



Is Attention Deficit Disorder (ADD/ADHD) a Legitimate Medical Condition That Affects Childhood Behavior?

YES: Michael Fumento, from "Trick Question" *The New Republic* (February 2003)

NO: Rogers H. Wright, from "Attention Deficit Hyperactivity Disorder: What It Is and What It Is Not," in Rogers H. Wright and Nicholas A. Cummings, eds., *Destructive Trends in Mental Health: The Well-Intentioned Path to Harm* (Routledge, 2005)

ISSUE SUMMARY

YES: Science journalist and writer Michael Fumento suggests that despite the extensive political controversy, it is clear that ADHD is a legitimate medical condition disrupting childhood.

NO: Psychologist Rogers Wright argues that ADHD is a transitory condition and fad diagnosis rather than an enduring disease.

Middle childhood is often a period of changing behavior. As children move from primarily spending time with their parents and family to primarily spending time with peers and at school, they often establish new habits and attitudes. While most children adapt to the changes well, there are inevitably some children who struggle. In these cases, many children can be disruptive, hyperactive, and deviant. Their behavior is no longer just a family issue, but it is an issue for the school and community in which they interact. The controversial question, is whether extreme behavior constitutes a medical disorder requiring medication or a radical variation on normal childhood created by social forces.

Part of the controversy is due to the success of drugs such as Ritalin in modifying the behavior of children. Individuals who were previously out of control and unable to concentrate have used Ritalin and related drugs to control their attention and behavior. These drugs allowed parents to manage unruly children and schools to educate difficult students. Does applying a medical model and medication to extreme behavior prove that ADHD is a legitimate medical condition?

Ritalin, like any psychoactive drug, alters brain chemistry: our concentration, mood, attention, excitement, energy, and so on. As such, a drug that alters brain

chemistry has the potential to both rectify disordered behavior and manage normal behavior. While some scholars argue that the efficacy of Ritalin and similar drugs proves the reality of ADHD, others argue that these drugs could have socially redeeming effects on anyone—including college students who have learned that Ritalin (and related drugs) will help their concentration and attention span.

Beyond the fact that Ritalin works to influence children's brains, statistics about ADHD serve to stir further controversy. First, ADHD is a relatively recent disorder—the diagnosis did not exist by that name until the last few decades. To some this suggests that ADHD is not an organic, or biological, disorder but an artifact of changing social norms. To others this demonstrates the advances made in medical science. Second, the overwhelming majority of cases of ADHD are diagnosed in North America. To some this suggests that ADHD reflects part of our culture that refuses to accept responsibility for the challenges of middle childhood. To others this shows the advanced progress of our system for managing children with serious problems. Third, ADHD is much more commonly diagnosed in boys than in girls. To some this means that ADHD is linked to male biology. To others this suggests that the tendency of boys to be more aggressive and assertive is more than contemporary parents and teachers can handle.

Michael Fumento asserts that any argument against the reality of ADHD is misguided. He points out that the efficacy of Ritalin in changing behavior should be considered positive, rather than negative. Children diagnosed with ADHD are different, and it is not just because of parenting. Ritalin helps them function effectively but it does not, contrary to popular opinion, create zombies.

Psychologist Rogers Wright, takes a clinical perspective and suggests that biomedical approaches to ADHD have gone too far. He notes that ADHD is an easy way to explain extreme behavior, but that medication can often do more harm than good. He also notes that behavioral interventions—efforts to systematically shape children's behavior through environmental changes—are a more effective primary option for dealing with disruptive children than medication.

POINT

- Mostly, the diagnosis of ADHD is based on clear and dramatic behavioral differences—similar to many other medical conditions.
- The behavioral problems that mark ADHD are extreme disruptions in functioning.
- The effectiveness of drugs such as Ritalin and the problems caused by ADHD clearly demonstrate that it is a neurological problem.
- Medications often help children and families to have the opportunity for normal developmental experiences.

COUNTERPOINT

- The frequency of diagnosing ADHD among children is a "fad" rather than a representation of a true medical condition.
- ADHD is more of a "behavioral aberration" than a real disease, similar to Social Anxiety Disorder.
- There is a difference between being hyperactive and having a neurological disorder that originates in dysfunction.
- Research suggests that behavioral interventions are more effective than medication—we are often too quick to medicate.

