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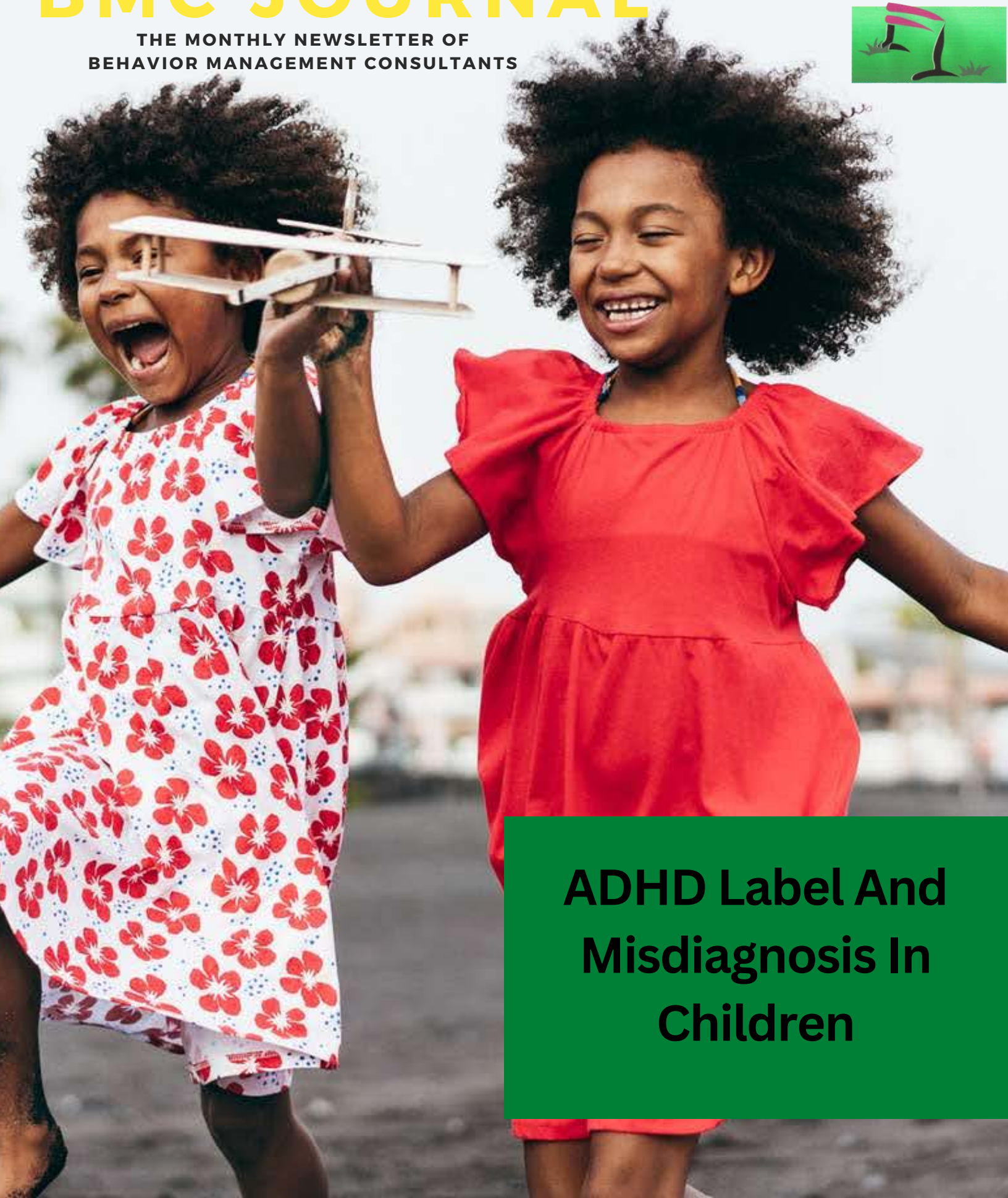


ADHD Label And Misdiagnosis In Children

Today, attention deficit hyperactivity disorder (ADHD) has become a common diagnosis in children and adolescents. Roughly 7% of American children between the ages of 7 and 13 are diagnosed with ADHD. This phenomenon has been on the rise since the early 1990s, when the first drug was discovered to help parents and teachers control the behaviors of children with what was considered extreme hyperactivity and difficulty concentrating. Individuals with attention deficit disorder (ADD) do not automatically meet the diagnostic criteria for ADHD.

According to studies, many children and teens are misdiagnosed with the H-factor (hyperactivity) when they don't actually meet that criterion. According to the diagnostic criteria from DSM-5, children and teens must exhibit a deficit in the area of attention and display symptoms of impulsivity, hyperkinetic activity, and blurt-out thoughts to receive a diagnosis of ADHD, as opposed to ADD.

The qualifiers most doctors seem to miss or gloss over are the words persistent and increasing when it comes to the diagnostic criteria. Some researchers are concerned that evaluators are placing too much stock in parent observation or what teachers have to say. Without following the DSM-5 criteria, these children and teens are labeled with ADHD, which can have negative consequences for them and their families. This emphasizes the importance of understanding, developing shared understanding among professionals, and ensuring that the education system, educators, and services provided to diagnosed children are appropriate and sensitive to the potential risk of stigma associated with labeling children with ADHD.

Roughly 7% of American children between the ages of 7 and 13 are diagnosed with ADHD.

The Difference Between Hyperactivity And ADHD

Children are typically quite active, and some may seem hyperactive, which is why they get the ADHD label. However, a child's hyperactivity coming from a teacher's or a parent's point of view may be subjective. Children are expected to sit for extended periods of the day in schools. For a child who likes to play, this may seem unreasonable. Depending upon how structured the home is, this may be the only time the child is expected to sit still.

Children are typically more active than most adults. They often play, run around, and show a variety of interests and curiosities in the world around them. If a child is bored or kept inactive for long periods, they may feel they are bursting from the seams with energy. Before parents, caregivers, or teachers label a child as ADHD and seek a supporting diagnosis, they may want to ask themselves a series of questions:

1. What am I doing to engage this child mentally?
2. In what ways and how do I provide physical activity opportunities for this child?
3. Do I allow enough socialization for this child?
4. Do I engage this child in discussions, group or individual?

