

THE MEDICALISATION OF CHILDHOOD IN MENTAL HEALTHCARE: THE PARADIGMATIC CASE OF ATTENTION DISORDERS

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El presente artículo es una invitación al debate sobre el fenómeno de medicalización en la infancia en salud mental, apelando a una toma de consciencia de los profesionales. Para ello analiza, en clave epistemológica, el ejemplo paradigmático del Trastorno de Déficit de Atención con o sin Hiperactividad (TDA-H). Aborda la construcción social del trastorno y el tratamiento, así como algunas falacias sobre las que se apoya: TDA-H es un déficit neurológico, es diagnosticado por profesionales especializados, los tratamientos son eficaces y se realizan en interés del menor.

Palabras clave: TDA-H, TDA, Medicalización, Atención, Déficit, Infancia, Trastornos, Epistemología, Diagnóstico.

This article is an invitation to the debate about the phenomenon of the medicalisation of childhood in mental healthcare, appealing for awareness among practitioners. For this purpose, we analyse, from the point of view of epistemology, the paradigmatic case of Attention Deficit Disorder, with or without Hyperactivity (ADD and ADHD). We deal with the social construction of the disorder and its treatment, as well as some fallacies on which it is based: that AD(H)D is a neurological deficit, that it is diagnosed by specialised professionals, that the treatments are effective and that these treatments are carried out in the interest of the minor.

Key words: ADHD, ADD, Medicalisation, Attention, Deficit, Childhood, Disorders, Epistemology, Diagnosis.

The current epidemiological data on attention disorders with or without hyperactivity (from here onwards AD(H)D) indicate a serious public concern, judging by the evolution of the figures in the recent past, and the predictions that can be made based on these data for the near future. Some studies indicate a range of between 6% and 10% of the population of school-age children (Soutullo, 2003). For other authors, the prevalence rate is usually situated around 5% (Cardo & Servera, 2003). The figures depend on the diagnostic criteria used in the different investigations. A behavioural definition situates the prevalence in several countries at between 10% and 20% of the general population, and the DSM-IV definition reduces the range to between 5% and 9% (Miranda, Jarque & Soriano, 1999). According to amendments made in the DSM-5, higher rates are anticipated (Frances, 2010). The European white paper on AD(H)D states that one in twenty European children and adolescents are sufferers (Young, Fitzgerald & Postma, 2013). In Spain, 400,000 children and adolescents are estimated to have AD(H)D (Fernandez-Jaen, Fernández-Mayoralas, Calleja & Muñoz, 2007).

This article attempts to analyse some key epistemological

issues related to the definition, detection and treatment of the disorder, questioning the very foundations upon which it is based. We start from the assumption that this process is leading many professionals, regardless of their ethical intentions, to severe patterns of medicalisation of children and adolescents in large areas of the planet. In light of this reality, we propose some tools for the debate.

THE TERM MEDICALISATION

The term medicalisation first appeared in the book "Medical Nemesis" by the Austrian philosopher Ivan Illich. This term referred to the colonisation by institutionalised medicine of facets of life that transcended the real and ethical boundaries of medical action itself (Illich, 1975). Defining as pathological any phenomenon from the broad possible spectrum that the map of human development can depict, and then proceeding to medicate it, is a clear act of medicalisation. These cases represent the exercising of social and political power of the medical institutions that regulate, define and correct the limits of what is socially tolerable and permissible at any given time (Foucault 2007, 2009). Today, medical intervention is not limited to the field of the disease, distress or demand of the patients, but rather it imposes itself with authority, as in the case of medical examinations for access to certain jobs or psychiatric legal expert reports (Castro, 2009)

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The medicalisation of existence means that much of our behavioural range is subject to medical checks, such as the changes associated with the cycles of life, minor irritations, or mild anxiety (Rodríguez, 2008). In a context such as the one described, the invention or extension of already existing diseases to large sectors of the population, is not only a form of social control (Moral, 2008; Manuel, 2010), reflecting the cultural and moral schemes of a given time, but also a lucrative business for health-based industries (Blech, 2005; Martínez, 2006). Child healthcare is no stranger to the phenomenon of transforming normal situations into pathologies and producing diseases from potentially treatable situations. But even assuming the multiplicity of actors involved in the commercialisation of disease, it is the healthcare professionals and institutions in charge of children's healthcare and safeguarding the fundamental rights of minors who are primarily responsible for understanding the problem and proposing solutions (Morell, Martínez & Quintana, 2009).