Trick Question

It's both right-wing and vast, but it's not a conspiracy. Actually, it's more of an anti-conspiracy. The subject is Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD), closely related ailments (henceforth referred to in this article simply as ADHD). Rush Limbaugh declares it "may all be a hoax." Francis Fukuyama devotes much of one chapter in his latest book, *Our Posthuman Future*, to attacking Ritalin, the top-selling drug used to treat ADHD. Columnist Thomas Sowell writes, "The motto used to be: 'Boys will be boys.' Today, the motto seems to be: 'Boys will be medicated.'" And Phyllis Schlafly explains, "The old excuse of 'my dog ate my homework' has been replaced by 'I got an ADHD diagnosis.'" A March 2002 article in *The Weekly Standard* summed up the conservative line on ADHD with this rhetorical question: "Are we really prepared to redefine childhood as an ailment, and medicate it until it goes away?"

Many conservative writers, myself included, have criticized the growing tendency to pathologize every undesirable behavior—especially where children are concerned. But, when it comes to ADHD, this skepticism is misplaced. As even a cursory examination of the existing literature or, for that matter, simply talking to the parents and teachers of children with ADHD reveals, the condition is real, and it is treatable. And, if you don't believe me, you can ask conservatives who've come face to face with it themselves.

Myth: ADHD Isn't a Real Disorder

The most common argument against ADHD on the right is also the simplest: It doesn't exist. Conservative columnist Jonah Goldberg thus reduces ADHD to "ants in the pants." Sowell equates it with "being bored and restless." Fukuyama protests, "No one has been able to identify a cause of ADD/ADHD. It is a pathology recognized only by its symptoms." And a conservative columnist approvingly quotes Thomas Armstrong, Ritalin opponent and author, when he declares, "ADD is a disorder that cannot be authoritatively identified in the same way as polio, heart disease or other legitimate illnesses."

The Armstrong and Fukuyama observations are as correct as they are worthless. "Half of all medical disorders are diagnosed without benefit of a lab procedure," notes Dr. Russell Barkley, professor of psychology at the College of

Health Professionals at the Medical University of South Carolina. "Where are the lab tests for headaches and multiple sclerosis and Alzheimer's?" he asks. "Such a standard would virtually eliminate all mental disorders."

Often the best diagnostic test for an ailment is how it responds to treatment. And, by that standard, it doesn't get much more real than ADHD. The beneficial effects of administering stimulants to treat the disorder were first reported in 1937. And today medication for the disorder is reported to be 75 to 90 percent successful. "In our trials it was close to ninety percent," says Dr. Judith Rapoport, director of the National Institute of Mental Health's Child Psychiatry Branch, who has published about 100 papers on ADHD. "This means there was a significant difference in the children's ability to function in the classroom or at home."

Additionally, epidemiological evidence indicates that ADHD has a powerful genetic component. University of Colorado researchers have found that a child whose identical twin has the disorder is between eleven and 18 times more likely to also have it than is a non-twin sibling. For these reasons, the American Psychiatric Association (APA), American Medical Association, American Academy of Pediatrics, American Academy of Child Adolescent Psychiatry, the surgeon general's office, and other major medical bodies all acknowledge ADHD as both real and treatable.

Myth: ADHD Is Part of a Feminist Conspiracy to Make Little Boys More Like Little Girls

Many conservatives observe that boys receive ADHD diagnoses in much higher numbers than girls and find in this evidence of a feminist conspiracy. (This, despite the fact that genetic diseases are often heavily weighted more toward one gender or the other.) Sowell refers to "a growing tendency to treat boyhood as a pathological condition that requires a new three R's—repression, re-education and Ritalin." Fukuyama claims Prozac is being used to give women "more of the alpha-male feeling," while Ritalin is making boys act more like girls. "Together, the two sexes are gently nudged toward that androgynous median personality . . . that is the current politically correct outcome in American society." George Will, while acknowledging that Ritalin can be helpful, nonetheless writes of the "androgyny agenda" of "drugging children because they are behaving like children, especially boy children." Anti-Ritalin conservatives frequently invoke Christina Hoff Sommers's best-selling 2000 book, *The War Against Boys*. You'd never know that the drug isn't mentioned in her book—or why.

"Originally I was going to have a chapter on it," Sommers tells me. "It seemed to fit the thesis." What stopped her was both her survey of the medical literature and her own empirical findings. Of one child she personally came to know she says, "He was utterly miserable, as was everybody around him. The drugs saved his life."

