



BACK TO NORMAL

Why Ordinary Childhood Behavior
Is Mistaken for ADHD,
Bipolar Disorder, and
Autism Spectrum Disorder

ENRICO GNAULATI, PHD



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*For Janet and Marcello,
my source of real happiness*

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Introduction

This book is about the normalcy of children's seemingly abnormal behavior. Mostly, I wrote it to give parents of struggling children hope, perspective, and direction. However, I also wrote it to counteract the pervasive tendency in our society to medicalize children's behavior and to categorize an increasing array of normal childhood reactions to stressful life situations as proof positive of a psychiatric diagnosis. Critics of American society insist that we are a nation of people who overpsychologize. Yet nowadays, when it comes to understanding children's behavior, clearly we underpsychologize. We shy away from trusting our own ability to decipher the ordinary human meanings, motives, and developmental reasons for why children act the way they do. This book aims to correct this imbalance.

While working as a psychologist with children and families for the past twenty-five years, I've observed that parents are nothing short of desperate for answers that will help them to tease apart whether their kid has transitory problems or is showing signs of a diagnosable condition. The truth is, it's exceedingly difficult to distinguish between, on the one hand, things like a lag in social and emotional growth, a mismatch between where a kid is developmentally and what is expected of him or her at school, patterns of emotional reactivity in the parentchild relationship, a difficult personality trait, or a perfect storm of all of these and, on the other hand, evidence of a psychiatric condition like ADHD (attention deficit hyperactivity disorder), bipolar disorder, or autism spectrum disorder. Yet when we look at the number of kids with these disorders, we get the impression that it's exceedingly easy.

As we'll see, ADHD is thought to be as prevalent as the common cold, with 1 in 10 children meriting the diagnosis—about as many children as use cold remedies at any given time.¹ Figures out of the famed Centers for Disease Control and Prevention estimate that 1 in 54 boys and 1 in 252 girls have autism spectrum disorder,² while bipolar disorder among youth has undergone a fortyfold increase in the past decade.³ What explains these sky-high numbers?

Part of the answer lies in how similar many of the symptoms associated with these disorders are to everyday childhood behaviors. This can make the diagnostic process overly subjective and thereby slant it in the direction of doctors and therapists yielding false positives. Take attention-deficit/hyperactivity disorder. We can see shades of all children in the core symptoms of ADHD: distractibility, forgetfulness, problems with

follow-through, not listening, talking excessively, fidgetiness, and difficulty waiting one's turn. Sophisticated clinical language characterizing autism spectrum disorder, such as "deficits in social-emotional reciprocity, nonverbal communication, and developing and maintaining age-appropriate relationships," really boils down to run-of-the-mill behaviors like showing yourself to be happy when someone else is happy, keeping good eye contact, responding to your name, and finding other kids your age interesting—phenomena that toddlers, the youngsters most apt to be under the autism spectrum lens, often have difficulty mastering. Similarly, when a toddler repeats words and phrases, is entranced by stimulating objects, and has rigid food preferences, is he or she working through something developmentally or on the spectrum? The common criteria for bipolar disorder are hard to separate from evidence of a difficult adolescent passage: irritability, temper outbursts, moodiness, fluctuations in motivation, sleep irregularities, overconfidence, and a propensity to engage in risky behaviors. This is particularly true in our twenty-first-century mediasaturated culture, where ready bedroom access to screens interferes with teenagers' sleep, causing teens to be groggy and irritable, and where participation in social-network sites like Facebook almost requires them to be self-promotional.

Another part of the answer for why these disorders are massively overdiagnosed lies in how casual we have become about incorporating mental health jargon into our everyday conversations. We pin diagnoses on ourselves as if they are faddish labels or give us outlaw celebrity status. "ADHD" happens to be the name of a song by the English alternative-rock band Blood Red Shoes, and the rapper Krizz Kaliko's hit "Bipolar" can be downloaded as a cell phone ringtone. It can seem cool to be bipolar when high-roller actors like Mel Gibson and Catherine Zeta-Jones, and legendary rock stars like Axl Rose, refer to themselves that way.

Yet there are good reasons to be cautious when it comes to these diagnoses. We may be remarkably casual about tossing around mental health labels, but unfortunately, studies show that the average American still harbors negative stereotypes about kids and teens with psychiatric disorders. Large swaths of the American public still believe that a depressed teenager is a would-be violent teenager. A mental health diagnosis can also follow a kid into adulthood and potentially disqualify him or her from careers in law enforcement, the military, and other professions; make it difficult to obtain a pilot's or trucker's license; and jack up life and disability insurance rates for him or her. And, of course, an easygoing attitude toward diagnosing can pave the way for uncritical consumption of medications, minimizing the undesirable side effects that often accompany their use.

The story of how pharmaceutical companies oversell the general public on mental illness and medications to boost their profits is a story that has been told many times. However, I will retell the relevant parts of this tale, taking the reader behind the scenes to look at how pharmaceutical reps often drive doctors' diagnostic habits, what recent research shows about the effectiveness of medications routinely used with children, and the latest ideas by leading scholars that call into question brain-based and chemical-imbalance theories of behavior.