Understanding the context and expectations placed on young people is crucial. Professionals should encourage teachers to consider alternative explanations for a child's behavior before resorting to labels that may carry a risk of stigma. Remember that labels matter, not only for the child but also for how their peers perceive and interact with them.

Some teachers may seem to forget that differentiating classroom instruction and activities does not apply only to children with a learning disability or exceptionalities. Different children have different personalities and learning styles, and education may not work as a one-size-fits-all.

The same is true at home. If a parent has five children, no two of them will be the same. Suppose one child, the oldest of two, is quiet, with a calm demeanor, never giving a moment of trouble. Their younger sibling comes along and is talkative and sometimes naughty. Strategies which work for the older child may not work for the younger child.

> Once an effective treatment is put in place, a child with ADHD can excel at home, at school, and anywhere else they go.

If a child seems to be displaying some of the traits of ADHD or ADD, it's important to get medical help and it may be beneficial to also seek mental health help.

When Is It Right To Seek A Diagnosis?

ADHD may be a very legitimate concern for some children and adolescents. It is a disorder, and that means that there is a persistent pattern of behaviour or symptoms that may interfere with the child's or adolescent's ability to function in their daily lives. If a child displays this pattern, it may be time to seek help from a professional.

The Dangerous Effects Of Misdiagnosis

Alternatively, there are the children who are never identified. Their thoughts and behaviors become uncomfortable for them, so they may learn to self-medicate either with alcohol or other substances by the time they reach adolescence. These adolescents may have just opened the door to substance use or abuse, and that has the potential to become a dangerous path or continuous cycle.

Many of the characteristics of the gifted child are often confused with that of ADHD. It is important to consult with a medical practitioner before labeling a child with ADHD-like symptoms. A gifted child requires a very different situation from a child with ADHD or ADD.

When a gifted child is placed with others who are also gifted or have above-average intelligence, difficult behaviors that may mask themselves as symptoms of ADHD will often diminish.

Frequently, parents or caregivers who are feeling frustrated or helpless with a child's behavior may be willing to accept the opinion of a teacher, school psychologist, or special education evaluator in search of answers. That opinion may not always be accurate, and parents or caregivers may want to seek outside help.

The Duality Of Being Mislabeled

There are also kids with dual exceptionalities; they are gifted and have ADHD, yet do not fit neatly under either label. As a recent study has suggested, it may be discomforting to realize that someone is so multifaceted that they cannot easily fit inside a box or be assigned a label. Often, it is simply easier to label a child as ADHD and place the child for treatments. Such students may carry this label with them from elementary school all the way through high school, as once diagnosed, the situation is rarely revisited.

Alternative Treatments

Before labeling a child as ADHD, it is important for parents, caregivers, teachers, and practitioners to recognize that a child is more than a diagnosis. It takes time, sometimes even months, of testing, trying different strategies, and working closely with the child by all involved parties before a diagnosis should be rendered. Most importantly, time should be taken before prescribing medication to quell ADHD symptoms.

While pharmacological treatments may be recommended for ADHD, nonpharmacological approaches are also being studied and practiced. Although medications can be an effective treatment for ADHD and may work quickly, the long-term side effects are not well known. Medication also doesn't necessarily address issues children may have managing academic performance or personal relationships. If you feel your child or adolescent may be living with ADHD or has recently been diagnosed, there are many effective treatments you can try before resorting to prescribing medications.

Behavioral Intervention

The American Academy of Pediatricians' 2011 treatment guidelines recommend behavioral strategies as the first line of treatment for ADHD in young children. The key to success is early and consistent intervention. These intervention treatments fall into three main categories: parent programs, teacher programs, and therapeutic recreational programs.

The parent program focuses on parents or caregivers rewarding children for good behavior instead of always commenting on the behaviors they deem bad or poor. This ensures children are getting attention for being good instead of always focusing on the negative.

Teacher programs focus on giving teachers behavioral strategies to use in the classroom. These often include giving children simple step-by-step instructions and announcing consequences ahead of time for not paying attention or following instructions. Contingency management is also used in teacher programs where children receive daily report cards outlining goals within the classroom. Children will receive rewards when they've met their goals.

Therapeutic recreational programs involve regular interactions between children with ADHD. In these programs, children learn traditional activities or sports, behavioral interventions, social skills, contingency management strategies, and team skills.

Online therapy is also a consideration for children and teens who have (or may have) ADHD. An online therapist can help and support a child to work through their feelings and establish strategies for coping with life at school and at home.

Lifestyle Changes

Lifestyle changes may be a powerful treatment for children or adolescents with ADHD and caregivers or others involved. Research shows that daily physical activity may help those with ADHD ignore distractions, focus on tasks, and improve academic performance. Studies also show that adequate sleep is crucial for children living with ADHD symptoms, and behaviors improved among children who got more sleep. Unlike adults who become fatigued and slow down with lack of sleep, children with ADHD often become hyperactive.

Online Therapy For Supporting Children Witih ADHD

Parents should be empowered by school counselors, teachers, and pediatricians to advocate for their children. Providing literature, seminars, webcast information, strategies, and the latest educational resources, as well as medical research, can benefit parents.

Until a proper diagnosis has been given and a decision made as to whether medication is the appropriate course of treatment, parents or caregivers may consider other forms of treatment such as behavioral therapies and interventions.

If you feel your child may have ADHD, a therapist may be able to help. BetterHelp is an online therapy platform that can provide you and your family with support and advice to get your child on the right track. An online therapist can offer parents help in processing their feelings about their child and a potential ADHD diagnosis. An online therapist can also be enlisted to help your child or teen develop the best way to cope with ADHD or ADD.

Online therapy has shown effectiveness in supporting parents who are caring for children with an ADHD diagnosis. In one virtual clinic for parents of children with ADHD, results demonstrated high parent satisfaction with the intervention and high usability.