Myth: ADHD Is Part of the Public School System's Efforts to Warehouse Kids Rather Than to Discipline and Teach Them

"No doubt life is easier for teachers when everyone sits around quietly," writes Sowell. Use of ADHD drugs is "in the school's interest to deal with behavioral and discipline problems [because] it's so easy to use Ritalin to make kids compliant: to get them to sit down, shut up, and do what they're told," declares Schlafly. The word "zombies" to describe children under the effects of Ritalin is tossed around more than in a B-grade voodoo movie.

Kerri Houston, national field director for the American Conservative Union and the mother of two ADHD children on medication, agrees with much of the criticism of public schools. "But don't blame ADHD on crummy curricula and lazy teachers," she says. "If you've worked with these children, you know they have a serious neurological problem." In any case, Ritalin, when taken as prescribed, hardly stupefies children. To the extent the medicine works, it simply turns ADHD children into normal children. "ADHD is like having thirty televisions on at one time, and the medicine turns off twenty-nine so you can concentrate on the one," Houston describes. "This zombie stuff drives me nuts! My kids are both as lively and as fun as can be."

Myth: Parents Who Give Their Kids Anti-ADHD Drugs Are Merely Doping Up Problem Children

Limbaugh calls ADHD "the perfect way to explain the inattention, incompetence, and inability of adults to control their kids." Addressing parents directly, he lectures, "It helped you mask your own failings by doping up your children to calm them down."

Such charges blast the parents of ADHD kids into high orbit. That includes my Hudson Institute colleague (and fellow conservative) Mona Charen, the mother of an eleven-year-old with the disorder. "I have two non-ADHD children, so it's not a matter of parenting technique," says Charen. "People without such children have no idea what it's like. I can tell the difference between boyish high spirits and pathological hyperactivity. . . . These kids bounce off the walls. Their lives are chaos; their rooms are chaos. And nothing replaces the drugs."

Barkley and Rapoport say research backs her up. Randomized, controlled studies in both the United States and Sweden have tried combining medication with behavioral interventions and then dropped either one or the other. For those trying to go on without medicine, "the behavioral interventions maintained nothing," Barkley says. Rapoport concurs: "Unfortunately, behavior modification doesn't seem to help with ADHD." (Both doctors are quick

to add that ADHD is often accompanied by other disorders that are treatable through behavior modification in tandem with medicine.)

Myth: Ritalin Is "Kiddie Cocaine"

One of the paradoxes of conservative attacks on Ritalin is that the drug is alternately accused of turning children into brain-dead zombies and of making them Mach-speed cocaine junkies. Indeed, Ritalin is widely disparaged as "kiddie cocaine." Writers who have sought to lump the two drugs together include Schlafly, talk-show host and columnist Armstrong Williams, and others whom I hesitate to name because of my long-standing personal relationships with them.

Mary Eberstadt wrote the "authoritative" Ritalin-cocaine piece for the April 1999 issue of *Policy Review*, then owned by the Heritage Foundation. The article, "Why Ritalin Rules," employs the word "cocaine" no fewer than twelve times. Eberstadt quotes from a 1995 Drug Enforcement Agency (DEA) background paper declaring methylphenidate, the active ingredient in Ritalin, "a central nervous system (CNS) stimulant [that] shares many of the pharmacological effects of amphetamine, methamphetamine, and cocaine." Further, it "produces behavioral, psychological, subjective, and reinforcing effects similar to those of d-amphetamine including increases in rating of euphoria, drug liking and activity, and decreases in sedation." Add to this the fact that the Controlled Substances Act lists it as a Schedule II drug, imposing on it the same tight prescription controls as morphine, and Ritalin starts to sound spooky indeed.

What Eberstadt fails to tell readers is that the DEA description concerns methylphenidate *abuse*. It's tautological to say abuse is harmful. According to the DEA, the drugs in question are comparable when "administered the same way at comparable doses." But ADHD stimulants, when taken as prescribed, are neither administered in the same way as cocaine nor at comparable doses. "What really counts," says Barkley, "is the speed with which the drugs enter and clear the brain. With cocaine, because it's snorted, this happens tremendously quickly, giving users the characteristic addictive high." (Ever seen anyone pop a cocaine tablet?) Further, he says, "There's no evidence anywhere in literature of [Ritalin's] addictiveness when taken as prescribed." As to the Schedule II listing, again this is because of the potential for it to fall into the hands of abusers, not because of its effects on persons for whom it is prescribed. Ritalin and the other anti-ADHD drugs, says Barkley, "are the safest drugs in all of psychiatry." (And they may be getting even safer: A new medicine just released called Strattera represents the first true non-stimulant ADHD treatment.)

