore the researcher approached a private hospital within the researcher's residential area. The researcher contacted two doctors telephonically, who held residence at the hospital, once agreement was reached an explanation of the research along with a questionnaire was hand delivered by the researcher to the practices of the clinicians concerned. Within a week the researcher was contacted by the secretaries of each clinician and told to collect the completed questionnaires from the practice.

(iii) Method of analysis:

The method of analysis used in this report is Qualitative content (thematic) analysis in order for the researcher to capture and make sense of the individual responses.

> Content analysis itself has been defined as a multipurpose research method developed specifically for investigating a broad spectrum of problems in which the content of communication serves as a basis of inference, from word counts to categorization (Cohen & Manion, 2000, p164).

According to Cohen and Manion (2000) approaches to content analysis are cautious to recognize appropriate categories and units of analysis, both of which will determine the nature of the document being analysed and the purpose of the research.

> …an analysis of this kind would tell us more about the social context and the kinds of factors stressed or ignored, and of the influence of political factors, for instance. It follows from this that content analysis may form the basis of comparative or cross cultural studies (Cohen & Manion, 2000, p165).

Hsieh and Shannon (2005) define qualitative content analysis as a research method that involves subjective interpretation of the content of data through the methodical classification of responses and identifying themes or patterns. According to Zhang (2006) this definition illustrates that qualitative content analysis places importance on an integrated view of data and its explicit context. Furthermore, it allows the researcher to understand and recognise social reality in a subjective but scientific manner (Zhang, 2006). The common themes and patterns that emerge from the data can be described in a systematic and concise way, in order for the researcher to gain an objective view of the themes identified. Consistent with these views, Zhang (2006) discusses the validity of the deduction within content analysis as being ensured by complying with methodical coding processes. In addition, qualitative content analysis goes further than merely counting words or extracting objective content from texts to observe themes, frequencies and patterns that appear or may be concealed within the apparent content.

(iv) Ethical considerations:

Initially the researcher gained ethical clearance from the University of the Witwatersrand's higher degrees committee (ethics clearance number: IH070203). Once permission was obtained the researcher set out to obtain the sample needed for the research in question. Obtaining permission from the various clinicians' was a vital necessity; permission was given verbally by each participant. After telephonic agreement was made and practitioners were aware of what the researcher was requiring, the researcher was able to gain informed consent from practitioners and was then able to send questionnaires to the various participants.

Another ethical consideration of great importance was that of confidentiality. Confidentiality was ensured throughout this report starting with the questionnaires, which did not require any personal information, furthermore documents were stored in a safe place at all times and only seen by the researcher, once the report has been completed all documents will be destroyed by the researcher. A formal letter was attached to the questionnaire, indicating the aim, rationale and ethical considerations of the research. A major consideration indicated in the letter involved the researcher using certain excerpts from the questionnaire in the report, allowing the practitioners the freedom to choose whether they would like to participate in the research or not. Furthermore feedback will be given to all participants regarding the findings of the research.

Ethical considerations that were brought to bear throughout this report involved the aspect of participants as volunteers, non disclosure of personal information on the part of the participants, and an explanation of the process of the report and a detailed copy of outcomes of participants. Notwithstanding the fact that many ethical considerations have been identified within the questionnaire there are a number of ethical elements that one may have difficulty maintaining, these are explained briefly by Cohen and Manion (2000).

> The questionnaire will always be an intrusion into the life of the respondents, be it in terms of time taken to complete the questionnaire, the level of threat or sensitivity of the questions, or the possible invasion of privacy. Questionnaire respondents are not passive data providers for researchers; they are subjects not objects of research.

> There are several sequiturs that flow from this. Respondents cannot be coerced into completing a questionnaire. They might be strongly encouraged, but the decision whether to become involved and when to withdraw from the research is entirely theirs (Cohen & Manion, 2000, p245).

Having described the method and instrument used in this research report, the next chapter will present the results of the questionnaire and responses.