Takeaway

It is okay if you feel frustrated, confused, or on edge about your child receiving an ADHD diagnosis. Maybe you're interested in learning about alternative treatments for managing ADHD symptoms. You could also want to learn more about a particular research domain of ADHD. When you reach out to an online therapist at BetterHelp, they can arm you with the most up-to-date, evidence-based strategies for parenting children with ADHD. They can also help you stay composed and manage your own emotions. Know that you are not alone, and help is available.

THE CHILDREN LEFT BEHIND

Thousands of kids are being underdiagnosed and undertreated for ADHD — due in large part to their race or ethnicity. Why is this happening, and what needs to be done to fix it?

When she was finally diagnosed with ADHD — after more than three decades of wondering what was wrong with her — Janel Dillard, of Clinton, Maryland, did what countless others before her have done: She threw herself into research. She watched online videos, read newspaper articles, and scoured the Internet for information on the neuroscience of ADHD and how she could best treat it. But from the moment she started her research, she said, she noticed something troubling: "I don't often see people who look like me."

Janel, 36, is African American, and she grapples with an uncomfortable truth: The face of ADHD in the U.S. is not black or brown, it is white — both in terms of the patients being diagnosed and the clinicians evaluating and treating them.

Battling ADHD stigma in the BIPOC community is nothing new, but evidence shows that people of color — black and Latino in particular — are much less likely to be diagnosed with ADHD, even though they show symptoms at the same rate as white people. And if they are diagnosed, they aren't as likely to receive treatment — even though many studies show that it can dramatically help kids and adults manage symptoms.

"ADHD is not a privileged disability," said Paul Morgan, Ph.D., professor of education and director of the Center for Educational Disparities Research, at Pennsylvania State University. "We don't want a situation where ADHD is a condition for wealthy white families. We want to be helping children who have disabilities, regardless of their race or ethnicity. But what we're finding is consistent evidence that white and English-speaking children are more likely to be identified — and that's an inequity."

The reasons for these disparities are complex, experts say, and correcting them will involve a multi-pronged approach that will most likely take decades — if not longer — to fully implement. But the ramifications of ignoring the problem are more severe. Properly diagnosed and treated ADHD can change the arc of a person's life, helping her manage everything from schoolwork to relationships to career — critical areas where people of color often face already-strong disadvantages. Undiagnosed ADHD, on the other hand — particularly its high association with risky behavior, drug use, and mood disorder — can be deadly.

The Case for Underdiagnosis

The question of under- or overdiagnosis of ADHD has long been up for debate, particularly since diagnoses started spiking in the 1990s. CDC data from 2011 to 2013 puts the rate of ADHD in childhood at 9.5 percent — a number that is sustained by white children, who are diagnosed at a rate (11.5 percent) that is significantly higher than that of their African American and Latino counterparts (8.9 and 6.3 percent, respectively). Critics and skeptics suggest that white children are being overdiagnosed (and overtreated) for ADHD, but the data may indicate otherwise.

Morgan conducted a well-regarded 2013 study that looked at more than 17,000 U.S. children. By the time the study's subjects reached eighth grade, African American children were 69 percent less likely — and Latino children 50 percent less likely — to receive an ADHD diagnosis than their white counterparts. A follow-up study, in 2014, found that the disparity actually started earlier: Before they even entered kindergarten, African American children were 70 percent less likely to be diagnosed with ADHD than white children. Children whose primary language was something other than English — a group that includes many Latino children — were similarly underdiagnosed.

A study that came out last year may make the case for underdiagnosis most decisively. Published in September 2016 in Pediatrics, it found that black children in the sample population showed symptoms of ADHD at a significantly higher rate than white children, but were diagnosed much less often.

And the health disparities don't stop at diagnosis. The 2016 study found that, once diagnosed, children of color were much less likely to take ADHD medication. Just 36 percent of black kids and 30 percent of Latino kids who had been diagnosed with ADHD were taking medication, compared to 65 percent of white children. The 2013 study found similar results.

Claims of overdiagnosis weren't supported by the data, researchers said. In the 2016 study, white children who didn't show ADHD symptoms weren't significantly more likely to be taking medication than similarly symptomless black or Latino peers. "White children in general were not significantly more likely to be taking medication," said Tumaini Coker, M.D., an associate professor at the University of Washington School of Medicine, and the author of the 2016 study. "That really suggests to us that the disparities we see were more likely from the underdiagnosis and undertreatment of African American and Latino children — rather than the overdiagnosis and overtreatment of white children."

Inequities in health care — particularly mental health care — aren't new. In 2002, the Institute of Medicine released a report entitled "Unequal Treatment," which found similar racial and ethnic disparities across the entire healthcare spectrum.

"Regardless of the condition you picked, you found disparities at every level of care," said Natalie Cort, Ph.D., a clinical psychologist and teacher at William James College.

Undiagnosed physical conditions, like heart disease or diabetes, indisputably increase the risk of death, Cort said. But disparities in mental health care can have more subtle — but no less serious — consequences. "Mental health professionals' misdiagnosis of minorities directly and indirectly contributes to racial and ethnic minorities being disproportionately represented in the criminal and juvenile justice system," she said. She calls it the "misdiagnosis-to-prison pipeline."

Missing the diagnosis is really just the start of the pipeline, she said. When teachers see ADHD behaviors — particularly those involving impulse control — without attributing them to a neurological cause, they often interpret them as defiance. Kids who are viewed as defiant or violent are labeled, said Cort — even if they're not accurately labeled with ADHD.

"He's going to be labeled as a 'bad kid' who is going to get suspended, and probably going to get expelled," she said. "And being suspended once or twice is highly associated with becoming involved in the juvenile justice system." Studies have estimated that up to 40 percent of inmates in the U.S. have ADHD — a rate that dwarfs that of the general population.