Indeed, a study just released in the journal *Pediatrics* found that children who take Ritalin or other stimulants to control ADHD cut their risk of future substance abuse by 50 percent compared with untreated ADHD children. The lead author speculated that "by treating ADHD you're reducing the demoralization that accompanies this disorder, and you're improving the academic functioning and well-being of adolescents and young adults during the critical times when substance abuse starts."

Myth: Ritalin Is Overprescribed Across the Country

Some call it "the Ritalin craze." In *The Weekly Standard*, Melana Zyla Vickers informs us that "Ritalin use has exploded," while Eberstadt writes that "Ritalin use more than doubled in the first half of the decade alone, [and] the number of schoolchildren taking the drug may now, by some estimates, be approaching the 4 million mark."

A report in the January 2003 issue of *Archives of Pediatrics and Adolescent Medicine* did find a large increase in the use of ADHD medicines from 1987 to 1996, an increase that doesn't appear to be slowing. Yet nobody thinks it's a problem that routine screening for high blood pressure has produced a big increase in the use of hypertension medicine. "Today, children suffering from ADHD are simply less likely to slip through the cracks," says Dr. Sally Satel, a psychiatrist, AEI fellow, and author of *PC, M.D.: How Political Correctness Is Corrupting Medicine*.

Satel agrees that some community studies, by the standards laid down in the APA's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, indicate that ADHD may often be over-diagnosed. On the other hand, she says, additional evidence shows that in some communities ADHD is under-diagnosed and under-treated. "I'm quite concerned with children who need the medication and aren't getting it," she says.

There are tremendous disparities in the percentage of children taking ADHD drugs when comparing small geographical areas. Psychologist Gretchen LeFever, for example, has compared the number of prescriptions in mostly white Virginia Beach, Virginia, with other, more heavily African American areas in the southeastern part of the state. Conservatives have latched onto her higher numbers—20 percent of white fifth-grade boys in Virginia Beach are being treated for ADHD—as evidence that something is horribly wrong. But others, such as Barkley, worry about the lower numbers. According to LeFever's study, black children are only half as likely to get medication as white children. "Black people don't get the care of white people; children of well-off parents get far better care than those of poorer parents," says Barkley.

Myth: States Should Pass Laws That Restrict Schools from Recommending Ritalin

Conservative writers have expressed delight that several states, led by Connecticut, have passed or are considering laws ostensibly protecting students from schools that allegedly pass out Ritalin like candy. Representative Lenny Winkler, lead sponsor of the Connecticut measure, told *Reuters Health*, "If the diagnosis is made, and it's an appropriate diagnosis that Ritalin be used, that's fine. But I have also heard of many families approached by the school system [who are told] that their child cannot attend school if they're not put on Ritalin."

Two attorneys I interviewed who specialize in child-disability issues, including one from the liberal Bazelon Center for Mental Health Law in

Washington, D.C., acknowledge that school personnel have in some cases stepped over the line. But legislation can go too far in the other direction by declaring, as Connecticut's law does, that "any school personnel [shall be prohibited] from recommending the use of psychotropic drugs for any child." The law appears to offer an exemption by declaring, "The provisions of this section shall not prohibit *school medical staff* from recommending that a child be evaluated by an appropriate medical practitioner, or prohibit school personnel from consulting with such practitioner, with the consent of the parent or guardian of such child." [Emphasis added.] But of course many, if not most schools have perhaps one nurse on regular "staff." That nurse will have limited contact with children in the classroom situations where ADHD is likely to be most evident. And, given the wording of the statute, a teacher who believed a student was suffering from ADHD would arguably be prohibited from referring that student to the nurse. Such ambiguity is sure to have a chilling effect on any form of intervention or recommendation by school personnel. Moreover, 20-year special-education veteran Sandra Rief said in an interview with the National Education Association that "recommending medical intervention for a student's behavior could lead to personal liability issues." Teachers, in other words, could be forced to choose between what they think is best for the health of their students and the possible risk of losing not only their jobs but their personal assets as well.

"Certainly it's not within the purview of a school to say kids can't attend if they don't take drugs," says Houston. "On the other hand, certainly teachers should be able to advise parents as to problems and potential solutions. . . . [T]hey may see things parents don't. My own son is an angel at home but was a demon at school."

