Is ADHD Overdiagnosed?
Guest: Enrico Gnaulati
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***Enrico Gnaulati is a clinical psychologist with over 25 years of experience providing psychotherapy to children and families. His book is called* Back to Normal: Why Ordinary Childhood Behavior Is Mistaken for ADHD, Bipolar Disorder, and Autism Spectrum Disorder.**

WOODS: Let's start off with ADHD, one of the disorders discussed in your book. Now you don't claim that ADHD is a made-up disorder that doesn't really exist. It does exist, so can you tell us first of all what it is, what a genuine case of it would consist of?

GNAULATI: It's a good way to start because, yes, I'm not a romanticist or a polemicist who wants to throw out this diagnosis. In my estimation, true ADHD has to do with the functional levels of impulse control. To wait your turn, being able to follow directions, stay in your area, just stay calm in your body to the point where you can pay attention for expectable periods of time in the classroom, for instance.

If you're motorically driven, where you're just constantly moving around and constantly on the move, where it's just disruptive to you and everybody around you, and it's resulting in real problems in a child's life—in other words, it makes them extraordinarily hard to parent and extraordinarily hard to educate—that's kind of, in everyday language, how I would define ADHD.

WOODS: Now we've seen an explosion in the number of cases, as you point out in the book. You say that in a typical American classroom there are nearly as many diagnosable cases of ADHD as there are of the common cold. So given that we've seen this extraordinary number of cases, is this in your judgment a reflection of the fact that there simply are more people who have ADHD, or is it the diagnosis itself that has exploded? Are people being overdiagnosed, and if so, why?

GNAULATI: I would say that, yes, it's being massively overdiagnosed. In the past ten years there's been a 41 percent increase. Actually, a little known statistic is a very revealing one: in the wake of the No Child Left Behind Act, the implementation of it in approximately 2001, within four years there was a 22 percent increase in the number of cases of ADHD throughout the country. And so partly it's the reason it's being overdiagnosed.

And I would say, just parenthetically, it is being overdiagnosed because we know from an NIMH study that 75 percent of kids who are diagnosed with ADHD no longer meet the criteria by the time they hit their mid-20s. ADHD, in my estimation, is probably a lifelong debilitating condition that you don't just somehow or other shed in your mid-20s. So my argument would be that it's being massively overdiagnosed partly because of new educational demands being placed on children in the school systems at younger and younger ages. And it's the children on the younger end who are the most vulnerable to being inappropriately diagnosed.

WOODS: So do you think it's a case of kids being asked to do things that correspond more to more mature years; and some kids just don't want to do these sorts of things? It doesn't correspond to normal childhood activity and so the response looks to the superficial observer like ADHD.

GNAULATI: I think that's partly true. And I would say though, Tom, it's not because kids don't want to meet the expectations that are being placed on them in the classroom. It's because it's developmentally out of reach to them.

WOODS: Okay.

GNAULATI: They can't do them. In kindergarten, for instance, you're looking at a situation right now where there's one study that I address in my book *Back to Normal* that shows that probably upwards of a million kindergarteners have been inappropriately diagnosed with ADHD just as a function of their being on the younger end of the classroom, and the inappropriateness of the academic demands being placed upon them. And so there's good scientific evidence out there right now to call attention to this phenomenon.

WOODS: Now, what are the real dangers of an improper diagnosis? I mean, okay, so you get the wrong diagnosis. Well, probably people get the wrong diagnosis about a lot of things. What's especially problematic about being improperly named as somebody who is suffering from ADHD? Is it because now you'll be put on a medical regimen that's inappropriate for you? What are the problems?

GNAULATI: Well, that's one of them. Especially with a diagnosis like ADHD, where oftentimes the diagnosis and the medication are sort of hand-in-glove. Now one of the downsides to that, or one of the risks to being inappropriately assigned a diagnosis of ADHD, would be that that child then has to suffer unpleasant side effects possibly. And with ADHD meds, more often than not there are unpleasant side effects.

The most robust study that exists out there, the multimodal treatment study on ADHD, is a long longitudinal study. The eight-year mark has found that medicated ADHD children, for instance, are two centimeters shorter and 2.7 kilograms lighter than children who are not medicated. So there can be growth issues with these meds. There's another study I look at in *Back to Normal* that shows that medicated ADHD children get about an hour's less sleep a night on average. There have also been heart irregularities associated with these meds. So there's the inappropriate taking of medication and the side effects that go along with that.

There's also, with a diagnosis like ADHD—it can, over time, if it's inappropriately applied and the child and everybody in the child's life believes that it's actually an appropriate diagnosis—oftentimes what happens is there's a self-fulfilling prophecy, the children learn to believe that they're incapable of certain things: finishing tasks, being organized, getting places on time, and so on and so forth. They think that they have a brand that disallows them to take responsibility or disallows them to develop capacity to just perform and complete everyday childhood tasks. That's another downside.