Not every person who has ADHD but hasn't been diagnosed winds up in prison. But untreated ADHD has far-reaching effects — on self-esteem, social functioning, career progress, and overall happiness. Janel, who wasn't diagnosed with inattentive ADHD until her mid-30s, can attest to that.

Looking back, she recalls having symptoms her entire life, but says that, without a diagnosis, she spent most of her childhood wondering what could possibly be going on. She couldn't keep anything neat, no matter how hard she tried, and was constantly scolded for the "trail of things" she left in her wake. Even though she did her homework, she seemed to leave it at home instead of turning it in. In school, detention was a frequent punishment for talking in class, but Janel felt she couldn't stop herself. "It got really out of hand," she said.

Her parents were frustrated — with her messy room, her inconsistent grades, the constant calls from school. "They sat and watched me do homework — helped me do homework," she said. "And now they're getting called because I haven't been turning in homework?" It was difficult for them to understand.

Despite all the calls, however, the school never suggested Janel be evaluated for ADHD — and no matter how often her parents tried to get her on track, Janel continued to struggle. "There was a lot of hiding," she said. "It felt like there was something wrong with me."

After she reached adulthood, little had changed. A promotion at work came with a slew of new responsibilities, and Janel felt herself crumbling under the pressure — not paying her bills, getting pulled over several times for the same broken taillight, leaving wet laundry in the washing machine for three days at a time. "It just started to feel like everything was falling apart," she said. She needed help, and even though she wasn't sure where to look, she decided to start with a therapist. "I basically went in and told her I felt like a failure as an adult."

Her therapist suggested she see a psychiatrist to discuss the possibility of ADHD. She was at first reluctant, but eventually agreed. Once she got the diagnosis, she was relieved — at first. But that relief was soon tinged with anger and regret. "Why couldn't I have known sooner?" she asked.

Diagnostic Biases

In many missed diagnoses, like Janel's, there's evidence that racial bias plays a role — particularly on the part of clinicians, who often rely on what are called "implicit biases" when evaluating a child's behavior.

"As providers — like most Americans — we carry implicit biases," said Cort. Implicit bias is the result of a lifetime of "classical conditioning," she said. "If you present two stimuli simultaneously, and you do it repeatedly, your brain — which wants to be efficient — will make an association [subconsciously] that when one stimulus is presented, the other one should come next."

A 1988 study of more than 300 psychiatrists found that, when presented with patients showing identical symptoms, they overwhelmingly diagnosed black men with severe conditions, like schizophrenia, while diagnosing white men with milder conditions, like mood disorder.

"Those psychiatrists were probably all lovely people," Cort said. But "they've also been exposed to the idea that, when they see black men portrayed on television, it's usually in reference to some violent action—something negative." On some level, "they think of black men as suspicious and dangerous and paranoid. That bias was impacting how they were reading the very same symptoms."

Studies show that implicit biases in white Americans are at about the same level as they were in the 1950s — and that they're still affecting how clinicians diagnose and treat patients.

"There is reporting that says health practitioners are more responsive to white and English-speaking families," said Morgan. "Minority families have reported that practitioners can be dismissive of their concerns for their child, or less likely to solicit developmental concerns." When doctors don't ask the right questions — or rely on unfair stereotypes when interpreting behavior—many kids with ADHD don't get the diagnoses they deserve, he said.

Community Stigma

Bias on the part of practitioners plays a pivotal role in missed diagnoses, but it isn't the only factor. Some of the disparity comes from the patients, in the form of community stigma about mental health or mistrust of the medical system.

Mental problems are considered "taboo" in some communities, Janel said. Her family mostly viewed her situation as a lack of willpower, particularly in light of the difficult history of African Americans in the U.S. "When my father was young, he went to segregated schools," she said. "Previous generations 'had it worse,' and no one went to find a therapist — they just dealt with it and moved on."

Plus, the issues that she struggled with the most — keeping track of homework, keeping her room clean, talking out of turn — weren't seen by her family as problems that warranted professional help. "That's something I just needed to figure out and get done," she said.

Coker, who is black, and has twin sons diagnosed with ADHD, said there's also a perception in some communities that "ADHD is a label that's put on a child as a form of racism or bias" — which can lead to parents rejecting the diagnosis or refusing to accept treatment. "It's hard to treat something that you think is just put on your child because of the color of [his or her] skin. And it's hard to get family involved in the strategies you're using to deal with your symptoms."
Janel's older brother, for one, was upset when she shared her diagnosis, telling her, "They're just going to pump you full of drugs." She would be "zoned out," he said, under the influence of medications that have "horrible side effects and health consequences."

His reaction isn't uncommon — and it may not be unwarranted. Though stimulants have been proven safe over the long term, they're not the only medication used to treat ADHD — and the other options aren't always as benign. Studies have shown that children of color, including those with ADHD, are more likely than their white counterparts to be prescribed strong antipsych0tics — even though the side effects can be severe and dangerous.

"If you're seeing little black children or little Latino boys and girls as being potentially dangerous and violent, and you have a drug that can help manage some of that behavior, then you might reach for that drug," said Cort. "Even though you know that antipsych0tics take years off your life."

All in all, minority communities may have a right to be suspicious of the medical establishment, Cort said. "The history is replete with minorities being deliberately harmed" by researchers —the Tuskegee Syphilis Experiment, in which African American men were intentionally infected with and denied treatment for syphilis, is perhaps the most notorious example. "The cultural mistrust is based on really, really egregious historical wrongs in the field — and that makes it hard for people to approach the field."

The Frog Pond Effect

Years of formal and informal segregation, redlining, and other discriminatory practices have led to vast disparities in the U.S. school system — disparities that, again, hit children of color the hardest.

"Children who are racial and ethnic minorities are more likely to be exposed to poverty," Morgan said. Wealthier schools have access to better resources — meaning the achievement level is generally higher than it is at poorer, under-resourced schools. This plays into something called "the frog pond effect," which influences the likelihood that a child will be identified for special education services.