If the real worry is "take the medicine or take a hike" ultimatums, legislation can be narrowly tailored to prevent them; broad-based gag orders, such as Connecticut's, are a solution that's worse than the problem.

The Conservative Case for ADHD Drugs

There are kernels of truth to every conservative suspicion about ADHD. Who among us has not had lapses of attention? And isn't hyperactivity a normal condition of childhood when compared with deskbound adults? Certainly there are lazy teachers, warehousing schools, androgyny-pushing feminists, and far too many parents unwilling or unable to expend the time and effort to raise their children properly, even by their own standards. Where conservatives go wrong is in making ADHD a scapegoat for frustration over what we perceive as a breakdown in the order of society and family. In a column in *The Boston Herald*, Boston University Chancellor John Silber rails that Ritalin is "a classic example of a cheap fix: low-cost, simple and purely superficial."

Exactly. Like most headaches, ADHD is a neurological problem that can usually be successfully treated with a chemical. Those who recommend or prescribe ADHD medicines do not, as *The Weekly Standard* put it, see them as "discipline in pill-form." They see them as pills.

In fact, it can be argued that the use of those pills, far from being liable for or symptomatic of the Decline of the West, reflects and reinforces conservative values. For one thing, they increase personal responsibility by removing an excuse that children (and their parents) can fall back on to explain misbehavior and poor performance. "Too many psychologists and psychiatrists focus on allowing patients to justify to themselves their troubling behavior," says Satel. "But something like Ritalin actually encourages greater autonomy because you're treating a compulsion to behave in a certain way. Also, by treating ADHD, you remove an opportunity to explain away bad behavior."

Moreover, unlike liberals, who tend to downplay differences between the sexes, conservatives are inclined to believe that there are substantial physiological differences—differences such as boys' greater tendency to suffer ADHD. "Conservatives celebrate the physiological differences between boys and girls and eschew the radical-feminist notion that gender differences are created by societal pressures," says Houston regarding the fuss over the boy-girl disparity among ADHD diagnoses. "ADHD is no exception."

But, however compatible conservatism may be with taking ADHD seriously, the truth is that most conservatives remain skeptics. "I'm sure I would have been one of those smug conservatives saying it's a made-up disease," admits Charen, "if I hadn't found out the hard way." Here's hoping other conservatives find an easier route to accepting the truth.

Rogers H. Wright



Attention Deficit Hyperactivity Disorder: What It Is and What It Is Not

It is almost axiomatic in the mental health field that fads will occur in the "diagnosis" and treatment of various types of behavioral aberrations, some of which border on being mere discomforts. Although the same faddism exists to some degree in physical medicine, its appearance is not nearly as blatant, perhaps in part because physical medicine is more soundly grounded in the physical sciences than are diagnoses in the mental health field. These fads spill over into the general culture, where direct marketing often takes place. One has to spend only a brief period in front of a television set during prime time to discover ADHD (Attention Deficit Hyperactivity Disorder), SAD (Social Anxiety Disorder), or IBS (Irritable Bowel Syndrome). Even when purporting to be informational, these are more or less disguised commercials, inasmuch as they posit a cure that varies with the drug manufacturer sponsoring the television ad.

The other certainty is that these "diagnoses" will fall from usage as other fads emerge, as was the case a decade or so ago with the disappearance of a once-common designation for what is now sometimes called ADHD. That passing fad was known as minimal brain syndrome (MBS) and/or food disorder (ostensibly from red dye or other food additives). From this author's perspective, these fad "diagnoses" don't really exist. Other writers in this volume have commented on the slipperiness of these "diagnoses"—that is, the elevation of a symptom and/or its description to the level of a disorder or syndrome—and the concomitant tendency to overmedicate for these nonexistent maladies.

Children and ADHD

Certainly, there are deficiencies of attention and hyperactivity, but such behavioral aberrancies are most often indicative of a transitory state or condition within the organism. They are not in and of themselves indicative of a "disorder." Every parent has noticed, particularly with younger children, that toward the end of an especially exciting and fatiguing day children are literally "ricocheting off the walls." Although this behavior may in the broadest sense be classifiable as hyperactivity, it is generally pathognomonic of nothing more than excessive fatigue, for which the treatment of choice is a good night's sleep.

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Distractibility (attention deficit) is a frequent concomitant of excessive fatigue, particularly with children under five years of age, and can even be seen in adults if fatigue levels are extreme or if stress is prolonged. However, such "symptoms" in these contexts do not rise to the level of a treatable disorder.