Chapter four: Discussion and Results

Section A: Individual information

Nature of qualifications	MBBCH, MRCP, FRCP, FCPsych, MMED Psychiatry, Neurology and Paediatrics, PHD, DCH
Specialization	Paediatric Psychiatrists. Neurologists. General Practitioners
Average years in practice	20- 40 years in practice
Number of patients seen	10- 30 patients (per week)
Average age of patients seen	3-12 years

From this simple table it is clear that all participants have medical qualifications. They all have a Bachelor of Medicine and Surgery (MBBCH), which is an undergraduate degree that all medical professionals have. However a number of these practitioners have specialised in specific areas of interest. A number of practitioners have acquired a Master of Medicine Degree (MMED) and further specialised in Neurodevelopment and Psychiatry, particularly child and adolescent psychiatry. The MRCP qualification held by some of the practitioners means that they are a Member and Fellow of the Royal College of Physicians. Furthermore, FRCP entitles the practitioner to a Fellowship of the College of Psychiatrists (FCPsych) qualification. Another qualification within the participant group is a Diploma in Child Health (DCH); this is awarded to a newly appointed General Practitioner who has completed a short period of training in paediatrics.

It is also clear that the participants in this sample have been in practice for a sufficient amount of time. The average years in practice range from 20- 40 years, which would suggest that they are quite knowledgeable in the area of ADHD. Not only have these participants been in practice for a significantly long time, but they also see a significant number of patients a week and these patients are within the age group of 3- 12 years old. This is the typical age group in which ADHD would be present and probably diagnosed.

Section B: Themes that emerged from the questionnaire

The researcher has identified five themes within the research questionnaire and intends to capture responses and discuss them in the context of some of the research literature reviewed earlier.

Theme 1: The gender based prevalence of ADHD

Three of the participants in the sample reported that they see patients with ADHD on a daily basis. According to two of the participants 2-4 patients presenting with ADHD are seen in their practices in a week. One of the participants reports that only 8 cases of ADHD are seen per month, whereas another participant reports seeing only 1 per month. According to one of the participants, nearly all cases seen in their practice have ADHD or a related developmental condition. Looking at the prevalence of ADHD and gender it is evident that there is consensus among the respondents on the occurrence of ADHD predominantly in boys. However, the participants' explanations for this prevalence tended to vary. According to one participant 'their behavioural aspects cause earlier referral', another participant believes that boys present more often than girls, and most epidemiological studies show male dominance. A number of the respondents discuss the prevalence in boys as being based on genetics and the influence it has on the development of ADHD. According to another participant males are slightly more prone than females in being diagnosed with ADHD, however this seems to be approaching the 50% mark, and the reasons for this are that, 'ADHD often manifests itself in the classroom or school environment where it is more commonly males rather than females who present with disruptive inattentive behaviour'.

From the responses provided above it is clear that the presentation of ADHD predominantly in boys corresponds with that reported in the research literature (Weiss, 1996).

Theme 2: Usefulness and efficacy of the DSM

The majority of the participants had been exposed to the DSM. Four participants agreed unreservedly that their understanding of ADHD is informed by the DSM. However, a number of participants stated that their understanding is only partly informed by the DSM. According to one of the participants the DSM informs his understanding to some extent however, i.e., for him 'DSM does

describe the symptoms of ADHD, there are others, particularly executive functioning, which are not included'. Of the participants who responded to the question regarding the DSM covering all the necessary dimensions of ADHD, half of the sample stated 'No' and the other half tended more toward 'Yes in its simplest, purest form, mostly'. Almost half of the participants believe that there are additional causes that should be included in the DSM regarding ADHD. For example 'DSM does not specify or address causes, it is a description of symptoms, and the links between ADHD and learning disabilities need more emphasis and maternal or emotional deprivation'.

Within the questionnaire the participants were asked to what extent they think the description of ADHD in the DSM matches what they have found in their clinical practice. Responses varied from agreeing that it does describe to a large extent what is found in practice, as well as serving as a useful guide. However there are the views that 'the disorder is far broader than what is covered in the DSM'. To some participants 'it is purely descriptive and quite narrow but is a good selection'. The views of another participant highlight the "narrowness" depicted by the previous statement and mentions that 'Impulsivity is not very well served by the DSM. The DSM does not deal with any of the developmental deficiencies'.