There are two factors to the frog pond effect, Morgan said. "One is the child's own behaviors or academic achievement — how he or she is doing in a classroom individually. But another is the context in which the child is being evaluated." That means that in a school dominated by high-achieving kids, a child with behavior or attention problems will stick out like a sore thumb. But in poorer schools — those that are overcrowded, understaffed, and underperforming — a similarly struggling child wouldn't be as noticeable. In other words, Morgan said, where the child is attending school matters when it comes to ADHD diagnosis — even though, in a perfect world, it shouldn't.

"From a clinical standpoint, it should be irrelevant," he said. "The disability criteria is set at the state and the federal level, and those are the benchmarks which should be considered — not how your school is doing." But it plays a part anyway, he said — and children at poorer schools pay the price.

Insurance also plays a role. Children of color are more likely to have public insurance, Coker said, which can make getting an ADHD diagnosis harder.

“If you’re dealing with Medicaid, you may need to use a community mental health center,” she said. “That waiting list is really long — it could be months before you even get assessed.” Behavioral therapy is hard to access under Medicaid, too, meaning that, even if these families get a diagnosis, the only treatment they may be offered is medication. “Not every family is going to agree to medication right away,” she said. “It’s one thing to give the diagnosis and the offer of medication, but another to give a diagnosis and to offer resources to help the family understand what [ADHD] is and why it’s happening. If you make a diagnosis and you can’t help, that’s an issue.”

The good news, according to Morgan, is that “we have ways to help children with ADHD. We don’t want it to be the case that only some kids are getting those treatments.” Correcting the disparity will require schools, doctors, and communities to work together. (See “Fixing the System” in the sidebar for potential solutions.)

No proposed solution can make a dent in the problem if the doctor-patient relationship — or the teacher-parent relationship — lacks trust, Cort said. After hundreds of years of racialized history, trust won’t come overnight, but it can be improved by diversifying the educational and medical communities, which remain overwhelmingly white. A 2016 report by the Department of Education found that only 18 percent of U.S. teachers are people of color, while nearly 90 percent of mental health professionals are non-Hispanic white.

William James College, in Newton, Massachusetts, where Cort teaches, is leading the charge toward diversifying the mental health field by pioneering programs focusing on the mental health of those of Latino or African descent. Cort herself is the director of the Black Mental Health Graduate Academy, a mentorship program that aims to develop a group of black clinicians who can be “present and powerful in the field,” she said.

“It’s really hard to push back against implicit bias if you don’t actually have something to challenge it,” she said. “We need more people of color in the field — by our presence, we challenge bias.”

Janel agrees. She's had her ADHD diagnosis for just over a year, but in that time, most real-life people with ADHD that she's come across have been young white boys. "When there are women, they're not usually of color," she said. More people of color are needed "to raise awareness of what ADHD is and dispel some of the stereotypes about it. It might look a little bit different, when you put it in the context of gender or culture, [but] people of color are affected just as much."

Fixing the System

When it comes to changing the racial disparities in ADHD diagnosis and treatment, "Being an optimist is necessary and practical," said Natalie Cort, Ph.D. "We all have to be part of this process, but it can happen." Experts highlight several key strategies for doctors, teachers, and communities to use in their fight for ADHD equity:

Education and outreach. Doctors have had success with "clinic-to-community partnerships," said Paul Morgan, Ph.D., in which doctors educate stakeholders in the community about ADHD symptoms and the benefits of treatment. Education can include courses in managing ADHD, discussion groups, or distribution of doctor-vetted information in libraries, gyms, or other central locations. "Making sure that results from ADHD studies are disseminated and minority families are able to access them" is critical to addressing ADHD's disparity, he said.

Push back against stigma. "Most people, unless they're directly affected by [ADHD], don't understand it," said Janel, an African American woman whose ADHD wasn't diagnosed until her mid-30s. In her experience, making ADHD personal can go a long way toward combating stigma. Once she shared her diagnosis with her skeptical parents, they were hugely supportive — even making efforts to educate themselves about ADHD using online videos. Janel's brother came around from his anti-medication stance, once he saw how her non-stimulant helped her.

Dismantle bias. Tackling implicit bias is a complex problem, since people who see themselves as tolerant often bristle at the suggestion that they hold racial biases. "But implicit bias does not mean you're racist," Cort stressed. "It doesn't mean you're a bad person — it just means this is what you've been exposed to." Accepting that everyone has unconscious biases — and recognizing how they may affect decisions — can help clinicians and teachers treat children of color in a more equitable way. "The more aware you are of it, the more you have control over the ability to mitigate it," she said. Formal bias training can be critical.

Use better diagnostic tools. Structured diagnostic tools can also help combat bias, by making the diagnostic process less susceptible to each doctor's unique (and possibly biased) interpretation of symptoms. "The American Academy of Pediatrics (AAP) has a great toolkit online for pediatricians to make the diagnosis and to think about treatment," said Tumaini Coker, M.D.

Have more invested doctors. Asking the right questions is the most powerful tool clinicians have at their disposal — regardless of the race or ethnicity of the patient. "It's one thing to ask how school is going and be satisfied when parents say, 'Fine,'" Coker said. It's another to "get into the nitty-gritty of what 'fine' means," she said. "It may mean that they're in detention, or that they're failing, or that they're getting A's, but we don't know if we don't ask the difficult questions."

ADHD & Latinos: Unique Challenges

Justine Larson, M.D., is a child and adolescent psychiatrist at Community Clinic, Inc (CCI), in Maryland, which serves a large Latino population and discusses the challenges of diagnosing ADHD in these communities.

How do language barriers affect doctor-patient interactions?

Dr. Larson: There's a huge shortage of psychiatrists nationally, and that's even truer when you're trying to find somebody who speaks Spanish. Some patients really want to see somebody who's from their own culture. Sometimes I see kids who have communication difficulties even within the family.

Do cultural barriers exist?

Larson: A lot of Latino parents are less likely to see behavior as something that you would see your doctor about. It's more of a discipline problem.