Conversely, when distractibility and/or hyperactivity characterize the child's everyday (especially if accompanied by factors such as delayed development, learning difficulties, impaired motor skills, and impaired judgement), they may be indicative of either a neurological disorder or of developing emotional difficulties. However, after nearly fifty years of diagnosing and treating several thousand such problems, it is my considered judgement that the distractibility and hyperactivity seen in such children is not the same as the distractibility and hyperactivity in children currently diagnosed as having ADHD. Furthermore, the hyperactivity/distractibility seen in the non-ADHD children described above is qualitatively and quantitatively different, depending on whether it is caused by incipient emotional maldevelopment (functional; i.e., nonorganic) or whether it is due to neurological involvement.

It is also notable that most children whose distractibility and/or hyperactivity is occasioned by emotional distress do not show either the kind or degree of learning disability, delayed genetic development, poor judgement, and impaired motor skills that are seen in children whose "distractibility/hyperactivity" is occasioned by neurological involvement. Only in children with the severest forms of emotional disturbance does one see the kind of developmental delays and impaired behavioral controls that are more reflective of neurological involvement (or what was known as MBS until the ADHD fad took hold). Differentiating the child with actual neurological involvement from the child that has emotionally based distractibility is neither simple nor easy to do, especially if the behavioral (as opposed to neurological) involvement is severe.

A major and profound disservice occasioned by the current fad of elevating nonspecific symptoms such as anxiety and hyperactivity to the level of a syndrome or disorder and then diagnosing ADD/ADHD is that we lump together individuals with very different needs and very different problems. We then attempt to treat the problem(s) with a single entity, resulting in a one-pill-fits-all response. It is also unfortunately the case that many mental health providers (e.g., child psychiatrists, child psychologists, child social workers), as well as many general care practitioners (e.g., pediatricians and internists), are not competent to make such discriminations alone. Therefore, it follows that such practitioners are not trained and equipped to provide ongoing care, even when an appropriate diagnosis has been made.

To add to an already complicated situation, the symptom picture in children tends to change with time and maturation. Children with neurological involvement typically tend to improve spontaneously over time, so that the symptoms of distractibility and hyperactivity often represent diminished components in the clinical picture. Conversely, children whose distractibility and hyperactivity are emotionally determined typically have symptoms that tend to intensify or be accompanied/replaced by even more dramatic indices of emotional distress.

Management of Children Exhibiting "ADHD" According to Etiology

It is apparent that somewhat superficially similar presenting complaints (i.e., distractibility and hyperactivity) may reflect two very different causative factors, and that the successful treatment and management of the complaint should vary according to the underlying causation. Neurological damage can stem from a number of causative factors during pregnancy or the birth process, and a successful remedial program may require the combined knowledge of the child's pediatrician, a neuropsychologist specializing in the diagnosis and treatment of children, and a child neurologist. In these cases appropriate medication for the child is often very helpful.

Psychotherapy for the child (particularly younger children) is, in this writer's experience, largely a waste of time. On the other hand, remedial training in visual perception, motor activities, visual-motor integration, spatial relations, numerical skills, and reading and writing may be crucial in alleviating or at least diminishing the impact of symptoms. Deficits in these skills can be major contributors to the hyperactivity and distractibility so frequently identified with such children. Counseling and psychotherapeutic work with the parents is very important and should always be a part of an integrated therapeutic program. Such children need to be followed by an attending pediatrician, a child neurologist, a child neuropsychologist, and an educational therapist, bearing in mind that treatment needs change throughout the span of remediation. For example, medication levels and regimens may need to be adjusted, and training programs will constantly need to be revised or elaborated.

It is also noteworthy that so-called tranquilizing medication with these children typically produces an adverse effect. This writer remembers a situation that occurred early in his practice, a case he has used repeatedly to alert fledgling clinicians to the importance of a comprehensive initial evaluation and ongoing supervision in the development of neurologically involved children.

John, a two-and-a-half-year-old boy, was referred by his pediatrician for evaluation of extreme hyperactivity, distractibility, and mild developmental delay. The psychological evaluation elicited evidence of visual perceptual impairment in a context of impaired visual motor integration, a finding suggestive of an irritative focus in the parietal-occipital areas of the brain. This finding was later corroborated by a child neurologist, and John was placed on diltantin and Phenobarbital. A developmental training program was instituted, and the parents began participation in a group specifically designed for the parents of brain-injured children. Over the next couple of years, the patient's progress was excellent, and his development and learning difficulties were singularly diminished. The parents were comfortable with John's progress and with their ability to manage it, so they decided to have a long-wanted additional child. In the meantime, the father's work necessitated moving to another location, leading to a change of obstetrician and pediatrician.

