Is the A.D.H.D. Diagnosis Helping or Hurting Kids?

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The skyrocketing number of children with attention deficit disorders has led some pediatricians to question whether the diagnostic criteria for them — which is necessary for medication prescriptions and disability accommodations — is too subjective. Some children may be over-diagnosed and over-medicated, while others who fall short of the diagnosis go unsupported.

Are attention deficit diagnoses helping or hurting kids?

The Diagnosis Does a Disservice

Dimitri Christakis, pediatrician and epidemiologist

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Diagnosis Is Key to Helping Kids

Tanya E. Froehlich, professor of developmental and behavioral pediatrics

Strong scientific evidence correlates A.D.H.D. with dire health and well-being consequences, which can be alleviated with treatment.

Worrying Disparities in Diagnosis of Black and White Children

Keith B. Wilson, professor, Rehabilitation Institute

Though they are more likely to experience symptoms of A.D.H.D., children of color are less likely to receive treatment or diagnosis.

Don’t Rush to Saddle Children With the A.D.H.D. Label

Donna Ford, professor of special education

Even when drugs are truly required, students still need strategies to help them pay attention and adjust their behavior when they have lots of energy.

Failure to Conform Accounts for Most Diagnoses

Susan Hawthorne, author, "Accidental Intolerance"

Children often get diagnosed not because they experience impairment but because they are difficult to manage.

The Diagnosis Does a Disservice to Children

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Dimitri Christakis, a pediatrician and epidemiologist at the University of Washington School of Medicine, is the director of the Center for Child Health, Behavior and Development at Seattle Children's Research Institute.

A.D.H.D. exists in an interesting paradigm: It is treatable with pharmaceuticals and behavioral modifications, but diagnosis is pretty arbitrary. Attentional capacity isn't something one can possess in full — it exists on a spectrum. Our current diagnostic approaches are too black and white, and they end up providing a disservice to many children.

Children who struggle with symptoms of A.D.H.D, like impulsivity and inattention, are dealing with problems of "executive function." Better executive function allows children (and adults) to make more considered choices, which can add up over time to make an enormous difference in quality of life.

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Consider a famous New Zealand study that followed children for 30 years: The researchers found that better executive function in early life was associated with lower rates of substance abuse, divorce and incarceration. There was no threshold at which poor executive function became a problem for these kids: Each incremental increase in self-control early in life was correlated with better outcomes in adulthood.

In our current system, to diagnose A.D.H.D., clinicians rely on a threshold to distinguish pathology from normalcy in a child's behavior. In one of the most widely used and well-validated diagnostic tests, a child needs to demonstrate 6 of 9 specific behaviors on a standardized form to be diagnosed, and thereby qualify for disability accommodations. But the assessments, usually completed by a teacher and parent, are subjective. They must decide, for example, whether a child "often" has "difficulty organizing tasks and activities" — or "very often."

If the answers determine that a child falls into the pathological range for A.D.H.D., medication or cognitive behavioral therapy is prescribed, and the child qualifies for certain disability accommodations under the Individuals with Disabilities Education Act.

If the child scores just below that cutoff and is pronounced A.D.H.D. free, however, there are no accommodations like extra time on standardized testing. Paradoxically, many children would be better off if they scored 1-2 points worse on their assessments so they too could benefit from treatment.

What's more, all children would benefit from better executive function, and studies have found

that their early environment affects it. We should shift from treating their distraction as a clinical disease, to targeting the best ways to help children maximize their ability to focus.

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Diagnosis Is Key to Helping Kids with A.D.H.D.

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Tanya E. Froehlich is an associate professor of developmental and behavioral pediatrics at the University of Cincinnati/Cincinnati Children's Hospital Medical Center.

Controversies in the news media have made many skeptical about A.D.H.D., and there are legitimate concerns about over-diagnosis and medication misuse when it comes to attention deficit disorders.

> Strong scientific evidence correlates A.D.H.D. with dire health and well-being consequences, which can be alleviated with treatment.

Access to these treatments is much harder without an A.D.H.D. diagnosis, and socioeconomically disadvantaged children are the ones who are most overlooked. In 2007, I found that among children who met gold standard diagnostic criteria for A.D.H.D., those who lacked health insurance were less likely to be diagnosed, and the poorest children were three to five times less likely than wealthier children to receive consistent A.D.H.D. medication treatment. So, for children who truly have A.D.H.D. — including and especially the members of our most vulnerable groups — diagnosis and treatment are critical for well-being. We do these children a huge disservice by demonizing A.D.H.D. and denying them access to important services.

That is not to say that critics of A.D.H.D. diagnosis in America haven't made some valid points. Diagnosing A.D.H.D. should not simply be a matter of parents endorsing a certain number of attention deficit-related symptoms on a rating scale at a single point in time.

Instead, pediatricians need to verify that each child's symptoms are actually impairing functioning, are long-standing and present from an early age, and occur at school as well as home. As clinicians, it is our job to rule out the many other diagnoses and circumstances that can produce A.D.H.D.-like symptoms by carefully interviewing the family, conducting a physical examination to rule out mimicking medical conditions, and diligently collecting information from the school.

Unfortunately, all of this cannot be done in the typical 10- to 20-minute medical visit. And, even when children don't meet full criteria for attention deficit disorders, it does not mean we cannot help them, and that they aren't experiencing any difficulties. The attentional and self-regulation capacities of all children can be improved by increasing physical activity, maintaining a healthy and well-balanced diet, improving sleep, limiting electronics, teaching organizational skills, and increasing structure and consistency at home and in school.