There are cultural differences in terms of the patient-provider relationship. In some Latino cultures, there is a more authoritarian relationship with the doctor. So when I'm trying to solicit opinions, people might not be used to that, or might not be comfortable with it. They might be expecting me to tell them what to do; I think it's more empowering to have a dialogue.

Among Latino patients, because of that authoritarian relationship, some people will agree and say yes to things — but inwardly, they're not comfortable with it. They might not necessarily tell me, because they feel like they have to say yes. Then they might not keep up with treatment.

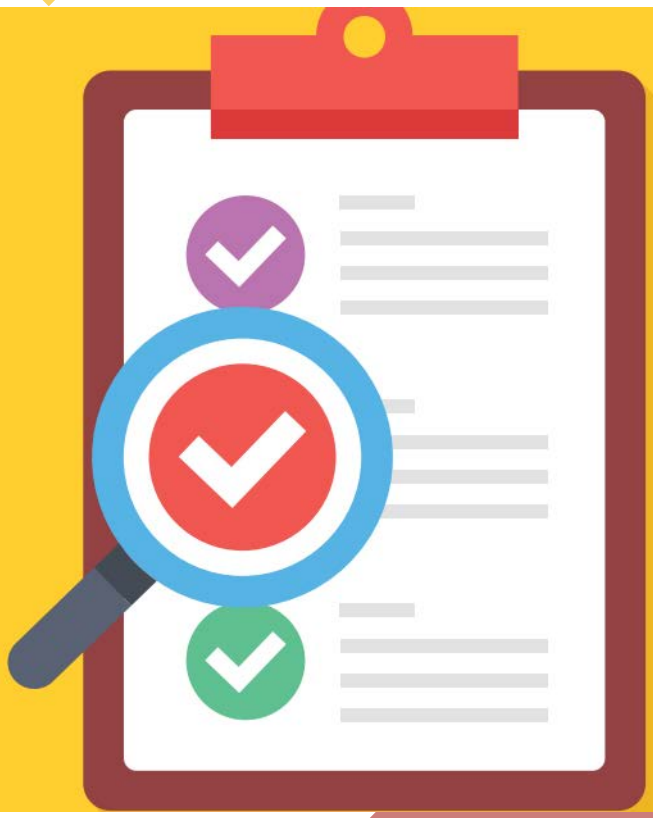
What unique concerns exist for immigrant children?

Larson: There is a lot of trauma and adversity in the population — either interpersonal violence or loss of parents or other people in their lives. It can definitely play a role: Trauma can impact attention; anxiety and mood disorder can impact behavior. In little kids, it's hard to tell the difference — they might not have the ability to express what's going on.

What's happening in schools that increases this disparity?

Larson: There are cultural differences in terms of school involvement. I see families where the parents don't know the names of the teachers — or can't talk to the teachers because they don't speak Spanish. There's less communication with the school about what's going on, or what the school could be doing to help.

9 Conditons Often Linked to ADHD



Anxiety At a Glance

Comorbidity with ADHD	• 25–40% of people with ADHD may also have an anxiety disorder. • 10% of people with anxiety are diagnosed with comorbid ADHD.
Suggestive Symptoms	• Difficulty controlling feelings of worry • Feelings of powerlessness • Restlessness, twitching, or sweating; tense muscles • Increased heart rate • Fatigue • Irritability or edginess • Trouble concentrating • Sleep difficulties • Trouble breathing or inability to stay in confined spaces • Panic attacks of intense fear, dizziness, heart palpitations, or shortness of breath
Professional to See	A psychologist can provide therapy. Your primary care physician or a psychiatrist will need to prescribe any medication. For children, see a child and adolescent psychiatrist.
Treatments & Medications	• Therapy, as well as relaxation and self-calming techniques • Anti-anxiety medications, such as buspirone (Buspar) • Benzodiazepines, such as clonazepam (Klonopin), alprazolam (Xanax), or diazepam (Ativan) • Antidepressants
Recommended Resources	• adaa.org • freedomfromfear.org • *Worry*, by Edward M. Hallowell, M.D. • *The Anxiety and Phobia Workbook*, by Edmund J. Bourne, Ph.D. • *Freeing Yourself from Anxiety*, by Tamar E. Chansky, Ph.D. • *Worried No More*, by Aureen Pinto Wagner, Ph.D. • *Seven Steps to Help Your Child Worry Less*, by Sam Goldstein, Ph.D., Kristy Hagar, Ph.D., and Robert Brooks, Ph.D.

Autism Spectrum Disorder At a Glance

Comorbidity with ADHD	• Nearly one third of children with ASD also meet the diagnostic criteria for ADHD. • Children with ADHD are 20 times more likely to exhibit some signs of autism spectrum disorder than neurotypical peers.
Suggestive Symptoms	• Delayed speech and learning gestures • Tendency to avoid eye contact • Difficulty imitating the actions of others • Preference for solitary play • Failure to respond to social cues • Failure to seek comfort when upset • Trouble understanding the perspective of others • Trouble creating sentences • Tendency to repeat words or phrases • Arranging objects in a particular order • Repetitive behaviors like twirling or rocking • Wiggling fingers or flapping hands In adults, lack of understanding of facial expressions, body language, or social cues; difficulty interpreting what others are thinking or feeling; inflection that does not reflect feelings; difficulty regulating emotion
Professional to See	Diagnosis and treatment should be conducted by a qualified developmental and behavioral pediatrician, child and adolescent psychiatrist or neurologist.
Treatments & Medications	• Behavioral therapy for children coupled with parent-training • Atypical neuroleptics including aripiprazole (Abilify), quetiapine fumarate (Seroquel), and risperidone (Risperdal)
Recommended Resources	• autismspeaks.org • autism.com • *Autism Spectrum Disorder*, by Chantal Sicile-Kira • *Early Intervention and Autism*, by James Ball, Ed.D. • *Ten Things Every Child with Autism Wishes You Knew*, by Ellen Notbohm • *The Autistic Brain*, by Temple Grandin • *The Reason I Jump*, by Naoki Higashida • *Life, Animated*, by Ron Suskind