And then finally I'll end with this thought: there's a study that shows that about a third of Americans currently think that an ADHD child is a dangerous child. So, still in our culture, even though we're very casual and folksy about talking about ADHD, bipolar disorder, and autism spectrum disorder in children, publicly we're very casual and folksy and bracing in the way we talk about it, but for any mental disorder that's assigned to children privately, the average American thinks that that child is a dangerous child whatever mental disorder applies. There's still strong stigmas attached to these disorders in our country.

WOODS: Right, so it's a difficult burden to carry around with you, especially when, as you say, it can become a self-fulfilling prophecy, and then you're somebody everybody wants to encourage their own kids to avoid. And then it snowballs, I would think.

GNAULATI: There you go.

WOODS: At one point you talk about childhood narcissism, and you say that this is a phenomenon that can account for some of the symptoms that we wrongly diagnose as ADHD. So what is childhood narcissism, for the layman?

GNAULATI: Good point, and in my book I really break it down. For instance, there are many kids who are just overconfident, who believe that they should just know things without having to learn them. They have a big belief in themselves and their own ability that doesn't square with reality. And that's a normal, to varying degrees, childhood tendency. I would say narcissistic tendency.

But to the extent that that overconfidence is sort of conditioned by the important adults in a child's life, that could lead to a child being so overconfident that they under-plan, under-prepare, under-practice. They just think that they should be capable of achieving certain goals; and so their performance breaks down in school. They don't memorize things that need to be memorized, so they become forgetful. They don't rehearse what needs to be rehearsed in their head because they're overconfident, so they become forgetful. And so that would be one normal childhood narcissistic phenomenon that can mimic an ADHD symptom—some of the forgetfulness and academic underachievements.

But it's also really hard to differentiate, I think, between true high productivity and a child just having narcissistic needs to be in the spotlight. Where they're always willing to call attention to themselves because they're used to getting either too little attention at home, like they're under-indulged or over-indulged at home. Too much attention. So much so that their own childhood narcissistic needs to be heard and seen and appreciated get acted out in the classroom, where they over-talk or they brag, they boast. They may even act out because negative attention is better than no attention at all, for narcissistic reasons, not for ADHD reasons.

So these are a couple of narcissistic phenomena that sort of mimic ADHD symptoms; but I really break that down in my book in ways that would help the average parent or teacher tease apart what is just childhood narcissism versus evidence of a disorder like ADHD.

WOODS: That brings up a good question. You do have a chapter specifically for parents here – the whole book is in some way for parents.

GNAULATI: Yeah.

WOODS: But what do you advise a parent to do who gets a diagnosis of – you cover several disorders, we'll try and get to the others in a minute – ADHD for a child? What's the next step? Is it a second opinion? Is it trying to diagnose the child yourself, which seems kind of difficult? What should the parent do?

GNAULATI: First, in terms of trying to figure out if the diagnosis is accurate or not—you know, the ambiguity comes into play in the mild cases. And I think that's the problem in our culture right now. It's mild cases that are getting diagnosed more and more; and the line between a mild case of ADHD and a struggling child or a slow-to-mature child or a child under transitory stress, is a really thin one.

So I would advise parents first off: if a child is ADHD-like at home but not school or at school and not home then the diagnosis probably doesn't apply. So, in other words, it would have to be with these sorts of ADHD-like symptoms that are occurring pretty much everywhere in a child's life and getting them into trouble that are making them difficult to parent, difficult to educate. And therefore, if that's the case, then there is not a whole lot of ambiguity, and a parent can enter the mental health system in the school system thinking, "Maybe my child does have this thing called ADHD, and I need to be open to the kind of interventions that work with that." But if it's a child who sort of goes through phases like in one teacher's class they interrupt, they're squirmy, they get in trouble, they underachieve, they act out—but in a different class the teachers are reporting none of that or very little of that—then we're talking about something other than ADHD. Then the door opens to all sorts of other childhood phenomena that I address in my book that could better explain these tendencies.

WOODS: Now when you make these claims about overdiagnosis of ADHD, I think you have a lot of support among the general public. I think the general public often is cynical about the whole phenomenon of ADHD because they feel it's being overdiagnosed.
But in your book you go on to talk about bipolar disorder and also autism, where I think people might be less likely to say that there's overdiagnosis going on. Now where would be the fun if we only dealt with the low-hanging fruit? So let's talk about autism. So again, just for the layman: we sort of know autism when we see it, but how does a professional know autism?