The second pregnancy proceeded uneventfully and eventuated in the birth of a second boy. Shortly after the mother returned home with the new infant, John began to regress, exhibiting a number of prior symptoms such as hyperactivity and distractibility, as well as problems in behavioral control. The new pediatrician referred the family to a child psychiatrist, who promptly placed John on a tranquilizer. Shortly thereafter, John's academic performance began to deteriorate dramatically, and his school counseled the parents about the possibility that he had been promoted too rapidly and "could not handle work at this grade level."

At this point, the parents again contacted this writer, primarily out of concern for John's diminished academic performance. Because it had been more than two years since John had been formally evaluated, I advised the parents that another comprehensive evaluation was indicated. The parents agreed, and a full diagnostic battery was administered to John, the results of which were then compared to his prior performance. It immediately became apparent that he was not functioning at grade level, and that the overall level of his functioning had deteriorated dramatically.

In his initial evaluation, John's functional level had been in the Bright Normal range (i.e., overall IQ of 110 to 119), whereas his current functioning placed him at the Borderline Mentally Retarded level (IQ below 60). The history revealed nothing of significance other than the behavioral regression after the birth of the sibling and the introduction of the new medication. I advised the parents that I thought the child was being erroneously medicated, with consequent diminution of his intellectual efficiency, and that the supposition could be tested by asking the attending child psychiatrist to diminish John's medication to see if the child's performance improved.

The attending child psychiatrist was quite upset by the recommendations and the implications thereof and threatened to sue me for "practicing medicine without a license." I informed the physician that I was not practicing medicine but rather neuropsychology, along with deductive reasoning known as "common sense," which we could test by appropriately reducing John's dosage level for a month and then retesting him. Faced with the alternative of a legal action for slander or libel for having accused this neuropsychologist of a felony, the child psychiatrist agreed.

Upon retesting a month later, the child's performance level had returned to Bright Normal, and his academic performance and behavior in school had improved dramatically. By this time approximately six to eight months had elapsed since the birth of the sibling, and John had become accustomed to his new brother. All concerned agreed that the medication had not been helpful and that the child should continue for another three to six months without medication. Subsequent contact with the parents some six months later indicated that John was doing well at school. The parents were quite comfortable with the behavioral management skills they had learned, which enabled them to handle a child with an underlying neurological handicap.

As noted earlier, the marked distractibility and/or hyperactivity in children with neurological involvement tends to diminish through adolescence, especially after puberty, as do many of the other symptoms. As a consequence,

these children present a very different clinical picture in adolescence and adulthood. Typically, they are characterized by impulsivity, at times poor judgment, and excessive fatigability. It is generally only under the circumstances of extreme fatigue (or other stress) that one will see fairly dramatic degrees of distractibility and hyperactivity. Thus an appropriate diagnosis leading to productive intervention is difficult to make.

Conversely, children who exhibit the symptoms of distractibility and hyperactivity on an emotional basis typically do not show the diminution of symptomatology with increasing age. In fact, the symptoms may intensify and/or be replaced by even more dramatic symptoms, especially during puberty and adolescence. It should also be emphasized that the kind of distractibility and hyperactivity exhibited by the emotionally disturbed youngster is very different in quality and quantity from that of a youngster whose hyperactivity and distractibility has a neurological basis. Unfortunately, it is also frequently the case that a youngster with a neurological handicap may have significant emotional problems overlaying the basic neurological problems, making diagnosis even more complicated. But the overriding problem confronting parents today is the misdiagnosis of emotionally-based symptoms that brings the recommendation of unwarranted medication.

In the largest study of its kind, Cummings and Wiggins retrospectively examined the records of 168,113 children and adolescents who had been referred and treated over a four-year period in a national behavioral health provider operating in thirty-nine states. Before beginning treatment, sixty-one percent of the males and twenty-three percent of the females were taking psychotropic medication for ADD/ADHD by a psychiatrist, a pediatrician, or a primary care physician. Most of them lived in a single parent home, and lacked an effective father figure or were subjected to negative and frequently abusive male role models. Behavioral interventions included a compassionate but firm male therapist and the introduction of positive male role models (e.g., fathers, Big Brothers, coaches, Sunday school teachers, etc.) into the child's life. Counseling focused on helping parents understand what constitutes the behavior of a normal boy.