I also will tell another story, one that most parents probably haven't heard before. This story is about how doctors' and therapists' education and training primes them to think in terms of disease and disorder and often blinds them to humanistic,

developmental, and commonsense explanations for children's troubling and troublesome behavior. I am a psychologist, so telling this story has been disquieting—to say the least. When parents bring their child to me for help, I like to first consider the likelihood that the child is experiencing a stressful reaction to life events, but is otherwise normal. I am comfortable with the idea that there's great variation across children in the rate at which their social and emotional development unfolds. Sometimes a child's troubles simply mean that he or she is slow to mature in an area and will do just fine with some combination of adjustments to his or her daily environments, targeted parenting interventions, and garden-variety talk and play therapy. I like to think in terms of normal human variation, developmental glitches, and wellness. This is not to say that I don't go into high gear when, over time, after an assortment of interventions, there is unquestionable evidence that a child has a disabling psychiatric condition and needs medication and other, more rigorous interventions. Sadly, however, when it comes to children's mental health, this way of thinking is not widely shared by doctors and therapists. Often parents face overwhelming pressure to medicalize and medicate their kid's behavior from the get-go in doctors' and therapists' offices. I want parents to be aware of the larger forces influencing the field of children's mental health.

One issue I address is why boys are far more likely to be perceived as behaviorally disturbed than girls, and what parents of sons can do about it. As a father of a son, I'm particularly sensitive to this issue. I see my son and quite a few other males his age act squirrely, rough-house, shun reading, stuff homework into messy backpacks, clam up verbally unless they have a shared activity to pursue or technical topic to discuss, and be quick to react when their pride is injured. Such observations give me a firm grounding in what's normal. I'm thankful for that grounding. It has helped me to see more clearly how, as politically incorrect as it may sound, our understanding of "normal" behavior for children has become feminized. We tend to judge boys using standards of behavior applicable to the average girl, not the average boy.

Another theme that I explore is how mental health symptoms sometimes are actually ancient, innate personality traits and coping mechanisms that have helped us adapt and survive as humans for thousands of years. Despite all the pathological talk about depression and mania, children and teens are capable of experiencing "healthy depression" and "healthy mania." At manageable levels, depression and mania are time-honored human responses reflecting the brain's hardwired ways of helping us to cope with attachment and loss in relationships, as well as to energetically strive for success and greater social status. Symptoms such as anxiety, aggressiveness, and action-orientedness are personality traits that would have been highly adaptive during hunter-gatherer times, but which are a liability in today's "chalk and talk" classroom. I will share with the reader practical ways in which kids' everyday environments can be changed in order to allow them to best adapt by making positive use of such inborn personality traits.

When I set about writing this book, I knew that I wanted it to contain ample stories to which readers could relate. I wanted to describe the behavior of children who may be difficult, but who are not suffering from psychiatric disorders, in such a way that a parent could see his or her own son or daughter in them. For instance, it was paramount for me to really bring alive how ADHD symptoms often mimic normal

childhood narcissism and to provide remedies for parents dealing with their kids' challenging developmental struggles. I labored to find evocative examples of the difference between true hyperactivity and a kid's habit of seeking needed attention and recognition in frenzied ways. I strove to highlight how sometimes a pattern of failing to finish tasks has little to do with a disordered brain and more to do with a child or teen approaching tasks with "magical thinking" about what can be accomplished. Similarly, I wanted to show how forgetfulness can sometimes be nothing more than a kid's underpracticing and underpreparing because he or she is overconfident. These scenarios, I thought, would help a parent discern whether his or her own child actually was afflicted with a disorder or was stressed for other reasons.

I felt it was necessary to include longer case descriptions in order for readers to confidently grasp the finer points of children's expectable, troubling reactions given their personalities and life circumstances, as compared with signs of a true psychiatric condition such as bipolar disorder. Readers will be introduced to seventeen-year-old Brandon, whose bipolar rages are best explained in terms of the harmful ways he deals with his tendency toward shame and the emotional flooding and reactivity that flares up when he and his mother are in conflict. Readers will also meet William, who was falsely diagnosed with autism spectrum disorder at age five. His case rather dramatically shows how brainy, introverted, individualistically minded boys with a passion for ideas and strong needs for interpersonal control can get mislabeled as autistic in their younger years.

In all the case snippets and studies that I've included, I changed names and disguised factual information for confidentiality reasons. But essential phenomena, meanings, and outcomes have been preserved. At no time do I use purely fictional accounts.