GNAULATI: Well, that actually is a more difficult question to answer than you would think. I mean, maybe I should talk about autism based on my own experiences and biases. I see true autism as a serious, debilitating lifelong neuropsychiatric condition that oftentimes involves little or no language development. Forty to 70 percent, depending on the study, of autistic children are mentally retarded. Forty percent of children with autism have seizures—serious seizures. There're extreme, bizarre behaviors in terms of repetitive behaviors, spinning around and around on a seat, needing routines like scripts, a routine for everyone in their life to follow, like being, you know, put to bed with a certain ritual. If you don't follow it to a T it can lead to massive tantrums. So we're talking about extreme behaviors.

True autism is something where there's very little ambiguity, and pretty much the professionals and the parents know that it applies. What has happened right now is it's the mild cases that have inundated the system. Kids who do have language development, kids who may be extraordinarily intelligent in certain areas, but have extreme social difficulties, extreme troubles reading social cues and playing along, appearing to not have empathetic responses to other kids around them, like they're in their own world, like they're cold and heartless. These types of phenomena are usually associated with the milder cases. But it's very, very difficult to tease apart, especially during the toddler years, which are the years where it's most commonly diagnosed these days. It's very difficult, in my estimation, to tease apart what is evidence of mild autism versus what is a difficult toddler, especially a boy. And that's a whole separate topic right there, about how boys, in my estimation, are being overdiagnosed and inappropriately diagnosed with mild autism.

WOODS: Now if that's the case, where is it coming from? I mean, are the professionals not getting the proper training? Is the training itself at fault? Is what's being taught in the medical schools wrong? Where's the error coming in? Why is this suddenly happening? Why is there suddenly such a grave amount of error in diagnosis here?

GNAULATI: It's a good question. And I think it's complex, the cluster of causes to explain it. But I think that you just named one of them right there: that when you look at the education training of health and mental health professionals—and given that I'm a psychologist myself it's disconcerting for me to admit this, and it's true certainly of my own education—these days most health and mental health professionals do not have a background in child development. And what little background they do have in child development is usually the textbook sort. The average health and mental health professional doesn't have a good, clear, palpable, concrete sense of how a normal child behaves under stressful circumstances that will allow them to tease apart what is evidence of that versus a mild case of ADHD or autism or bipolar disorder.

Believe it or not, there's one study that I quote in my book that shows that 40 percent of pediatricians—and pediatricians are the professionals most likely to diagnose ADHD in the country right now—that 40 percent of them calling themselves pediatricians haven't even done a residency in pediatrics, let alone have a background in pediatric mental health, or, for that matter, child development. So yeah, the education and training of health and mental health professionals is one factor for it.

Another factor has to do with our insurance systems and how they're set up. With cost-cutting, the rationing of care, and the insurance system—it's led to a lot of professionals seeking to maximize coverage, engaging in what's called upcoding. In other words, if there's a question in terms of whether or not a child meets a diagnosis, more and more professionals are assigning them that diagnosis in order to ensure that treatment gets covered. Even though a child may enter the office where they're struggling and they do need help but they don't really need a diagnosis, if you don't assign them a diagnosis, especially a severe one, their treatment won't be covered. So it's almost like the tail wagging the dog there that we're seeing more and more going around in the system.

WOODS: Do you get a lot of positive feedback on a thesis like this from people in your profession? Perhaps some of them want to have their names withheld, or they may say to you secretly, "Yes, I know this is a big problem but I certainly don't want to go on the record about it." Is there a minority of people out there who professionally agree with you and who want to see some type of reform or are you a voice in the wilderness?

GNAULATI: You know, I think it's fellow professionals and colleagues telling me in private that they're not willing to go public themselves. There's that. But I can tell you the response to my book has been enormous and mostly from parents and teachers throughout the country and even internationally. I mean, the response to my book has actually been overwhelming and surprising to me; so it makes me think I've really touched a nerve out there in the country right now, in terms of just how out of sorts the system is with respect to overdiagnosing these disorders.

WOODS: Well, if you say there is an international dimension here, is it nevertheless the case, as far as you know, that this phenomenon of overdiagnosis is at its strongest in the United States? I'm just taking a wild guess, yet I have a funny feeling I'm right.

GNAULATI: You know, you are right. I actually had a journalist from Ireland call me, wanting me to comment on the Irish system, which I know nothing about. But she said, "We have the opposite problem over here, where kids who truly do have autism, the parents are seeing it as eccentric behavior, a developmentally delayed behavior or this, that, and the next thing, when clearly it's autism. So we have the opposite problem in Ireland than you do in the U.S." So I think you're onto something there, Tom.

WOODS: Well, how about that. I wish I had some cultural explanation. I'm sure there's a Ph.D. dissertation in there somewhere: why this happens in the U.S.

Dr. Gnaulati, I appreciate your time. I want to urge everybody to read your book, *Back to Normal*, and to visit your website – www.gnaulati.net – for more information.