Bipolar Mood Disorder At a Glance

Comorbidity with ADHD	• 25–40% percent of people with bipolar disorder have ADHD. • 5–7% of people with ADHD will be diagnosed with bipolar disorder at some time in their lives.
Suggestive Symptoms	**Depressive Phases:** • Feelings of sadness, hopelessness, and apathy • Extreme feelings of guilt and regret • Sharp decrease in energy • Distorted appetite—either noticeably increased or diminished • Loss of interest in favorite activities • Noticeably poor performance in work or school • Thoughts of suicide **Manic Phases:** • Feelings of euphoria • Severe, uncharacteristic irritability • Unusually high self-esteem • Poor judgment (particularly when it comes to risky behavior like Drug or alcohol use, gambling, or promiscuous sex) • Rapid speech—often to the point that the listener is unable to follow • Behaving aggressively or too exuberantly • Decreased need for sleep • Dramatic boost in sex drive • In very extreme cases, psychosis—breaking from reality—which can include delusions or hallucinations
Professional to See	Your primary care physician or a psychiatrist will need to prescribe any medication. For children, see a child and adolescent psychiatrist
Treatments & Medications	• Psychotherapy, such as cognitive-behavioral therapy (CBT), family therapy, interpersonal, or social rhythm therapy • Lithium, or another mood stabilizer • Atypical antipsychotics, such as aripiprazole (Abilify), quetiapine fumarate (Seroquel), or lurasidone (Latuda)
Recommended Resources	• dbsalliance.org • ibpf.org • *The Bipolar Disorder Survival Guide*, by David J. Miklowitz, Ph.D. • *An Unquiet Mind*, by Kay Redfield Jamison • *The Bipolar Child*, by Demitri Papolos, M.D. and Janice Papolos • *What Works for Bipolar Kids*, by Mani Pavuluri, M.D., Ph.D.

Depression At a Glance

Comorbidity with ADHD	• Nearly three times more common in people with ADHD than in the general population; by some estimates, as many as 70% of people with ADHD will be treated for depression at some point in their lives. The rate in children with ADHD is lower, estimated between 10–30%. • Roughly 30-40% of children and adults with depression also have ADHD.
Suggestive Symptoms	• Loss of interest in activities • Change in appetite • Difficulty sleeping, or sleeping more than usual • Fatigue or lack of energy • Agitation or irritability • Feelings of worthlessness, hopelessness, guilt or inadequacy • Difficulty concentrating or making decisions • Unexplained aches and pains • Recurrent thoughts of death or suicide • In children, a sudden drop in grades or apathy about the future
Professional to See	A psychologist can provide therapy. Your primary care physician or a psychiatrist will need to prescribe any medication. For children, see a child and adolescent psychiatrist.
Treatments & Medications	• Cognitive-behavioral therapy (CBT) or talk therapy • Antidepressants, such as fluoxetine (Prozac), citalopram (Celexa), escitalopram (Lexapro), or bupropion (Wellbutrin) • Stimulant medications may be used as augmenters, regardless of whether the patient has ADHD
Recommended Resources	• adaa.org • dbsalliance.org • aacap.org • *Undoing Depression*, by Richard O'Connor • *Feeling Good*, by David D. Burns, M.D. • *The Noonday Demon*, by Andrew Solomon • *The Childhood Depression Sourcebook*, by Jeffrey A. Miller, Ph.D. • *More Than Moody*, by Harold S. Koplewicz, M.D.

Learning Disabilities At a Glance

Comorbidity with ADHD	• About 50% of people with ADHD have a comorbid oral language deficit. • 20–60% of children with ADHD have one or more learning disabilities or language problems.
Suggestive Symptoms	**Reading Disabilities:** • Difficulty associating or recognizing sounds that go with letters • Difficulty separating the sounds within words • Difficulty sounding out words • Delayed speech development • Trouble rhyming • Problems understanding and using words and grammar • Poor spelling or reverses letters • Short attention span • Difficulty following directions • Trouble distinguishing letters, numerals or sounds **Language/Auditory Processing Disorders:** • Difficulty following spoken directions • Difficulty following multi-step directions • Difficulty expressing self verbally; recalling words or translating thoughts into words • Poor working memory • Extreme difficulty focusing or paying attention in noisy environments • May hear, and thus speak, imprecisely (saying "dat" instead of "that"; running words together) • Difficulty following and participating in conversations • Poor reading comprehension • Poor written output **Written Language Disabilities:** • Handwriting is slow and/or illegible • Inconsistent spacing, or running out of space on the paper; irregularly sized letters • Speaking the words out loud while writing • Omitted words in sentences • Difficulty with grammar and syntax structure • Avoidance of writing tasks • Difficulty organizing thoughts when writing them down **Math Disabilities:** • Slow to develop counting and math problem-solving skills • Trouble understanding positive versus negative value • Difficulty recalling number sequences • Difficulty computing problems • Problems with time concepts • Poor sense of direction • Difficulty completing mental math
Professional to See	Evaluation should be conducted by a school psychologist or special education professional. School supports may be provided by special education professionals and/or your child's classroom teacher. Parents may hire an educational advocate to help them secure services. Children with dysgraphia should see an occupational therapist (aota.org).
Treatments & Medications	• No medication to treat learning disabilities • Child may qualify for an Individualized Education Program (IEP) to receive special-education services or accommodations

Obsessive Compulsive Disorder (OCD) At a Glance

Comorbidity with ADHD	• 25–33% of children with OCD are diagnosed with ADHD.	
Suggestive Symptoms	• Recurrent, unwanted thoughts (obsessions), such as fear of dirt, germs, contamination, or becoming ill/dying; fear of losing control and causing harm to oneself or others; intrusion of perverse, forbidden, or "horrific thoughts; extreme need for order, symmetry, or "perfection" • Repetitive behaviors (compulsions) that are intended to lessen anxiety, such as counting or repeating; checking or questions; arranging and organizing; cleaning or washing; collecting or hoarding; "preening" behaviors	
Professional to See	A psychologist can provide therapy. Your primary care physician or a psychiatrist will need to prescribe any medication. For children, see a child and adolescent psychiatrist.	
Treatments & Medications	• Cognitive-behavioral therapy (CBT) or exposure-response therapy	• Antidepressants • Anti-anxiety medications
Recommended Resources	• iocdf.org • beyondocd.org • *Brain Lock*, by Jeffrey M. Schwartz, M.D.	• *Triggered*, by Fletcher Wortmann • *Freeing Your Child from Obsessive-Compulsive Disorder*, by Tamar E. Chansky, Ph.D. • *What to Do When Your Child has Obsessive-Compulsive Disorder*, by Aureen Pinto Wagner, Ph.D.