I've concentrated on success stories. These are the kids in my practice who appeared to be poster children for major psychiatric disorders when I first met them, but with family lifestyle changes, parenting interventions, play and talk therapy, and the passage of time, did not merit any such diagnosis. These sorts of cases are not rare. The reader will be reassured to learn about scientific evidence showing that upwards of a third of teenagers diagnosed with bipolar disorder are no longer diagnosable as bipolar by their mid- to late twenties and that approximately one in five toddlers diagnosed with autism spectrum disorder prior to age three don't meet the diagnosis when assessed a few years later. A National Institute of Mental Health study even shows that three-quarters of ADHD children outgrow their condition by the time they reach their midtwenties.

Lastly, at the end of the book, in a nonblaming, reasonable, highly practical way, I lay out dozens of strategies, tips, and lifestyle changes that parents can utilize to foster self-discipline, even-temperedness, and greater social competence in their kids. Guidelines are included for when to consider pursuing outside professional help and what to look for in a therapist.

My guess is that you picked up this book because you sympathize with the notion that as a society we have become too casual medicalizing and abnormalizing children's behavior. Chances are you eagerly wish to build your knowledge base of commonsense psychological and developmental explanations for children's emotional issues. Maybe you're a parent who is perplexed and exasperated by your child's

wayward behavior. You urgently desire a deeper understanding of why your child behaves in a maddening way and what can be done about it. You want your child diagnosed with a psychiatric disorder only if he or she really has one. If you are aided by my book, the countless hours I have spent poring over research literature and magazine articles, reflecting on my work with clients, and taking solo writing trips on retreat in the desert at Joshua Tree, California, will have been well worth it.

Mad Science and Mad Medicine

Back in 1985, I was a lowly mental health intern at a community clinic in Seattle, Washington, when I experienced my first rude awakening about my chosen profession. I was on a crisis-intervention team. Most of the clients I was responsible for were severely mentally ill. George, a homeless eighteen-year-old young man, was no exception. On the dreary Seattle day on which I met with him, there was fire in his eyes. He told me with conviction that the KGB was plotting against him. He was being followed and harassed. The KGB had implanted a transistor in his teeth and was constantly monitoring his whereabouts. Disturbingly, George was even convinced that the KGB was determined to rape him. Weeks earlier, he had traveled across the Canadian border into British Columbia to escape KGB agents who were close on his tracks. But he returned, believing it would be harder for KGB agents to operate in the United States, given President Reagan's tough stance against the Soviet Union.

I did what most caring interns would do. I listened intently. I tried not to appear rattled. Most of all, I focused on winning George's trust so that he would agree to be hospitalized. On that score, I was successful. George voluntarily agreed to go to the local psychiatric ward at the University of Washington Medical Center.

Several days later, I put in a follow-up call to one of the psychiatric nurses at the hospital and asked how George was faring. I was dumbfounded to learn that his condition had worsened. He was in a fullblown catatonic state, refusing to talk, eat, or bathe. The medications he had been given seemed to be having no impact.

I asked the nurse to walk me through George's hospital-intake process. She told me that he had undergone a standard physical exam, which had been more invasive than usual because of the sores and scabs that had accumulated on George's body. She mentioned in passing that George required a rectal exam because his lack of hygiene had caused infections in that region of his body. Later, I asked the nurse for the name of his internist. It turns out that the doctor had an Eastern European name and a thick accent. It suddenly occurred to me that, in a sense, George's paranoid delusion had come true: he had been invasively probed by a foreign agent. It then made sense to me why George's condition had worsened.

George's case is a rather extreme and dramatic example of the blind spots and failures of common sense that can occur in the practice of mental health, particularly when a practitioner views a client as the embodiment of a diagnosis or the victim of a

disordered brain and unquestioningly follows some treatment protocol. When the interaction is medicalized in this way, the practitioner can see it as essentially irrelevant to understand *why* a client acts the way he or she does.

Mental health professionals are often prone to look at kids' problem behaviors as something to be medicated, controlled, or changed. Yet problem behaviors always communicate something. If we fail to take the time to conscientiously explore what purposes or functions a behavior holds for a child, we may miss an opportunity for imparting genuine and lasting change.

The standard approach to hyperactivity, for example, explains it solely as the mere outcropping of a child's disordered neurophysiology. You would no more try to understand what purposes it serves a kid to be hyperactive than you would try to understand what purposes it serves a kid to have an elevated blood-sugar level. There are those kids whose hyperactivity is rooted in their compromised brain development. Arguably, for these individuals, medication and behavioral control are necessary and humane interventions. Yet most kids whose behavior is hyperactive exhibit such behavior for a cluster of reasons. Maybe it's because they have learned that their exhibits of hyperactivity will mean that an otherwise preoccupied and randomly available, though loving, parent will finally take notice. Maybe it's also their way of communicating that the sedentary demands of home and school life leave them desperately needing more kinetically mobile play experiences. Maybe it's because they have a flare for the dramatic and tend to be showy and loud when they have a strong desire to be recognized for demonstrating a skill or ability. To be of assistance in any thoughtful way, we have to understand the multiple meanings of what a child is trying to communicate through his or her hyperactivity.