TWO EXAMPLES OF THE SOCIAL CONSTRUCTION OF DIAGNOSIS IN MENTAL HEALTH

Before presenting the fallacies upon which the diagnostic construction of AD(H)D and its mass pharmacological treatment rest, we present two introductory cases, with the intention of helping to reflect on the sometimes precarious objectivity of the scientific method in mental health. To illustrate the influence of powers outside the scrupulous application of scientific methodology with regards to the definition and classification of diagnoses, as well as psychiatric treatments, we present below the historical cases of "homosexuality" and "lobotomy" respectively.

As Moser and Kleinplantz (2004) affirm, all societies stipulate criteria of control for their members with regard to sexual behaviour. Defining certain sexual interests as mental disorders can lead, depending on the culture of origin, to death or jail or to the loss of civil rights or other sanctions. Masturbation, oral sex, anal sex and homosexuality were, in times past, recognised as typified mental illnesses or recorded as symptoms of other diseases. In 1973, the American Psychiatric Association (1974) stated its position: that homosexuality *per se* is not a diagnosable mental disorder. This act was triggered, more than from the new political, social and historical scenarios arising in those years, from the more concrete mobilisation of the Committee Against the Deletion of Homosexuality from DSM-II, which called for a

referendum within the APA on this issue. In 1985, while the revised DSM-III was being produced, the terms "ego-dystonic homosexuality" and "premenstrual dysphoric disorder", the latter sponsored by the mobilisation of feminist groups, were debated until their final disappearance from the DSM III-R, published in 1986 (Urionabarrenetxea, 2008). Both cases show how the influence of cultural bias and the influence of politically articulated movements can affect supposedly objective scientific decision-making, especially in the mental health field which is particularly prone to this, given the uniqueness of the phenomena that it studies.

THE SOCIAL CONSTRUCTION OF TREATMENT

The following example began to take shape in 1935, when the Portuguese neurologist Antonio Egas Moniz became one of the pioneers in the application of prefrontal lobotomy in humans for the treatment of diseases such as schizophrenia, depression or generalised anxiety. In 1947 he received the Nobel Prize in Medicine for this invention, as well as for the creation of the diagnostic technique known as angiography (Jansson, 1998). Two years earlier, the American neuropsychiatrist Walter Freeman had modified the technique creating transorbital lobotomy or "ice pick lobotomy", which consisted of introducing -with the aid of a hammer- a punch of metal through the orbit that communicates directly with the frontal lobe severing the nerve fibres (Jinich, 2009). This procedure reduced the costs involved, with neither general anaesthesia nor a surgeon any longer being required. The practice of lobotomy became a quick outpatient procedure. In 1960, when this surgical practice began to die out, 100,000 lobotomies were recorded as having been performed in the United States alone. In 1986, the Department of Technological Advice in Great Britain published a literature review which concludes that the prefrontal lobotomy still lacks scientific basis. Today it has come to be outlawed in several countries (Hernández, Zaloff & Rosler, 2010).

In the abovementioned cases, the examples of both diagnoses and treatment, the majority of the scientific community defended the objective accuracy of the data studied, oblivious to the logical fallacies upon which they were based and the devastating influence of the environment on the conclusions. These cases in recent history show that the epistemological asepsis of studies and practices in mental health are sometimes, although it



is unintentional and attempts are made to control it, more driven by cultural, economic and political forces, and the environment in which they occur, than by the immaculate logic of a particular methodological procedure.