Although the participants mentioned the merits of the DSM, they did not endorse it completely. They agreed that it describes many symptoms but they felt that it does not link to areas involving learning disorders and etiology. It is interesting to note the importance participants placed on the co-morbidity of ADHD and learning disabilities and the lack of this emphasis in the DSM. This shortcoming is understandable if we bear in mind that

> At the present time in child and adolescent psychiatry, classification systems have their greatest role in facilitating communication for both clinical and research purposes; their role in prediction is somewhat more limited, and their explanatory value is often quite limited (Volkmar, 1996, p 417).

The participants agreed that the DSM is useful as a guide for practitioners, but they failed to agree on its efficacy in diagnosing ADHD. This dispute is understandable given that, according to Volkmar (1996), the child's overall development may have a major impact on the way in

which other disorders can or will be expressed. For example, a child with Autism who may also exhibit conduct problems, or a child with ADHD may exhibit a learning disability.

Theme 3: Participants explanations of the causes of ADHD

The majority of the participants explain the causes of ADHD as being primarily genetic. The second most common theme identified from the responses shows environmental factors as playing a significant role in causing or predisposing a child to be diagnosed with ADHD. A number of environmental factors were mentioned particularly relating to prematurity or brain trauma, environmental toxins or drugs during pregnancy, family environment and social circumstances. A number of the participants believed the causes are multifaceted involving elements such as the child's diet, stimulant medication (e.g. nasal sprays), insufficient stimulation (e.g. excessive T.V watching), or over- stimulation[1] and emotional problems. Participants also stated that 'in most cases ADHD is a symptom or comorbid state, e.g. associated with learning problems'. According to one participant all suspected cases of ADHD need full intervention be it medical, level of function, social circumstances, or emotional problems.

The controversies surrounding the causes of ADHD is evident from the discussion above and is echoed in the literature as well.

> The 1970's and 1980's saw the arrival of explicit diagnostic criteria and a rapid growth of research. Intensive biological, experimental, psychological and psychopharmacological investigations made attention deficit the childhood condition most written about and most cited in *Index Medicus*. … An increasing appreciation of the heterogeneity of the problems subsumed within the diagnosis has led to reappraisal of the components of the disorder (Taylor, 1994, p285).

[1] The participant did not elaborate on this statement. However it seems that he/she meant that modern parents try to compensate for the time they do not spend with their children by providing them with a full day of activities thus leading to the over stimulation of these children.

According to Taylor (1994) cultural differences remain and the history of thinking and gaining knowledge about these behaviours in the past still affects the range of therapeutic efforts in the present.

> The attentional problems of a child whose difficulties arise only as a result of an inappropriate school placement would not, for example, merit a diagnosis of attention deficit disorder (Volkmar, 1996, p418).

According Volkmar (1996) an infant's environment allows for the development of reactions and change, in so doing causing the infant to react in a number of ways. This author additionally indicates that cultural differences in fact affect diagnostic concepts, criteria and practice.

Theme 4: Treatment of ADHD

It became apparent that medication is the unanimous form of intervention for the treatment of ADHD among the participants; however it is important to note that it is not the only form of treatment used by the participants. According to one participant 'most doctors use medication, e.g. Ritalin, as a first line treatment, although I prefer using behavioural therapy, e.g. play therapy before starting drugs'. This multifaceted approach is a common theme among a number of the participants. Alternatives to medication ranged from behaviour modification, remedial education, speech therapy, occupational therapy, to diet, supplements, brain gym, and biofeedback. Addressing academic difficulties, behavioural problems, associated visual and auditory perception was identified by a participant as a starting point, however for the purpose of treating ADHD and co-morbid psychiatric conditions, medication seems to be the answer.

A number of participants revealed that they rely to a large extent, on medication. Although this may seem to be a rather bold statement, many of these practitioners are at the end of the process when alternative treatments have already been explored. One respondent commented, 'the usual reason for referral to me is for an opinion regarding medication for ADHD therefore many of my patients are on medication'. According to the participants the reliance on medication may be due to the lack of affordability for behavioural management, in addition a respondent stated, 'once all other differential diagnoses have been excluded then pharmacological treatment is started'.