Also, context is everything when trying to understand behavior. If we view a child's behavior as a symptom to be checked off and do not inquire about the everyday conditions under which it occurs, we can get a skewed picture of that child's functioning.

For example, the rages my ten-year-old client Cynthia has when at home are profound and may even seem bipolar. At least four or five times a month, Cynthia becomes unmanageably agitated for periods of up to half an hour. On the surface, she is set off by things like being forced to wear a floral dress or to attend an obligatory church event. In such instances, she screams at the top of her lungs, paces, and believes others have it in for her. Awkward, benign smiles by family members in these moments can leave Cynthia feeling mocked and ridiculed. She shrieks out threats to harm them if they do not stop laughing at her. Family members then try to appear sincere and somber. Nevertheless, Cynthia still believes they are mocking her.

Yet Cynthia is a straight-A student. She has never once lost her temper at school in a way that would elicit concern on the part of her teachers. She is high-strung and bossy with her friends, but she has never emotionally lashed out at them. Why does Cynthia rage in some contexts, but not in others? In my intensive parenting work with Cynthia's mother, we discovered some key contextual understandings: Cynthia is more likely to explode when she is suddenly expected to stop an enjoyable activity without being forewarned and to comply with a demand that she perceives to be highly undesirable. When Cynthia's mother "goes on the counterattack," Cynthia's episodes are more severe and prolonged. When Cynthia's mother is able to "get in empathy

mode” or “play amateur psychologist” and softly mirror back what Cynthia is feeling and why, there’s a better chance that the episode will be defused. Without these contextual understandings, it would be hard to imagine how to effectively handle the situation in a worthwhile way.

The public generally assumes that mental health professionals are trained to be interpersonally sensitive, to query with the right kind of questions so as to get at deeper meanings regarding kids’ behavior, to always put behavior in context, to distinguish between normal and abnormal behavior in kids, to be well informed about kids’ social and emotional development, and to diligently include parents in child therapy. As surprising as it may seem, these are skills and types of knowledge bases that are not typically emphasized in medical or graduate school.

TRAINED PROFESSIONALS KNOW BEST, OR DO THEY?

A pediatrician is the professional who is most likely to be consulted when a child is suspected of having ADHD. While teachers often are the first to suggest to the parents of a child that the child should be assessed, a pediatrician is commonly sought out for a formal judgment. While many pediatricians are adequately educated and trained to assess and treat ADHD, this is more the exception than the rule. How many physicians who actually call themselves pediatricians have specialized training in pediatric medicine and/or pediatric mental health?

Several years ago, Gary L. Freed, MD, chief of the Division of General Pediatrics at the University of Michigan, initiated a survey of physicians listed as pediatricians on state licensure files in eight states across the United States: Ohio, Wisconsin, Texas, Mississippi, Massachusetts, Maryland, Oregon, and Arizona.¹ According to the survey, 39 percent of state-identified pediatricians hadn’t completed a residency in pediatrics. And even for those who had, their training in pediatric mental health was minimal. Currently, the American Academy of Pediatrics (AAP) estimates that less than a quarter of pediatricians around the country have specialized training in child mental health beyond what they receive in a general pediatric residency. The latest data examining pediatricians who have launched themselves into practice reveals that 62 percent of them feel that mental health issues were not adequately covered in medical school.² Nevertheless, this lack of training doesn’t seem to discourage them from identifying ADHD. Survey data publicized by the AAP indicate that upwards of 90 percent of pediatricians feel qualified to evaluate ADHD.³

Moreover, the average length of a visit with a pediatrician is sixteen minutes.⁴ This small allotment of time surely precludes much, if any, deeper discussion of a child’s worrisome behavior to make sure that any diagnosis arrived at actually applies.

These days the typical child psychiatrist is not trained to observe, listen to, and think deeply about a kid’s behavior. In the 1960s and ’70s, learning how to do psychotherapy was a core requirement for psychiatrists. Current numbers out of Columbia University suggest that only one in ten psychiatrists provide psychotherapy to all of their clients.⁵ A 2005 report that looked at the attitudes toward psychotherapy training of psychiatry residents in seventy programs across the country produced an unflattering statistic.⁶ Forty-three percent of those surveyed believed that learning how

to do psychotherapy in medical school was somewhat of a burden. The majority of chief residents in this same survey indicated that trainees saw an average of one to four clients, taking up six hours of their time a week—hardly intensive training by any standard. Daniel Carlat, MD, whose book *Unhinged: The Trouble with Psychiatry—A Doctor’s Revelations about a Profession in Crisis* brought him national acclaim when it was released in 2010, summarizes the situation: “As psychiatrists have become enthralled with diagnosis and medication, we have given up the essence of our profession—understanding the mind. We have become obsessed with psychopharmacology and its endless process of tinkering with medications, adjusting dosages, and piling on more medications to treat the side effects of the drugs we started with.”⁷

Insurance reimbursement systems are set up to reward psychiatrists for performing medication evaluations and engaging in brief check-ins instead of time-consuming psychotherapy. The “fifteen-minute med check” is standard in the field. A psychiatrist can pack in four such med checks in the hour it takes to see one psychotherapy client; it is the more lucrative course of action. If a family finds its way to a psychiatrist, it is almost guaranteed these days that the discussion will center on symptom patterns, possible diagnoses, and available medications.