After an average of nearly eleven treatments with the parent and approximately six with the child, the percentage of boys on medication was reduced from sixty-one percent to eleven percent, and the percentage of girls on medication went from twenty-three percent to two percent. These dramatic results occurred despite very strict requirements for discontinuing the medication, which seems to point to an alarming overdiagnosis and overmedication of ADD/ADHD and greater efficacy of behavioral interventions than is generally believed to be the case by the mental health community. . . .

Summary

When hyperactivity and/or distractibility is truly one of the presenting symptoms, it is indicative of a complex situation that warrants extensive and thoughtful evaluation, and, more often than not, complex and comprehensive treatment planning from the perspective of a variety of specialists.

In situations where the attention deficit and/or hyperactivity reflects problems in parenting, chemotherapeutic intervention for the child is likely to be, at best, no more than palliative and, at worse, may succeed in considerably complicating the situation. In this writer's experience, chemotherapeutic intervention for emotionally disturbed children is a last resort and of minimal value in addressing the overall problem. Psychotherapeutic intervention with the parents, which may or may not include the child, is more often than not the treatment of choice. This is a judgment that is best made only after exhaustive study by pediatrics, psychology, neurology, and perhaps, last of all, psychiatry, which so often seems all too eager to overmedicate (see chapter 6).

Where the presenting complaints of hyperactivity and distractibility are in a context of delayed development, excessive fatigability, learning deficits, and other such signs, the complexity of the diagnostic problem is substantially increased. In such circumstances, it is absolutely not in the child's best interest to limit the diagnostic evaluation to a single specialty. With the increasing evidence that neurological involvement can follow any number of prenatal and postnatal exposures, wise and caring parents will insist on a comprehensive evaluation by specialists in pediatrics, child neurology, and child neuropsychology. More often than not, if medication is indicated, it will be of a type quite different than what is used in the management of so-called ADHD.

Furthermore, treatment intervention and case management will likely involve skilled educational training of the specialized type developed for use with the brain-injured child. In the case of a friendly pediatrician, a concerned psychologist, or a caring child psychiatrist, any or all attempting unilaterally to diagnose and/or manage the treatment regimen, the concerned and caring parent is well advised to promptly seek additional opinions. . . .

CHALLENGE QUESTIONS



Is Attention Deficit Disorder (ADD/ADHD) a Legitimate Medical Condition That Affects Childhood Behavior?

- One piece of evidence commonly used to question the trend toward diagnosing ADHD for disruptive children is to note that the diagnosis occurs much more frequently in North America and among boys. If ADHD is a standard medical condition, how would you confront that evidence?
- There is no conclusive medical test for ADHD; instead it is diagnosed by the clinical judgment that sufficient criteria for the disorder are met. How might the lack of a clear diagnostic test influence this controversy?
- Are children who deviate from obedient and compliant behavioral expectations troubled or simply challenging? How much can parents, communities, teachers, and schools change the behavior of difficult children? Can people really change just by making enough effort?
- While drugs such as Ritalin do not always work, both authors would likely acknowledge that these drugs can produce dramatic behavioral changes in children. What seem to be the relative risks and benefits to using medication to modify childhood behavior?

Suggested Readings

- American Academy of Pediatrics, "Clinical Practice Guideline: Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder," *Pediatrics* (October 2001). Also at: www.aap.org/policy/s0120.html
- "An Update on Attention Deficit Disorder," *Harvard Medical Health Letter* (May, 2004). Also at: http://www.health.harvard.edu/newswave/An_update_on_attention_deficit_disorder.htm
- R. A. Barkley, "Psychosocial Treatments for Attention-Deficit/Hyperactivity Disorder in Children," *Journal of Clinical Psychiatry* (vol. 63, suppl. 12, pp. 36-43, 2002).
- A. Bowd, "'Curing' ADHD," *Skeptical Inquirer* (May/June 2006)
- D. Cohen and J. Leo, "An Update on ADHD Neuroimaging Research," *The Journal of Mind and Behavior* (Spring 2004)
- L. Diller, "Defusing the Explosive Child," *Salon* (August 18, 2001)
- D. Matthews, *Attention Deficit Disorder Sourcebook* (Omnigraphics, 2002)