The problem/difficulties in the diagnosis of ADHD and the use of medication to treat it, which was identified by this sample of practitioners, can be seen in the published literature as well. According to Jacobs (1998), mild cases of Hyperkinetic disorder are not often seen, and therefore there are particular complications in addition to severity. He further states that for some of these children there has been a question surrounding the diagnosis and quality of the disorder. In other cases there have been difficulties with the medication given that it needs to be provided in a controlled setting (Jacobs, 1998). This author delves into the complications of medication given to these children, and on the strength of discusses the importance of addressing issues children may face with such a diagnosis and the medication given. One such area of concern is the effect it has on the child's social skills or the treatment of a co-morbid disorder such as anxiety or aggression associated with conduct disorders, or oppositional defiant disorder. .

Jacobs (1998) further states that there may be a question regarding parental attitudes in the diagnosis and treatment of ADHD. That is, parents may often construe the child's exuberance and excitability as a disorder and therefore seek a 'quick-fix' solution to the 'problem'. Jacobs (1998) and Weiss (1996) discuss the implications of medication and intervention in great detail, including areas of neurological difficulties, co-morbid psychiatric difficulties, behavioural approaches and parental influence regarding the diagnosis. The decision on whether to use stimulants, according Weiss (1996), is a crucial clinical question for which there is no guiding research, except the knowledge that stimulants are highly effective in ameliorating symptoms of the disorder, however, once discontinued, the symptoms return. Weiss (1996) endorsed this view and he stated that "The children are not cured and outcome is not affected significantly by treatment with stimulants alone" (p554).

Theme 5: Labelling and stereotyping

This theme was a rather contentious topic for the researcher and for the participants. Responses varied considerably and consequently comparisons were extremely difficult to make. A significant number of participants believed that the label ADHD has become an easy diagnosis for certain stereotyped behaviours in children. According to a number of participants 'many of these behaviours are seen in normal children'. Some participants saw such stereotyped behaviours as guidelines toward a diagnosis of ADHD.

Participants were required to comment on the prevalence/over-diagnosis of ADHD in South Africa. One participant indicated that 'ADHD has almost become an umbrella term for any type of behavioural disorder or psychological problem especially among children'. At the same time other participants believed that it is not over-diagnosed, but rather under-diagnosed specifically in disadvantaged communities. According to the participants holding this view there was a 'very infrequent assessment of learning problems in township children and therefore little diagnosis of ADHD'. A number of participants believed that in some instances ADHD is 'an over-diagnosed and an under-diagnosed disorder'. This apparent contradictory perception can be explained by the participant who stated that, 'there is certainly more awareness amongst various professionals dealing with children but [there is] still a large resistance amongst them and [their] families to treat [ADHD] medically'.

The prevalence of ADHD in South Africa generated a number of opinions. The majority of participants were aware of the prevalence, however only a few participants provided a possible figure. There seems to be consensus that the figure lies between 5-7% in line with the rest of the world. As stated by one of the participants 'there are about 25000 children treated for ADHD nationally (industry figures, not researched)'. Identifying the prevalence of ADHD in a particular socio- cultural group was more complicated than was initially thought by the researcher. Even though a number of the participants tend to see people within socio economic groups, they belong to socio economic stratum. However, there were several participants who held the view that the diagnosis is 'more prevalent in middle to upper socio economic groups, possibly related to better facilities to pick out the ADHD children (e.g. schools with therapists, social workers etc)'. In addition, it was stated that 'prevalence lies within the middle to upper income groups. This is largely because of negative parental influence especially poor discipline and the fact that many children now come from broken homes'.

Throughout the literature there has been a significant amount of emphasis placed on the question of prevalence of ADHD in particular socio- cultural groups. However, the following excerpt identifies the effect the label of ADHD has on children.

> The term *diagnosis* refers both to the notion of assigning a label to a given problem and to the act of evaluation. In important respects it is the diagnostic process (Cohen et al, 1988) that is the most important of the two. Although diagnostic labels have

> considerable value, they do not provide information about the individual, which is unique and uniquely related to intervention. Diagnostic categories will, and should, change, and children may exhibit a disorder for variable periods of time. The needs of individuals will vary depending on the individual and not simply as a function of whatever disorder(s) he or she has (Volkmar, 1996, p418- 419).