This brings me to my own cherished profession—psychology. The general public often is unable to define the difference between a psychiatrist and a psychologist. Both are doctors. However, psychiatrists attend medical school and have MDs. They learn mostly about anatomy and physiology. Psychologists attend graduate school and have PhDs or PsyDs. They take courses in such subjects as abnormal psychology and psychological assessment. They learn advanced statistics and research methods. In addition to taking these courses, psychologists obtain training in how to do psychotherapy. When they are finished with graduate school, psychologists are supposed to become what is called in the profession “scientist-practitioners.”

In reality, most psychologists come out of graduate school heavy on the “scientist” end and weak on the “practitioner” end, because most psychologists are, ironically, trained to practice like scientists. The current generation of psychologists are being encouraged to utilize only what are called “evidence-based treatments.” These are interventions university-based academic psychologists have found to be effective in controlled studies. Psychologists are supposed to refer to manuals to select specific actions to take to address a client’s presenting problem or diagnosis. Dr. Catherine Lee, a professor in the clinical psychology department at the University of Ottawa, captures the fervor with which new psychologists are expected to embrace this new approach: “If students are to master evidence-based practice, then they need not only to be convinced of its benefits, they must also learn how to do it. This involves competencies in critical thinking and effective research skills, as well as relationship competencies that are informed by detailed guidance from treatment manuals.”⁸

This is far from a humanistic way of approaching human problems. Scripts for interacting with clients are the new norm—scripts that rely on manuals and research protocols. Graduate schools of psychology are generally not in the business of promoting skills and processes like “clinical intuition” or “personal insights that might have relevance to understanding the human condition.” Trainee psychologists are not encouraged to integrate “book knowledge” with “personal knowledge”—to integrate

clinical concepts with insights derived from their own psychotherapy and life experiences, and to use their own subjective thoughts and feelings when they are with clients to arrive at clinical judgments.

Yet personal perceptions of a client, when sensitively utilized, can make or break an accurate clinical judgment. This happened in four-year-old Juan's case. I was consulted for a second opinion after an extensive evaluation at the University of California at Los Angeles Neuropsychiatric Institute concluded that Juan was autistic. All the prescribed evidence-based assessment measures and procedures had been used. Yet within two minutes of meeting Juan, I knew that he was not autistic. Sitting on the floor in front of a toy castle in my office, I motioned for him to join me as I picked up a plastic figure of a knight mounted on a horse. "Oh dear," I said. "I think little blue knight's horsey has to go poo-poo." Juan smiled. I smiled more vibrantly. We shared prolonged eye contact. I became more exuberant: "Oh *dear* . . . I think little blue knight's horsey is going to make a big . . . *big* . . . poopoo." Juan smiled more broadly. I then made a huge raspberry noise simulating loud defecation. Juan and I laughed hysterically together. In my mind, the degree of emotional synchrony we experienced at that moment automatically ruled out anything on the order of autism.

What does survey data tell us about the current training of child psychologists? A 2010 study out of the University of Hartford in Connecticut provides such a snapshot.⁹ The authors found the results encouraging. This was somewhat mystifying to me. Poring over their numbers, I discovered that 45 percent of graduate students in child psychology had either no exposure to, or had just an introductory-level exposure to, coursework in child/adolescent life-span development. It is in these college classes that students learn about what is developmentally normal to expect in children. Fifty-two percent of would-be child psychologists had either no exposure to, or had just introductory-level exposure to, conducting parenting interventions. Almost 60 percent of them had no exposure to, or had just introductory-level exposure to, social issues affecting children, adolescents, and their families. What the authors seemed to base their encouraging words on was the 72 percent of would-be child psychologists who were receiving a great deal of experience and expertise in learning about evidence-based interventions.

What I derive from this study is that a sizable percentage of newly minted child psychologists have questionable preparation in knowing what types of behavior in kids are developmentally expectable. They may be more apt to practice therapy with a child one-on-one and be at a loss to know how to involve parents in any intensive way. They may be devoid of a larger cultural lens that enables them to see "big picture" issues, thereby throwing contemporary kids' behavior into perspective. "Big picture" issues might include the changing nature of children's play in American society or how monitoring kids' video-gaming habits has added a new wrinkle to the parent-child relationship over the past several decades. Perhaps the most striking takeaway from this study is that myriad would-be child psychologists leave graduate school with a scientific and conceptual knowledge of kids' behavior. But a more humanistic, experiential, individualized approach is required to reach, comprehend, and help kids.

MEASURING, OR MISMEASURING, KIDS' BEHAVIOR?