THE PARADIGMATIC CASE OF AD(H)D

The ICD-10 diagnostic catalogue includes hyperkinetic disorder, which in turn includes activity and attention disorder, hyperkinetic conduct disorder and other hyperkinetic disorders. It does not include attention deficit disorder because, according to the World Health Organization (1992), this could lead to the over-diagnosis of apathetic children, daydreamers or children with anxious concerns, whose problems would have a different origin and appearance.

However, it is the definition of the DSM that has garnered greater acceptance among professionals, academics and researchers (Calderón, 2003). It is particularly the timid, vague and questionable diagnostic requirements of this catalogue that have largely caused a global epidemic of attention disorders. However, the updated catalogue in the form of the DSM-5 seems to be far from correcting the faults produced by its predecessor (American Psychiatric Association, 2013). According to Allen Frances (2010, 2014), one of the leaders of the previous edition, it contains dangerous modifications. Among them, Frances highlights the extension of the age of onset of the disorder; the elimination of the requirement of disability, making the mere presence of symptoms sufficient for diagnosis; the halving of the symptoms required for a diagnosis in adults; and permitting children with autism to be diagnosed with AD(H)D. Up to 70% of people described with pervasive developmental disorders meet the criteria of AD(H)D (Ruggieri, 2006). These changes give greater leeway and flexibility to the label, enabling it to host under its diagnostic umbrella a large, almost unimaginable, portion of the child and adult population. It also paves the way to stimulant abuse in populations that are in particularly vulnerable situations such as children with autism.

But beyond the descriptions contained in the two classic diagnostic catalogues of mental health at the international level, agreement on the definition of the pathology and the data derived from it far from cultivate an acceptable consensus in the scientific community. As Lasa (2007) notes, examining the current debate on AD(H)D, agreement is far from being reached, and there exists a wide range of discrepancies in the set of investigations

that have been carried out, such as exaggerated variations in incidence and prevalence; an abusive increase in stimulant drugs and misdiagnoses; significant differences in the criteria used for diagnosis; and therapeutic monitoring that is poorly controlled or not controlled at all. In short, there is intense controversy both among researchers and intervention practitioners (Pelayo, Trabajo & Zapico, 2012).

Thus, we consider AD(H)D to be a paradigmatic example of the medicalisation of mental health, since it combines many of the characteristics that push towards mass medicalisation: a definition that can encompass vast amounts of the population, the pathologising of healthy behavioural responses in unhealthy environments, the "biologising" and cerebrating of the causes, stigmatising and chronicising, among others.

THE FALLACIES THAT MAKE UP AND SUSTAIN AD(H)D

The Dictionary of the Royal Academy of the Spanish Language defines fallacy as "deception, fraud or lies with which you try to hurt someone" or "the habit of using untruths to harm others." This article, as we have already mentioned, does not question the goodwill of the professionals and researchers in the mental healthcare of children, nor that of the other stakeholders, but neither does it question the damage that is being caused to thousands of children based on a set of fallacies, starting with the one that defines the scientific method as alien to any endeavour of political and/or economic power. In the words of Nietzsche (cited in Nardone, 2008), sometimes "the road to hell is paved with good intentions."

AD(H)D is a neurological deficit

In an emblematic publication, dated 1998 and promoted by the National Institute of Health in the US, a consensus view was sought among experts in AD(H)D on the results of decades of research (National Institute of Health, 2000). It was concluded that there was no neurological deficit associated with the diagnosis. To date, no organic etiology has yet been found to explain its existence. The parameters used for diagnosis are merely descriptive. A set of symptoms has been compiled, subjectively evaluated by the parties involved in the process, and compared on a questionable scale of normality.

