

*The authors report no financial relationships with commercial interests.*

*This letter (doi: 10.1176/appi.ajp.2010.10010105) was accepted for publication in March 2010.*

### Dr. Gilmore Replies

TO THE EDITOR: I thank Drs. Read and Bental for their interest in my editorial comments about brain development and the causes of schizophrenia. I am pleased they are in agreement with the overall argument made. They rightly point out that risk factors across the entire range of prenatal and postnatal development ultimately contribute to schizophrenia and call our attention to the literature regarding early childhood adversity. As they note, hypothalamic-pituitary-adrenal axis alterations and epigenetic regulation are likely candidate mechanisms that deserve study. Their discussion of the potential role of environmental enrichment is very important, since we realize that it may be difficult to prevent many of the multiple causes of schizophrenia but may be possible to identify and modify developmental trajectories of risk.

JOHN H. GILMORE, M.D.  
Chapel Hill, N.C.

*The author's disclosures accompany the original editorial.*

*This letter (doi: 10.1176/appi.ajp.2010.10010105r) was accepted for publication in March 2010.*

### Increasing the Age at Onset for ADHD?

TO THE EDITOR: In their commentary, published in the January 2010 issue of the *Journal*, Christian Kieling, M.D., et al. (1) presented the rationale for a DSM-5 proposal to increase the required age at onset for attention deficit hyperactivity disorder (ADHD) from age 7 years to 12 years. Unfortunately, the commentary did not include a risk/benefit analysis. The authors focus only on the benefit of reducing false negatives and ignore the considerable risk that eliminating this age of onset gatekeeper will result in a flood of new false positives for a diagnosis that may already be quite overinclusive.

Especially in adolescents and adults, real or perceived attention problems are so common and so nonspecific that ADHD can be easily overdiagnosed in those suffering from any number of other mental disorders and in those who are merely seeking performance enhancement (2–6).

#### References

1. Kieling C, Kieling RR, Rohde LA, Frick PJ, Moffitt T, Nigg JT, Tan-nock R, Castellanos FX: The age at onset of attention deficit hyperactivity disorder. *Am J Psychiatry* 2010; 167:14–15
2. Visser S, Lesesne C: Mental health in the United States: prevalence of diagnosis and medication treatment for attention-deficit/hyperactivity disorder: United States, 2003. *JAMA* 2005; 294:2293–2296
3. Faraone S, Sergeant J, Gillberg C, Biederman J: The worldwide prevalence of ADHD: Is it an American condition? *World Psychiatry* 2003; 2:104–113
4. Olfson M, Gameroff M, Marcus S, Jensen P: National trends in the treatment of attention deficit hyperactivity disorder. *Am J Psychiatry* 2003; 160:1071–1077

5. Bogle K, Smith B: Illicit methylphenidate use: a review of prevalence, availability, pharmacology, and consequences. *Curr Drug Abuse Rev* 2009; 2:157–176
6. Wilens T, Adler L, Adams J, Sgambati S, Rotrosen J, Sawtelle R, Utzinger L, Fusillo S: Misuse and diversion of stimulants prescribed for ADHD: a systematic review of the literature. *J Am Acad Child Adolesc Psychiatry* 2008; 47:21–31

ALLEN FRANCES, M.D.  
Coronado, Calif.

*The author receives royalties from American Psychiatric Publishing for a DSM-IV guidelines book.*

*This letter (doi: 10.1176/appi.ajp.2010.10010097) was accepted for publication in March 2010.*

### Drs. Christian Kieling, Renata Kieling, and Rohde Reply

TO THE EDITOR: On the behalf of all authors, we appreciate Dr. Frances' interest in our commentary documenting the rationale for changing the age at onset criterion for ADHD in DSM-5. Since the preparation of DSM-5, the implementation of an evidence-based approach to the development of diagnostic criteria has been an essential step toward strengthening the scientific bases of psychiatric nosology. Any modification in DSM is intended to be a consequence of comprehensive literature reviews, re-analyses of available data sets, and results from field trials (1).

Accordingly, our systematic review of the literature found no evidence for retaining the 7-year-old cutoff as a valid criterion for parsing individuals with and without ADHD. It is important to note that this recommendation derives from 31 studies (including the DSM-IV field trials) assessing a variety of outcomes in multiple settings across different countries (2). Prospective data of an existing data set corroborate these findings, revealing that extending the age at onset criterion to 12 years resulted in a negligible increase of 0.1% in the prevalence of ADHD (3). Results from upcoming field trials should finally assess the suitability and consequences of the proposed modification (4).

The lack of internal and external validity of the 7-year-old cutoff indicates that it impedes the accurate diagnosis of adolescents and adults for whom a comprehensive clinical assessment should identify other more valid criteria in order to reduce false positives (5). Indeed, from a statistical point of view, the inclusion of any additional arbitrary criterion leads to a reduction in the overall prevalence of a disorder. However, as highlighted by Wakefield and Spitzer (6), lower prevalence rates do not necessarily imply more valid diagnostic criteria. The shift from committee-recommended to evidence-based criteria in the development of DSM should be sustained to further increase the clinical validity of the manual.

#### References

1. Widiger TA, Frances AJ, Pincus HA, Davis WW, First MB: Toward an empirical classification for the DSM-IV. *J Abnorm Psychol* 1991; 100:280–288
2. Kieling C, Kieling RR, Rohde LA, Frick PJ, Moffitt T, Nigg JT, Tan-nock R, Castellanos FX: The age at onset of attention deficit hyperactivity disorder. *Am J Psychiatry* 2010; 167:14–16
3. Polanczyk G, Caspi A, Houts R, Kollins SH, Rohde LA, Moffitt TE: Implications of extending the ADHD age-of-onset criterion to