For child psychologists, behavior-rating forms filled out by parents and teachers are tools of the trade. They are as much a key part of the child psychologist's assessment storehouse as the thermometer is for the family physician. There are a plethora of them. But they all more or less follow the same format. Parents or teachers are asked to select which of the terms "never," "sometimes," "often," or "always" applies to a given statement describing a child's behavior. The statements are typically concise, such as: "has a short attention span" or "follows directions easily." The responses are then counted and can be computer scored. Profile scores and graphs are obtained indicating whether the evaluated child scores at the clinically significant range, compared to his or her same-age peers, on general mental health categories such as hyperactivity, anxiety, and depression. There is a scientific veneer to the process and to the final product. Nevertheless, as we shall see, a behavior checklist is not an objective instrument in the way that a thermometer is an objective instrument, and measuring behavior is not like measuring body temperature.

In twenty years of practice using behavior checklists, I am often astonished by the radically different readouts parents and teachers provide on the same child. Of the hundreds of ADHD assessments I have conducted that have included behavior-checklist data, parents and teachers agree on a clear-cut perception of the child as ADHD at best a third of the time. My experiences tend to align with what researchers have noticed. A well-designed 2000 study that looked at fifty-five kids who had been accurately diagnosed with ADHD combined type (symptoms of hyperactivity and inattention) found that teachers and parents agreed in a meager seventeen cases.¹⁰ Likewise, Dr. Desiree Murray at Duke University Medical Center and a host of colleagues from prestigious institutions around the country in 2007 compared the ratings of parents and preschool teachers and discovered they jointly agreed upon ADHD in approximately one in four cases.¹¹

Indeed, one of the most robust findings in social science research is the lack of agreement between parents and teachers when they are rating children's behavior. There are many explanations for this divergence. A kid's behavior in the context of a classroom is generally different than in the context of a home. Teachers are required to run classrooms. They may be biased in the direction of overrating behaviors by students that cause social disruption—like being uncooperative or talking out of turn. At the same time, they may underrate behavior that is linked to a child's internalizing psychic pain. The moderately depressed teenager who sits at the back of the class but who has a clean attendance sheet, completes homework, and obtains above-average grades is less likely to show up on a teacher's problem-child radar. However, that same teenager's mother or father may be acutely aware of the pain that their child is experiencing.

Of course, parents and teachers are human. Their ratings of a kid's behavior will always to some degree reflect their own value systems, tolerance levels, and cultural sensitivities.

Given the starkly different ratings that parents and teachers often provide, experts caution against using only one source when evaluating a child. The multi-university research team headed by Dr. Murray was emphatic on this point: "Obtaining ratings from multiple informants is . . . critical for obtaining a full picture of a young child's functioning." This also is one of the "best practices" included in the American

Academy of Pediatrics' guidelines for evaluating ADHD. It also is a safeguard against ADHD being overdiagnosed. When the two-informant requirement is strictly adhered to when diagnosing ADHD, studies show that the number of true cases of ADHD shrinks considerably—by up to 40 percent.¹²

How often is the mandate to obtain ratings from multiple informants followed by pediatricians? A study published in a 2005 edition of the journal *Pediatrics* found that only 20 to 30 percent of pediatricians gathered behavior ratings from multiple sources when assessing for the presence of ADHD.¹³ An earlier 2002 survey in the *School Psychology Review* brought to light that a mere 12 percent of pediatricians obtain information on a kid's classroom behavior when conducting ADHD assessments.¹⁴ These findings are quite disturbing for one important reason. In order for ADHD to even be officially diagnosed according to the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the handbook relied on by clinicians to arrive at a diagnosis, the symptoms have to be remarkable across two settings—usually home and school. Not obtaining information from teachers as well as parents should foreclose any reasonable judgment about ADHD.

Controversy surrounds another popular assessment instrument used with kids—the continuous-performance test. What makes this type of test appear scientific is that devices and computer screens are involved. The Conners' Continuous Performance Test (CPT) and the Test of Variables of Attention (TOVA) are the two most widely used. The basic testing principle is the same. Kids are told that a series of numbers or symbols will flow across a screen. They are instructed to press a button or click a computer mouse only when they see the target symbol or number—ignoring everything else. Scores are then generated for factors like “correct detection,” or the number of times a kid accurately responded to the appropriate stimulus. “Omission error rates” are computed. These pertain to the number of times a kid failed to press a button or click a mouse when the appropriate stimulus passed along the screen. “Commission errors” refer to times when the kid pressed a button or clicked a mouse when the appropriate stimulus was not visible. The end product is a computer printout of these detection and omission/commission error rates. A chart is produced indicating where a kid falls relative to same-age peers. If the kid places above cutoff scores, he or she is considered to have clinical problems with attention and concentration.