Regarding the supposedly objective information gathered by health professionals, the diagnosis and treatment of AD(H)D conforms to a reductionist and



simplistic view of psychopathology. Once the symptoms have been detected, the contextual, systemic and ecological etiology that could explain the child's state is ignored, as well as the emotional cues involved and their psycho-evolutionary history. In an erroneous leap of logic, an organic alteration is deduced from the mere presence of a set of symptoms evaluated in terms of social parameters.

As Pérez Álvarez (2011) states, there is currently a tendency to assume certain brain traits as causal factors of behaviour. To counter what he has called **cerebrocentrism** (Pérez Álvarez, 2012), the aforementioned author offers two well-known examples from the neuroscience literature. First, he cites the brains of London taxi drivers, whose posterior hippocampus is significantly increased in size, a proportional relationship being established between this increase in volume and the number of years of professional practice. Nobody has advocated that taxi drivers choose their profession driven by the size of their hippocampus, but rather the reverse happens, as in the case of musicians (Pérez Álvarez's next example) for whom it has been argued that it is the years of continuous professional practice that have generated anatomical changes in their brains. In the case at hand, defining certain neurological disorders as the cause of a behavioural condition is to throw scientific logic to the wind. Brain characteristics are not exclusively the causes or consequences of behaviour, but rather part of a process of biological, social and cultural relationships that have materialised in a history of individual development. Not even in the case of finalising a description of specific neurological alterations can one assign a causal role to it.

In short, there is no credible evidence upon which to proclaim that there is a neurological deficit that endorses the implementation of psychopharmacological treatments (Doyle, Biederman, Seidman, Webwe & Faraone, 2000; Hechtman, 2000), a fact which does not prevent most of the interventions from acting as if this were the case. The etiology of the condition labelled AD(H)D may be due more to social and educational parameters than to neurological disorders (García de Vinuesa, González Pardo & Pérez Álvarez, 2014).

The diagnostic method is objective

There are no medical diagnostic tests that examine the biological characteristics of the subjects evaluated in order to determine the presence or absence of AD(H)D. The fundamental method is the observation of specific

behavioural areas by specialised professionals. The presence or absence of certain behaviours as well as their frequency at a given time, are what determine the inclusion or exclusion of individuals in this diagnostic category. To facilitate the collection of information, observational scales have been designed based on the list of the defining symptoms of the disorder. These lists are either a literal transcription of the requirements of the DSM-IV, or they are adaptations thereof to everyday language and situations. Of these lists, we have chosen the Conners Scale (Conners, 1997) as an example, due to its popularity among practitioners and researchers.

The Conners scale is a list of symptoms with a Likert response format. There are four versions of the test: two long versions (one for parents and another for teachers) and two abbreviated versions (again, one for parents and another for teachers).

Most of the studies that have analysed the level of agreement between parents and teachers, regarding the assessment of the same subject, found a moderate level of agreement. At present, there is insufficient data to assess in determining whether AD(H)D is present or not. Some studies indicate that the information from the teachers must prevail, others support the information from both teachers and parents, and yet others support the data collected from the parents (Amador, Idiazabal & Sangorrín, 2002). The absence of a unified criteria for diagnosis undermines the credibility of the evaluations, even assuming the reliability of the subjective parts.

Moreover, the Conners scale does not provide a clear differential diagnosis. Children that could be positively diagnosed with AD(H)D using this scale could pertain to other psychiatric diagnostic categories or have learning disabilities (Advokat, Martino, Hill & Gouvier, 2007).

The opinion of parents and teachers is not only influenced by their own beliefs and prejudices, but also by a relational history with the subject that is being evaluated. This reality could actually have a constructive sense within psychotherapy, which respects the subjective truth of each of the parties, but not for a treatment that prescribes psychoactive stimulants under the guise of a falsely objective reality.