The prevalence of ADHD in South Africa has not been established as far as the current researcher was able to ascertain. In order to establish such prevalence future researchers would need to bear in mind that

> For several reasons DSM-IV, as a diagnostic instrument, results in a larger number of patients receiving a diagnosis of ADHD, and these patients are potential candidates for stimulant therapy. We have seen an increasing number of girls in elementary school and both male and female adolescents who are not hyperactive-impulsive or disruptive, but who present with severe underachievement because of inattention and who fit criteria for ADHD- inattentive type. This together with making the terminology suitable also for the diagnosis of adults, has resulted in an increase in the number of patients given the diagnosis and for whom stimulants may be prescribed. It has been estimated that DSM- IV has increased the diagnosis of ADHD by 24% (Lahey, 1994), even without counting adults thus far (Weiss, 1996, p545).

Chapter Five: Conclusion and Limitations

The purpose of this study was to provide some indication on the efficacy of the DSM in diagnosing ADHD. Extensive literature and a questionnaire were used in order to establish whether the DSM is efficacious as a diagnostic system. The conclusions drawn from both were discussed on the premise that the DSM does, to some extent, inform practitioners about the disorder but is not entirely the most useful tool in diagnosing it.

There were a number of significant themes identified throughout this report, particularly relating to the DSM and ICD diagnostic systems. These systems were compared on the basis of their attributes for medical use, as well as their process of development. There is a desperate need for these systems within the medical realm; however the inconsistency between them raises many concerns. From the lack of consensus on what should and should not be included in the manuals, to the lack of consensus in the descriptions of mental disorders, and the criteria for diagnoses. While they were cognisant of the shortcomings of the DSM the respondents believed that it was still the best diagnostic means available to them at this point.

The DSM saw a number of revisions due to the inconsistencies found in previous versions, which made it difficult for the researcher to piece together. However, what still remains is that the DSM was developed in order to provide statistical information and therefore does not seem to be the most reliable system for diagnosing ADHD. According to the participants in the present study the DSM is simply a guide for practitioners. Its value as a diagnostic tool is still questionable. The ICD- 10 on the other hand aims to provide a system that addresses descriptions for clinical and research diagnoses by incorporating an inclusive description of clinical concepts surrounding various disorders, as well as differential diagnoses and diagnostic procedures, furthermore including additional symptoms that should be present for a complete diagnosis. For the purpose of this report the ICD- 10 was not thoroughly explored in its entirety and is therefore recommended for further research.

This research report set out to investigate the diagnosis of ADHD, by a selected number of practitioners. This investigation intended to establish how these practitioners understood ADHD and how they diagnosed it. The various questions that were addressed challenged the existence of a disorder and how one decide on the best suitable diagnostic criteria. Firm conclusions cannot be

extrapolated to the general population since the evidence gained in this study came from a small sample, one that does not represent the greater population of practitioners. However, it is clear that this area is in desperate need of clarity and consensus needs to be reached on the basis for diagnosis.

The main purpose of the DSM-IV-TR is to provide a form of research, case conceptualization and a treatment planning manual for practitioners of all forms to rely on for categorisation and identification. However, Beamish (2001), has noted that this has not been the case for family practitioners or counsellors, as there are direct consequences for diagnostic practices. The potential for causing an individual or family harm is fairly evident. Identifying the effectiveness of the DSM was an extremely challenging task. It is evident that there is a need for there to be a diagnostic system which practitioners of all fields can rely on in order to understand mental disorders. However, the inconsistency between the systems produces a number of concerns. As Kitchner (1986) points out there is a concern for the potential harm caused by labelling someone.

It almost seems like people, or their behaviour, are socially acceptable when they are given a label to explain such out of character behaviour, when it is not considered normal. When a child is diagnosed as having ADHD, it is 'so much easier' to then deal with them. They have now been pathologised giving a reason for their unusual behaviour.

In traditional diagnostic systems, such as the DSM, it is believed that the causes of psychological and behavioural problems lie mainly within the realm of the individual. It has been noted that these approaches overlook and at times contradict the assumptions of family systems theory (Beamish, 2001). The incompatibility of the traditional diagnostic systems, such as the DSM-IV-TR and ICD-10, may lead to many ethical dilemmas for family counsellors or other practitioners, issues such as misrepresentation, trust, malfeasance, and confidentiality may arise (Beamish, 2001). An important point to note is the misconception that a mental disorder classifies people, when in fact it is merely a classification of a disorder which people have. This idea can be linked to the sensitivity toward labelling.