Many psychologists and educational consultants reap the financial benefits of adding a continuous-performance test to their assessment battery. These tests add upwards of \$500 to the cost of an evaluation. Yet there is no sizable body of evidence that confirms that they are any more accurate in detecting ADHD than behavior rating scales, which are a fraction of the cost to administer and score. In fact, a team of investigators from universities across the United Kingdom in 2009 revealed that teacher ratings of kids' classroom behavior on three different questionnaires accurately detected true cases of ADHD, while scores on the CPT did not.¹⁵

Wouldn't the level of fatigue a child experiences affect continuous-performance test scores? Isn't a tired kid a less mentally vigilant kid? Dr. Renee Lajiness-O'Neill from Eastern Michigan University hoped to answer this question a few years ago when she oversaw a study of twenty-five young adult males and females undergoing rigorous assessment for signs of ADHD.¹⁶ Each of the recruits was administered the

CPT before and after a battery of tests. It was brought to light that CPT scores were more likely to be in the ADHD range on the rerun of the test. It turns out that the sequence of when a CPT is administered relative to other tests during an assessment can have a bearing on whether a person gets diagnosed with ADHD.

I have always resisted using a computer performance test. I could never wrap my mind around how a child's ability to accurately respond to symbols floating by on a screen generalizes to everyday life challenges. When a child has difficulties with attention and concentration, this usually occurs in the context of a human interaction or in the context of a learning situation that involves reading, writing, or performing math calculations. Observing and gathering information on how attentive and mindful kids are in these everyday situations has always seemed to me to be the main data bank on which to rely.

DRUG COMPANIES AND MARKETING REPS CALLING THE SHOTS

On December 13, 2006, paramedics arrived at the Plymouth County, Massachusetts, home of four-year-old Rebecca Riley only to find her slumped over on her parents' bed, dead. The medical examiner on hand identified the cause of death as heart and lung failure brought about by the medications she was on. Rebecca was being prescribed Depakote, Seroquel, and Clonidine by Dr. Kayoko Kifuji, a Tufts–New England Medical Center child psychiatrist. She had diagnosed Rebecca with ADHD and bipolar disorder when she was two years old. Rebecca's death provoked a national debate on how a child as young as two could ever be diagnosed with major mental illnesses and be put on powerful tranquilizers. Katie Couric eventually covered the story in a *CBS 60 Minutes* segment.

Ultimately, Rebecca's parents were tried for and convicted of murder due to allegedly overdosing her. But this harrowing outcome didn't take the national spotlight off the shocking revelation that a toddler could be diagnosed with mental illness and put on not just one but three powerful tranquilizers. None of the drugs Rebecca was prescribed was approved by the Food and Drug Administration for use with kids her age—not then and not now. There was absolutely no robust scientific justification for Dr. Kifuji making the medication choices that she made. How could a reputable psychiatrist be so inclined to diagnose a child so young with diagnoses so severe and treat with medications so unapproved? The main answer lies with the spectacular success of twenty-first-century pharmaceutical marketing of psychiatric drugs.

In 2008, psychiatric drugs sold in the United States netted their makers \$40.3 billion.¹⁷ A good portion of that amount involved drugs commonly prescribed to kids. A *Wall Street Journal* report indicates that between 2002 and 2007, prescriptions for psychiatric drugs for kids rose by nearly 45 percent.¹⁸ The most recent estimates suggest that up to eight million American kids are on one or more psychiatric medications.¹⁹ Meds for kids are big business and highly profitable. Prices of ADHD meds at the middle dose for ninety pills on Drugstore.com in 2011 were Concerta, \$540; Vyvanse, \$532; Intuniv, \$500; Adderall, \$278; and Ritalin, \$191. The price of the most common antidepressants, like Prozac, Celexa, Lexapro, Zoloft, Cymbalta, and Wellbutrin, for ninety pills, was around \$380. Two of the drugs prescribed to

Rebecca Riley by Dr. Kifuji happen to be quite pricey. [Drugstore.com](#) rates in 2011 for 180 500 mg tablets of Seroquel were \$1,048 and for Depakote, \$708.

Among drug reps, it is common knowledge that kids are a lucrative market. At the urging of doctors, parents, and teachers, kids are required to buck up and take their meds. In the words of Gwen Olsen, who worked for fifteen years as a drug rep with such pharmaceutical-industry mainstays as Johnson & Johnson and Bristol-Myers Squibb: “Children are known to be compliant patients and that makes them a highly desirable market for drugs, especially when it pertains to large-profit-margin psychiatric drugs, which can be wrought with non-compliance because of their horrendous side-effect profiles.”²⁰

Most large-profit-margin psychiatric drugs are approved by the FDA strictly for use with adults, not kids. However, doctors are allowed to use their discretion and prescribe them to kids for “off-label” purposes. Doctors can use their medical instincts to determine whether a drug approved for adults might also ease the suffering of kids. But there is no scientific backing for such use. The studies haven’t been conducted. The FDA approval hasn’t been obtained. Off-label prescribing relies on doctors’ instincts alone. While drug manufacturers and their marketing staff are bound by law not to influence doctors’ off-label prescribing habits, it’s not the law that’s foremost on the minds of drug reps fanning out to doctors’ offices all over the country. It’s upping sales.