Pediatricians must take a larger role in educating families about these critical lifestyle interventions, in addition to diagnosing A.D.H.D. and managing its medical treatment.

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Worrying Disparities in Diagnosis of Black and White Children

Keith B. Wilson is a professor at the Rehabilitation Institute at Southern Illinois University, Carbondale.

While the cause of A.D.H.D. is still undetermined, the discrepancy between diagnoses in black and white children is well established.

Though they are more likely to experience symptoms of A.D.H.D., children of color are less likely than white children to be given a diagnosis and receive medication. A 2013 study found that black children were 69 percent less likely to be diagnosed based on their symptoms, while Latino children were 45 percent less likely to get appropriate attention and treatment.

It's not entirely clear why children of color are overlooked when it comes to these issues, though it could be a matter of lower expectations and a lack of resources.

But it's not just A.D.H.D. These discrepancies are consistent across all forms of health care and education in the United States.

It is important to acknowledge that discrimination can be conscious (intentional) or unconscious (unintentional) on the part of educational and health care providers, but the effects are still harmful to both children and their parents and guardians. Without appropriate diagnosis, many black and Latino children miss out on badly needed opportunities to succeed.

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Don’t Rush to Saddle Children With the A.D.H.D. Label

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Having spent about 25 years in education, I have seen teachers quickly assume that students who are more active than their classmates (and who are more active than their teachers’ tolerance for high activity levels) require medication.

I see too little time devoted to helping such students adjust or to finding intervention strategies to support them. The rush to saddle them with a disorder, with little prior intervention, contributes to misidentification and societal over-medication. Even when drugs are truly required, students still need strategies to help them pay attention and adjust their behavior when they have lots of energy. It's unnerving to hear your student say, “I need my medication to pay attention,” or “I can’t sit still until I have my medication.” I have heard this more times than I want to remember, even from elementary-aged students.

> Even when drugs are truly required, students still need strategies to help them pay attention and adjust their behavior when they have lots of energy.

There are several problems that contribute to A.D.H.D. misdiagnosis. The first is the subjective and limited nature of the evaluations used to diagnose an already high-energy population (kids). A checklist of behaviors should not be the only or primary source of an evaluation when so much is at stake. Observation over a period of time and in multiple settings are needed. How active and attentive are students when they are watching TV or playing games, for example? What are they like in places of worship or when they are traveling, and so on? It is worth considering, in every case, how a child changes his or her behavior based on location and time of day.

It is also important to consider the comparison group when determining what counts as “normal.” For example, most students labeled as having A.D.H.D. are males and many are black males. But boys tend to be more active than girls, and African-Americans are known for being movement-oriented, tactile and kinesthetic. This is considered normal and healthy in the African-American community but not necessarily so in schools.

The structure of the school day also needs to be considered when we address the shorter attention spans, disinterest and frustration of students. Hours of seat work, few breaks, lack of recess, and few tactile and kinesthetic activities do not match how many students prefer to learn; it does not reflect their home and community experiences. Schools need to be restructured to be more hands-on. This will help decrease unnecessary referrals, mislabeling and over-medication.

I, for one, would like to see educators examine their tolerance levels for children who require more active days, rather than jump to unnecessary labels and medication.

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Failure to Conform Accounts for Most A.D.H.D. Diagnoses

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Current conventional wisdom is that A.D.H.D. is a chronic, physical and medically treatable condition, comparable to diabetes. But this is not the case. The diagnostic criteria really measure whether children (or teens or adults) fail to meet today's social expectations.

Even if there were a distinct physical cause of A.D.H.D. — something no one has yet demonstrated — why would it count as a disorder? According to the official diagnostic criteria, A.D.H.D. is treated like a disability because those who meet the criteria are impaired: They suffer from A.D.H.D.-specific symptoms.

> Children often get diagnosed not because they experience impairment but because they are difficult to manage.

For example, a distressed tween struggling to complete her homework could be a candidate for diagnosis. But her parents' and teachers' expectations are really at the root of her distress, and what marks her difference as a disorder.

More pointedly, children often get diagnosed not because they experience impairment but because they are difficult to manage, like a very active preschooler who will not sit quietly at circle time. Again, social failure accounts most acutely for the diagnoses of this disorder.

And as pressures to conform mount for children and adults, so do the number of diagnoses.

By high school nearly 20 percent of all boys will have met the diagnostic criteria for A.D.H.D., a huge increase from even 10 years ago. This categorization reflects many influences and expectations — including the pressures of a competitive, desk-bound world; time and money constraints on parents, teachers, schools and clinicians; and drug company research priorities.

Whatever the rationale, the corrosive effect of an increase in A.D.H.D. diagnoses is the spread of a cultural stereotype — that of the distractible student or annoying peer, marked for certain failures because of his or her difference. The spread of this stereotype also ensures that people will also stigmatize children who "seem" A.D.H.D., and will criticize the parents for not seeking diagnosis.

Might diagnosis and treatment be useful despite these concerns? Maybe. Typical treatment — medication — provides short-term gains in attention span and work completion. Despite professionals' expectations, however, medication has not been shown to improve long-term education or work achievements.

I believe we should move away from the A.D.H.D. diagnosis by individualizing expectations of children, developing more flexible care and education strategies, investing more resources in young people, and prioritizing research that is not beholden to drug companies. Of course, some children would still experience serious social rejection or be unable to attend to any work at hand. These children, like those with severe A.D.H.D. symptoms today, would need special care.

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