The intended research focused on the questions relating to the existence of diagnostic criteria for ADHD. Due to the increasingly high incidence of ADHD, as identified throughout this report, there is a need to determine a clear and precise understanding of the symptoms presented and whether

those diagnosed do in fact have the disorder or are simply highly energised, active children. Green (1996) discusses ways in which parents can deal and cope with their ADHD children; however he does point out, the age at which children need a diagnosis in order to explain their somewhat destructive behaviours. In the preschooler there are two problems that makes a diagnosis difficult: one is that at this age there is an extreme of behaviours which is accepted as normal, therefore making it hard to determine where the 'terrible twos' combines with ADHD, the other problem involves the misperceptions held by parents (Green, 1996). This misperception makes it difficult to determine whether a real problem exists or whether parents misunderstand their highly spirited children.

Therefore Green (1996) argues that when diagnosing ADHD one need's to look for a pattern of behaviours that causes the child to be 'out of step' when compared to others at the same level of development. A diagnosis should only be made if these 'out of step' behaviours cause a considerable amount of difficulty. A child may be active, impulsive or even explosive, but if everyone around this child is happy then a diagnosis need not be considered (Green, 1996). "A problem is only a problem when it causes a problem" (Green, 1996, p2).

According to Hallowell and Ratey (1994) the best way to understand what ADD is, and what it is not, is to see how it affects the lives of people who actually have it. Therefore one need's to define the syndrome carefully, and for ADHD to have specific meaning, rather than just be a scientific, or medically sounding label for the complexities of society, it should be clearly identified and understood. Hallowell and Ratey's (1994) who were both diagnosed with ADD have noticed the struggles individuals face with the inaccuracy of being labelled and unfairly judged. "It is no more a thing to be ashamed of than being nearsighted is" (Hallowell & Ratey, 1994, p10).

There are a number of limitations that should be noted in this study. One such limitation is the sample size. Due to the relative lack of interest of many practitioners the researcher was only able to obtain 9 participants. Therefore there was a limited indication of views held by practitioners regarding the DSM and its usefulness. This group could not be compared to the larger community of practitioners, it was merely an indication of the beliefs held by a very specific, highly selected group. The time needed to complete the questionnaire must be considered as another limitation.

There is an extensive amount of literature on the topic of ADHD; however, it was difficult to present it all within the scope of this report, due to time constraints. The main value of this study lies in the awareness created for practitioners in all fields pertaining to the controversies surrounding the diagnosis of ADHD. The DSM is a manual that was constructed in a first world country; therefore it is questionable as to its relevance or use within South Africa, which is home to a multitude of cultures and extremely diverse communities. Consensus on the prevalence within the socio- economic group seen by participants can not be reached. However, these participants are not able to comment on the socio- economic grouping such as working class or rural groups. From this it is evident that there is a need to develop a more flexible and integrative diagnostic system.

The findings of this study support the need for further research on a suitable and reliable system for diagnosis, particularly in a South African context. Further research would add to the clinician's or practitioners' understanding of ADHD in its entirety. It would also allow for interventions that could facilitate the diverse symptoms experienced by all children with the disorder and further aid in the management and understanding of these children's particular needs.

Appendix A

TO:	FROM: **Sharna Brest**
COMPANY:	DATE:
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER: **6 pages**
PHONE NUMBER:	SENDER'S REFERENCE NUMBER: **082 430 2525**
RE:	YOUR REFERENCE NUMBER:

NOTES/COMMENTS:

To

My name is Sharna Brest, I am an educational psychology intern at Epworth children's village for this year and I am currently completing my Masters Research report. This report involves issues surrounding the use of the DSM- IV in diagnosing Attention Deficit Hyperactivity Disorder. Your participation in this report is greatly appreciated and will benefit the validity of its results. I have included a brief description of the research topic as well as a brief questionnaire.

Thanking You

Sharna Brest

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Appendix B

Explanation of Research

On the efficacy of the DSM- IV- TR, in the diagnosis of children with Attention Deficit Hyperactivity Disorder (ADHD). A survey of medical practitioner's perceptions.

