

Coming Someday Soon... The Last Normal Child

By Lawrence Diller, M.D.

IN OUR ZEAL TO HELP OUR CHILDREN FEEL BETTER ABOUT THEMSELVES, ARE WE REALLY DOING THEM ANY FAVORS, OR COULD WE ACTUALLY BE HURTING THEM? IT'S COUNTERINTUITIVE, BUT OUR WORRIES OVER OUR CHILDREN'S SELF-IMAGE AND SELF-ESTEEM MAY BE UNWARRANTED AND UNINTENTIONALLY LEAD TO UNNECESSARY MEDICAL INTERVENTION AND POSSIBLE HARM.

I'VE COME TO THIS OPINION after evaluating and treating over 2,500 children for attention deficit/hyperactivity disorder, the condition that has become the explanation for virtually all children's underperformance and misbehavior at school.

November is a busy month for me because it's time for the first parent-teacher conferences prior to the year's first report card for most schools. And this time of year parents are all asking the same question, "Does my kid have ADHD?"

As someone who has prescribed drugs like Ritalin, Adderall and Concerta to children for more than a quarter century, I've become very uneasy about how much medication we use in this country. In 1998, I wrote a book called *Running on Ritalin*, which examined the factors that might explain the phenomenal growth and use of this drug in the United States.

However, I came to realize my analysis of the ADHD/Ritalin epidemic was incomplete. Nor did I sufficiently explain why parents of less and less disabled

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children, parents of children as young as two, or the kids themselves (especially teenagers) were seeking the ADHD diagnosis and medication. Neither was I entirely clear on why parents were also interested in medications like Prozac, whose use in children has also grown exponentially in the last 10 years.

These parents weren't after perfect "trophy" children. They loved their kids but were worried about them. It occurred to me that it was their worry over their children's feelings, especially their self-image and self-esteem, that was driving this epidemic of psychiatric drug use.

In our concern about our children's feelings, we've ironically become less and less tolerant of minor differences or variations in their behavior and school performance. Several years ago, I treated an eight-year-old patient who had an IQ of 130 but was getting only B's and C's at his private school because he wouldn't turn in his homework despite his teachers' and parents' best efforts. He was more focused on reading adult level texts about the Sahara desert, his current interest. But he was feeling worse and worse about his less-than-stellar grades, so I ultimately prescribed Ritalin for him. After that experience and many similar ones, I began to wonder if someday I'd be seeing "the last normal child" in my office.

This concern about our children's feelings reflects a profound change in our society's values over the past four decades. Our beliefs have shifted away from religion and meaningful politics to an obsession about caring and believing in ourselves.

In the process, how we feel has become much more important to us, and we expect (and possibly demand) that we feel good. And that's especially true for our children.

Yet despite much popular belief, there is little evidence that in the long run children's views of themselves make any difference.

Most of the original work on self-esteem was based on retrospective interviews (notorious for creating

distortions). It didn't matter whether the subjects were now CEOs, artists or criminals. All of them seem to have had lousy childhoods. Both the successes and the failures in life told researchers that as kids they suffered low levels of self-esteem. And more reliable types of studies have failed to prove that high or low self-esteem in childhood is predictive of good or bad outcomes later in life.

Whatever its influence right now, a child's self-concept appears to have little long-term influence.

Still, we want our children to feel good, right? But what if that means taking them to the doctor, getting a diagnosis that may have lifelong implications and taking a medication potentially for years? Does that make sense? Is it the best thing for our children?

ADHD has become the ubiquitous way we view problems of children's behavior and performance. While the Centers for Disease Control report 2.5 million children take a medication for ADHD, most research epidemiologists say the number is closer to four million. A more precise gauge comes from a medication insurance clearinghouse report that shows nearly one in 10 11-year-old white boys is currently treated with a stimulant such as Ritalin.

The amount of legal stimulants used as medication and produced in our country has grown 2,000 percent in the last 15 years. Data from the U.N. Narcotics Control Commission has been consistent over the years: The United States consumes 80 percent of the world's legal stimulant drugs (this does not include our use of illegal stimulants like cocaine or methamphetamine).

More parents, teachers and doctors are ready to accept a biological explanation (an ADHD diagnosis) and a medical treatment for children's underperformance at school, where children are being asked to learn more at an earlier age. With more two-parent working families, parents have less time to spend with their kids, either for monitoring homework or having fun.

Our discipline practices have changed. We put forth much more effort in talking to our kids about bad

behavior before we take action (a style poorly suited for the hyperactive mind).

Money also plays an important role. Insurance companies reward doctors more for brief "med checks" than longer talking sessions. The doctors make more money by prescribing and the drug companies make money, too.

Indeed, the single biggest influence on the way we think about our kids' problems may be the power the drug companies have on the doctors' behavior, medical research and teaching (mostly funded these days by drug companies), and advertising directed to the consumer (parents and teachers).

Yet the bedrock supporting this epidemic is our love, fear and worry over our children's present and future feelings. Must we make a pathology of our children's struggles and treat them with psychiatric drugs for "their own good?"

I suggest there is another way. Perhaps, the primary reform we should undertake as a society is to breathe a "collective sigh" about our kids. Things will likely turn out well for most of the offspring of the middle-class families who bring their kids to the doctor's office for evaluation. Don't forget that some of our greatest strengths are the result of compensating for our weaknesses.

Also, there are a number of simple actions we could take to help our kids that don't involve using a psychiatric medicine at all:

First, we should make a concerted effort to involve fathers more immediately and directly in the evaluation of their children's behavior or school performance. In my years of practice, I can recall only about a dozen fathers who lived in the area who refused to participate in an evaluation, especially if I called the dad directly.

Father's involvement is critical. He often has a different perspective than the mom (he generally sees less of a problem because he's around less and also stereotypically is more effective with discipline). His participation with

any behavior plan (or medication treatment for that matter) makes its success far more likely than without him.

Second, all kids should have a minimal educational evaluation at school or by the doctor before they are started on a medication. So many of the children I see have learning or processing problems that have been ignored. It's no wonder they are looking out the window when the teacher is talking if they have an auditory processing disorder (or another learning problem). Yet over and over again, I get kids referred who have not even been screened by their school.

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Finally, I make a direct plea to my colleagues in child psychiatry and behavioral-developmental pediatrics. You, who have achieved the pinnacle of power and expertise within the community to evaluate and treat children for these problems, are spending way too much time in your offices "diagnosing" disorders and dispensing pills. Instead you should be going out to the schools to attend individualized educational plan meetings to coordinate an effective behavioral-educational plan between the school and parents. Over and over, parents tell me the single most valuable effort I made in helping their child was the 45 minutes I spent with them at such a school meeting.

I know there's a core group of kids that—no matter what you do for them—will need these medications, but I think this group is about one-tenth of the number we treat now.

We too often forget that medication is not a moral equivalent to helping children cope with what has become an increasingly perilous journey through childhood. ●

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