AD(H)D is diagnosed by specialised professionals

The diagnostic methodology described in the section immediately above means that, in many cases, it is the parents and teachers who are primarily responsible for



making the observations that determine the diagnosis. These observations are not made following an appropriate observational methodology that respects the standards of reliability and validity worthy of any seal of confidence, rather they are based on the memory and the subjective views of people who lack both mental health training and the necessary methodological knowledge. Between 40% and 50% of males are deemed hyperactive by parents and teachers (Fernández-Jaen et al. 2007). It should be added that for practical reasons the diagnosis sometimes comes from educational or medical professionals, who also lack specific training in mental health.

The aim of the intervention is to ease the suffering of the child

If, at school, a child does not pay attention to detail or makes mistakes in their schoolwork, finds it difficult to focus on it, does not finish it, finds it hard to play quietly during leisure time, or to stay seated for a long time in the classroom, often forget tasks from one day to the next and tends to get distracted in class, this is a clear example of a child affected by a deficient attentional capacity. This is described in the main psychiatric diagnostic manual (DSM). And as mentioned earlier in this article, the number of children affected are reaching epidemic proportions and increasing. We believe that the vast majority of professionals, when contemplating these diagnostic criteria which appeal more to their purely human conscience and understanding than to the trained perspective of scientific or professional thinking, must glimpse something of the enormous absurdity involved in such a description. A society that, based on such behaviours, does not engage in any self-criticism regarding the drift of its education system and the emotional and relational deprivation of contemporary society (Bauman, 2002), merely allocating a diagnostic label and cerebral dysfunction to the children that behave like this, should seriously stop and think about its professional work. The distress represented in the child's behaviour may be largely due to a lack of adaptation to an outdated school environment, from the outset conditioned by the Prussian systems of bureaucratic organisation (Bowen, 1985), the pedagogical models of Catholic inspiration (Foucault, 2009), especially in Europe, and the economic needs of the industrial society. The current policy tends to focus more on the disastrous school failure, reflected in the absence of academic

achievement, than on constructive criticism that questions the foundations of an outdated educational system which is diametrically opposed to the emotional, physical and cognitive needs of the students. However, there has been a noticeable increase recently in such criticism on the part of distinguished academics (Bauman, 2008; Gardner, 1997; Marina, 2010; Morin, 1999; Naranjo, 2002; Schank, 2011). From the perspectives assumed by these critics, substituting the original hypothesis, that the student's maladaptation to the school environment is the result of a pathology, with one describing the same phenomenon as a normalised human response (and increasingly normalised, as we are close to reaching the figure of one in every twenty students) to a pathological education system, becomes an mandatory healthy exercise of professional reflection. Although, in this article, we advocate a hypothesis that is halfway between the two, it is necessary to question the educational environment in which most cases of AD(H)D tend to be detected, in order to put the true reality of the phenomenon into perspective.

However, it is not only necessary to question the teaching methods of our current educational system, but also to focus more clearly (and this is becoming urgent) on analysing the other social contexts influencing the child population that is diagnosed. Kabat-Zinn (2007) has even suggested that his own country, the United States, might well be diagnosed with ADD. In a society that promotes impulsiveness, a lack of critical thinking, which feeds habits in which continued attention is difficult to achieve and hyperactivity at all levels of the cultural ecosystem, from the workplace to the family, from the role of the consumer to that of the spectator, it is hardly surprising that individuals are being created that reflect with particular intensity, an uncomfortable intensity, several of the main characteristics of the system in which they are growing up. Assuming the reality of AD(H)D not only as an individual pathology, but also as a sign of the erroneous nature of our education systems and a reflection of the ways our culture functions, poses serious problems to anyone. It is easier to solve the issue by building a psychopathological epidemic than reformulating and rethinking many of the socio-cultural patterns in which we are immersed. In an illustrative sense, it is easier to medicate one in twenty European children and adolescents than to change the entire education system from its foundations.