Aim:

This research report aims to establish how useful medical practitioners find the DSM criteria for diagnosing ADHD. Whether in their own practice and experience, they believe the criteria may need to be extended in order to include other things.

Rationale:

This research intends to identify whether medical practitioners find the DSM criteria adequate, based on their clinical experience. ADHD is a problematic phenomenon, a subject of contradiction. There is competing understanding of the disorder, yet according to some researchers this label being applied, has various consequences. Subsequently, this research intends to examine the issue. The main purpose of the DSM-IV-TR is to provide a form of research, case conceptualization and treatment planning manual for practitioners of all forms to rely on for categorisation and identification.

Ethical considerations:

Obtaining permission from the various clinicians' is a vital necessity; permission has been obtained verbally. Another consideration of great importance is that of confidentiality. The questionnaires will not require any personal information and the documents will be kept in a safe place at all times and only seen by the researcher, once the report has been written up all documents will be destroyed. This document serves to indicate that the researcher may use certain excerpts from the questionnaire in the report, allowing the practitioners the freedom to choose whether they would like to participate in the research or not. Feedback will be given to all participants regarding the findings in the research report.

Questionnaire

1. What are your qualifications?

_____

2. In what year did you qualify in your particular area of practice?

_____

3. How long have you been in practice for? (Please tick)

1- 5 years 5- 10 years 10- 20 years 20- 30 years 30- 40 years

4. What is the average number of patients you see a week? (Please tick)

5- 10 10- 20 20- 30 30-40 40- 50

5. What is the average age of the patients you see? (Please tick)

3- 12 years old 12- 16 years old 16- 18 years old 18 and above

Section B

6. How often are you presented with a case of ADHD?

_____
_____
_____
_____

7. Since you started practicing how many cases of ADHD have you diagnosed?

_____
_____
_____
_____

8. In your opinion, what are the causes of ADHD?

_____
_____
_____
_____

9. If you qualified prior to 1994 have you been exposed to the Diagnostic and Statistical Manual for mental disorders? If not please go to Question 13

10. Is your understanding of ADHD informed by the DSM?

11. Do you think the DSM covers all the necessary dimensions of the disorder?

12. Are there any additional causes that you think should be included?

13. What in your experience are the presenting problems of ADHD?

14. What agencies or individuals are responsible for referring such cases to you (i.e. Doctors, psychologists, teachers, parents etc)?

15. In your experience what kind of interventions are usually recommended for treating ADHD?

16. Have you referred an ADHD child to an alternative institution or therapist?

17. If so, who have you referred them to or where?

18. To what extent do you think the ADHD description in the DSM match what you have found in your clinical practice?

19. To what extent do you rely on pharmacological treatment for ADHD?

20. What is your understanding of the comorbidity of ADHD with other disorders?

21. Are you aware of any other comorbid disorders?

22. Do you think that the label ADHD has become an easy diagnosis for certain stereotyped behaviours in children?

_____
_____
_____
_____

23. Are you aware of the prevalence of the disorder in South Africa?

_____
_____
_____
_____

24. Do you think that ADHD has become an over diagnosed disorder in South Africa?

_____
_____
_____
_____

25. In your experience is there a prevalence of ADHD in a particular Socio- Cultural group?

_____
_____
_____
_____

If yes, why do you think this is the case?

_____
_____
_____
_____

26. In your experience is there prevalence for ADHD in terms of gender?

_____
_____
_____

If yes, Why?

_____
_____
_____

References:

Beamish, P.M. (2001). *The use of the DSM-IV in family counselling: Ethical considerations* (ERIC DOCUMENT ED. 457 468)

Bennet, F.C., & Sherman, R. (1983). Management of childhood 'hyperactivity' by primary care physicians. *Journal of Development and Behaviour,* 4(2), 88- 93

Cohen, L. Manion, L. & Morrison, K. (2000). Research methods in Education (5th edition). Routledgefalmer: London and New York

Creswell, J.W. (1994). Research Design: Qualitative and Quantitative approaches. London: Sage Publications.

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association. (2000).

Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report, 8* (4), 597-607.

Green, C. (1996). *ADHD in the under fives, survival psychology* (ERIC DOCUMENT ED 404 776)

Hallowell, E.M. and Ratey, J.J. (1994). Driven to distraction: Recognising and coping with attention deficit disorder, from childhood through adulthood. Simon & Schuster: New York.