The right to use adult meds with kids for off-label purposes has left many physicians easy prey to drug reps and pharmaceutical companies’ marketing ploys. A glaring example of this was uncovered in the largest health-care fraud case ever handled by the US Department of Justice, in 2009.²¹ Pfizer agreed to a \$2.3 billion settlement for promoting offlabel use of a variety of drugs, one of which was the antipsychotic medication Geodon. One of Pfizer’s illegal actions was paying 250 child psychiatrists to promote its off-label use with teens. Dr. Neil Kaye, for example, was paid \$4,000 a day in speaker’s fees to give speeches to other physicians with titles like, “the off-label use of Geodon in Adolescents.”²² Geodon happens to be a highly expensive and highly profitable drug. At [Drugstore.com](#) in 2011, it cost \$1,400 for 180 40 mg capsules. It currently nets Pfizer \$1 billion a year.²³

At the time of Rebecca Riley’s death in 2006, the number of drug reps in the United States was at an all-time high: 102,000.²⁴ It was the heyday of doctor-seducing, trinket-driven psychiatric medicine. Carl Elliott, in his shrewd article in the *Atlantic* that year, titled “The Drug Pushers,” spoke of drug reps ponying up sports tickets for doctors, televisions for their waiting rooms, and expensive tropical vacations. One drug rep revealed to Elliott that he constructed a makeshift putting green in a hospital and gave away a putter to any doctor who got a hole in one.²⁵

Of course, doctors deny that their diagnostic decisions and medication-prescribing practices are swayed by drug reps’ sales pitches, promises of lunches and gifts, or provision of free samples of the medications the drug rep is promoting. But the research doesn’t back them up. Many doctors who take free samples of drugs are far more likely to later prescribe that drug, even when cheaper and equally effective drugs are on the market. One study that pored over psychiatry residents’ chart notes found a high correlation between drug reps’ sales visits and new prescribing habits involving

the drug promoted.²⁶ The turnaround time in switching over to prescribing the freshly promoted medication was fast—within twelve weeks. An often-cited 2001 survey shows that 61 percent of doctors believe interactions with a drug rep have no influence on their medical decisions. Yet only 16 percent of them believe this is true of other doctors.²⁷

A surprisingly high number of doctors actually rely on information drug reps provide to keep up with what is supposedly cutting-edge in the world of pharmaceuticals. Several years ago, a Kaiser Foundation poll of 2,608 doctors indicated that 75 percent of them found the information supplied by drug reps “very useful” or “somewhat useful.”²⁸ More often than we’d like to think, drug reps are quasi-medical advisors. It’s somehow overlooked that they’re selling a product and that the information they provide to doctors detailing how their new medication might help certain patients with certain emotional problems, better than the alternatives on the market, is potentially biased. After all, they’re trying to make a sale.

The conflict of interest inherent in drug reps supposedly providing objective information about the uses and effectiveness of medications, yet upping the sales of their own, mirrors what exists in the entire field of psychiatric-medication research. Take the case of Dr. Joseph Biederman. He has the honor of being chief of the Clinical and Research Programs in Pediatric Psychopharmacology and Adult ADHD at the Massachusetts General Hospital, the teaching hospital of Harvard University. Dr. Biederman’s work is responsible for loosening our understanding of how manic-like behavior should be thought of in kids. Historically, manic behavior has been considered rare, especially in kids. When psychologists like me see it in a person, it can be identified right away. The manic person hasn’t slept for days, believes he or she has inexhaustible energy and superhuman abilities, and, most prominently of all, talks a blue streak. Dr. Biederman redefined manic behavior in kids in terms of irritability, severe tantrums, and rapid mood swings. His work burst the doors wide open. This looser definition of manic-like behavior heralded a fortyfold increase in the diagnosis of bipolar disorder in youngsters, based on the latest data set we have.²⁹

In a Senate hearing in 2008, it was revealed that Dr. Biederman had received \$1.6 million in speaking and consulting fees from many of the pharmaceutical-industry giants manufacturing antipsychotic medications for use with children thought to have bipolar disorder.³⁰ It turns out that Dr. Biederman was on the payroll at AstraZeneca, the makers of Seroquel, which is among the most frequently prescribed drugs for bipolar disorder with kids today and one of the medications prescribed by Dr. Kifuji to Rebecca Riley back in 2006.

Dr. Biederman’s case is just one example of the industry norm. Large pharmaceutical companies commonly fund psychiatric-research programs. Because of this, there is an inherent potential for biased reporting or for researchers to strictly report favorable findings on the medications they are funded to study. Results that are successful get published and end up on glossy brochures in doctors’ offices. Results that are unsuccessful don’t get published and are filed away in the basement. The Medical Products Agency in Sweden estimates that as many as 40 percent of clinical studies of antidepressants don’t get published or publicized.³¹ Before approving a drug, the FDA does, however, require a pharmaceutical company to release the results