Even assuming the accurateness of this diagnostic



strategy, we can still ask ourselves whether the proposed solutions are suitable for lessening the suffering of children. Let us observe the process. Once the subject is diagnosed, socially labelled as suffering from a disorder, he¹ is ascribed a set of stereotypes and preconceptions of the social environment in which he lives, creating thoughts and emotions in those with whom he interacts that are independent of his actual behaviour (Rüsch, Angermeyer & Corrigan, 2005; López, Laviana, Fernández, López, Rodríguez & Aparicio, 2008; Muñoz, Pérez, Crespo & Guillén, 2009). This relational context, and the possible side effects of the drugs that he takes, compound a process of stigmatisation that grows dangerously as the life of the individual progresses (Muñoz et al 2009). Moreover, such labelling leaves the individual and her relatives defenceless. As Fromm affirmed decades ago, ambiguous contemporary psychiatry has defined the field of pathology as a deviation from what is normal. In ancient times, this normalising social function was exercised by other questionable powers, the individual could defend himself psychologically from those who attacked him as an opponent of a particular doctrine, but in this day and age who can defend themselves against science? (Fromm, 2007).

Pharmacological therapy is the most appropriate

The use of psychostimulants, such as methylphenidate, one of the main treatments for AD(H)D, can produce clear signs of docility in children and animals, without thereby improving academic performance or enriching the range of behaviours that allow the child greater adaptation to her environment (Breggin, 1996). The continued use of psychostimulants, such as the abovementioned methylphenidate or dextroamphetamine, causes apathy, social withdrawal, emotional depression, and docility, as well as obsessive and repetitive behaviours, all of which are especially apt to develop in highly structured environments such as today's schools (Breggin, 1999). To the extent that scientific evidence does not solve the most important issues regarding the treatment of diagnosed children and no conclusive evidence has even been found to support the objective existence of a neurological disorder, the act of using a powerful substance to medicate young children seems, as we mentioned above, to be more due to the submission of the needs of the child

to those of the adult world (Cohen, 2009) than an effective treatment for a disorder of unknown causes, not to mention the economic implications of its use. Suffice to note that in the decade between 1993 and 2003, the global consumption of medication for ADD tripled and the global cost increased nine-fold (2,400 million US dollars in 2003) (Scheffler, Hinshaw, Modrek & Levine, 2007).

In this section, there is one fundamental problem that we have not analysed, because it exceeds the prescribed field of study for this article, but it is nevertheless vital to mention it here as it refers to the existence of a wide range of side effects of the psychoactive drugs that are being administered.

CONCLUSION

Given the epidemic magnitude of the phenomenon, the discussion has gone beyond the academic and professional spheres, producing a social echo which questions and discusses global and macroeconomic aspects, such as the power of the pharmaceutical companies or the great effectiveness of the modern strategies of persuasive advertising. But this article does not focus on this perspective, rather it is an invitation to the practitioners who work in areas related to the diagnosis of children with attention disorders and the associated care practices to make a conscious decision to stop and think. The ethical concern that guides our professions is to promote the integral development of children, to alleviate their suffering and that of their families, honouring the interests that are at the very heart of our work, whether in the health, educational and/or social fields. To act assuming a margin of inertia and protocol that will facilitate our work is normal and desirable, but when the reality fails to fit with such shortcuts, taking us further away from our objectives, it is necessary to stop and critically analyse the situation. If, far from honouring the code of ethics of our profession, we are being active agents in creating and maintaining a pandemic, it is necessary to stop, think and build a new action strategy. From the perspective assumed by this article, it does not matter whether the inertia that guided us was motivated by the speculative interests of pharmaceutical companies or other always controversial powers in the background, or it was simply due to the infinitely complex reality of the world, we cannot be

¹ *Translator's note:* From here onwards in the text, male and female pronouns will be used alternatively to avoid the use of 'he/she' and 'his/her'.



indifferent to the distancing from the purpose that defines our work as professionals and researchers. At this point, it is necessary to do what we do best: to work for the interest, education and health of the children who come to our services, to provide real and effective help that does not violate the Hippocratic principle *primum non nocere*, and that offers the best possible route to alleviating the suffering of these children.

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