Hechtman, L. (1996). Developmental, Neurobiological, and Psychosocial aspects of Hyperactivity, Impulsivity, and Attention. Lewis, M. (1996).*Child and Adolescent Psychiatry: Comprehensive textbook (2nd Edition).* Williams and Wilkins: Baltimore.

Hsieh, H.F. and Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research,* 15 (9), 1277-1288.

Holmes, G., & Stalling, J.E. (2001). *Alternatives to the DSM-IV-TR for multicultural counselling: Some preliminary concerns* (ERIC DOCUMENT ED 456 345).

Illich, I. (1976). Limits to medicine. Manon Boyars: London.

Jacobs, B. (1998). Externalising disorders: Conduct disorder and Hyperkinetic disorders. Green, J. & Jacobs, B. (1998). *In- Patient child psychiatry, Modern practice, research and the future.* Routledge: London and New York.

Kramer, M. (1968). The history of the efforts to agree on an international classification of mental disorders. In, *Diagnostic and statistical manual for mental disorders (2nd Ed) (p xi-xx).* American Psychiatric Association: Washington.

Levy, F. and Hay, D.A. (2001). Attention, genes and attention deficit hyperactivity disorder. Brunner- Routledge.

Maniacci, P., and Sackett- Maniacci, L.A. (2002). The use of the DSM-IV in treatment planning: An Adlerian view. *Journal of individual psychology,* 58(4), 388- 397.

Pledge, D.S. (2002). *ADD and ADHD: An overview for school counsellors* (ERIC DOCUMENT ED 470 600).

Postman, N. & Weingartner, C. (1971). Teaching as a subversive activity. Hamondsworth, Middlesex: Penguin Books.

Rosenthal, R. & Jacobson, L. (1968). Pygmalion in the classroom. Holt, Rinehart & Winston, Inc.

Rutter, M., Shaffer. D., and Shephard, M. (1975). A Multi- Axial classification of child psychiatric disorders. World Health Organisation, Geneva.

Schmidt, K.H. (1994). An investigation of the perceptions and management of attention deficit hyperactivity disorder (ADHD) within a select group of family practitioners in the southern Transvaal.

Schwab- Stone, M.E. and Hart, E.L. (1996). *Systems of Psychiatric Classification: DSM-IV and ICD- 10*. In Lewis, M. (1996), Child and Adolescent Psychiatry: A Comprehensive Textbook, p 423- 430 (2nd Edition). Williams and Wilkins: Baltimore.

Selikowitz, M. (2004). ADHD: The facts. Oxford University Press.

Spitzer, R. and Williams, J.B.W. (1980). Classification in Psychiatry. In Kaplan, H., Freedman, A. and Saddock, B. (1980) (eds). *The comprehensive textbook of psychiatry*. Williams and Wilkins: Baltimore.

Taylor, E. (1994). Syndromes of Attention Deficit and Overactivity. Rutter, M. & Taylor, E. (1994). *Child and Adolescent psychiatry*. Blackwell Scientific Publications: Oxford.

Tramonte, M.R. (1997). *School psychologists in the multicultural environment: Recognizing the diagnostic limitations of using the DSM-IV and the mental status examination* (ERIC DOCUMENT ED 411 492).

Volkmar, F.R. (1996). Classification in child and adolescent psychiatry: Principles and issues. Lewis, M. (1996).*Child and Adolescent Psychiatry: Comprehensive textbook (2nd Edition)*. Williams and Wilkins: Baltimore.

Weiss, G. (1996). Attention Deficit Hyperactivity Disorder. Lewis, M. (1996).*Child and Adolescent Psychiatry: Comprehensive textbook (2nd Edition)*. Williams and Wilkins: Baltimore.

Wender, P.H. (1995). Attention Deficit Hyperactivity Disorder in Adults. New York: Oxford University Press.

Wicks- Nelson, R; & Israel, A.C. (2003). Behaviour Disorders of Childhood. New Jersey: Prentice Hall.

Zhang, Y (2006). Thematic content analysis. In Wildemuth, B. *Application of social research methods to questions in information and library science.* (Book in preparation).