Opositional Defiant Disorder (ODD) At a Glance

Comorbidity with ADHD	• 25% of boys with ADHD and 10% of girls with ADHD will develop ODD. • About 40% of those children will get progressively worse and develop Conduct Disorder (CD).
Suggestive Symptoms	• Often loses temper • Often argues with adults • Often actively defies or refuses to comply with adults' requests or rules • Often deliberately annoys people • Often blames others for his or her mistakes or misbehavior • Often easily annoyed by others • Often angry and resentful • Often spiteful or vindictive In adults, feeling mad at the world, losing temper regularly, relentlessly defending self when criticized or blamed; may present as spousal abuse or road rage
Professional to See	A family therapist or counselor. A child and adolescent psychiatrist will need to prescribe any medication.
Treatments & Medications	• Psychotherapy, including training or counseling for parents • Stimulant medications used for ADHD • Atypical antipsychotics, including aripiprazole (Abilify) or risperidone (Risperidal)
Recommended Resources	• aacap.org • conduct disorders.com/community • empoweringparents.com • *Taking Charge of Anger*, by W. Robert Nay, Ph.D. • *Your Defiant Child*, by Russell A. Barkley, Ph.D. • *Your Defiant Teen*, by Russell A. Barkley, Ph.D. • *The Explosive Child: Parenting Easily Frustrated, Chronically Inflexible Children*, by Ross W. Greene, Ph.D. • *The Defiant Child*, by Douglas A. Riley, Ph.D.

Sensory Processing Disorder At a Glance

Comorbidity with ADHD	• An estimated 40–60% of children with ADHD or SPD also have symptoms of the other condition.
Suggestive Symptoms	• Experiencing muted sights, sounds, and touch, as if a shade has been pulled over the outside world • Sensory-seeking behaviors include swinging, spinning • Inability to screen out external stimuli Feelings of sensory overload may be triggered by tags or seams on clothes or coarse fabrics, strong odors, loud noises, right lights, hair brushing, tart or bitter foods, being hugged
Professional to See	Diagnosis and treatment should be conducted by a trained occupational therapist.
Treatments & Medications	• No medication can treat learning disabilities • An occupational therapist may provide a "sensory diet" to gradually accustom a child to a range of sensations
Recommended Resources	• spdstar.org • aota.org • *Too Loud, Too Bright, Too Fast, Too Tight*, by Sharon Heller • *The Out-of-Sync Child*, by Carol Stock Kranowitz • *The Out-of-Sync Child Has Fun*, by Carol Stock Kranowitz • *Raising a Sensory Smart Child*, by Lindsay Biel and Nancy Peske • *Sensational Kids*, by Lucy Jane Miller

Tourette Syndrome At a Glance

Comorbidity with ADHD	• About 7% of children with ADHD have Tourette Syndrome. • 60% of children with Tourette Syndrome have ADHD.
Suggestive Symptoms	• Simple motor tics, such as blinking or shrugging • Complex tics, such as hopping or touching things • Simple vocal tics, such as snickering, throat clearing, grunts, or barking • Complex vocal tics, such as repeating words or phrasesW • Uncommon symptoms: coprolalia, the vocal tic of swearing or saying inappropriate things; copropraxia, the motor tic of making obscene gestures
Professional to See	A child and adolescent psychiatrist will need to prescribe any medication. Child may also benefit from therapy provided by a child psychologist.
Treatments & Medications	• Behavioral therapy to help alleviate tics • Alpha-adrenergic medications, including clonidine (Catapres) and guanfacine (Intuniv) • Anti-psychotic medications, including haloperidol (Haldol) and pimozide (Orap)
Recommended Resources	• tsa-usa.org • *Tics and Tourette Syndrome*, by Uttom Chowdury • *The Tourette Syndrome & OCD Checklist*, by Susan Conners • *Coping with Tourette Syndrome*, by Sandra Buffolano • *Nix Your Tics!* by B. Duncan McKinlay, Ph.D. • *Front of the Class*, by Brad Cohen

FOR BLACK FAMILIES, NEURODIVERGENCE MEANS CHALLENGES—AND ENDLESS OPPORTUNITIES TO REDEFINE PARENTING

> A diagnosis of neurodivergence can be daunting for Black families, who are often doubly marginalized. Fighting for acceptance is the first step in receiving the support they need.

Natasha Nelson rejected the narrative that receiving a diagnosis would label her family and limit their possibilities. Still, after she and her daughters were diagnosed with autism, unsolicited opinions hinted towards the shame of being categorized.

"'You don't want them to label your child.' That's what I kept hearing when I was voicing my concerns about Paris showing early signs to family and moms in mom groups on Facebook," wrote the mother of two, who lives in Stone Mountain, Ga., and believes conditions like autism and attention deficit hyperactivity disorder (ADHD) are simply a variation of normal.

Her own autism prepared her to thrive in school, the military, later as a military spouse, and as a positive discipline educator. Now she leans into her differences—as an autistic Black mother with sensory processing disorder—to create a community that normalizes neurodiversity. Neurodiversity is an all-encompassing, sociological term which implies that brain differences are normal, not something to fix. The resources she's developed support Black and neurodivergent parents in their efforts to raise children with grace, empathy, and self-love.

According to scholar Kimberlé Crenshaw, racism impacts Black family dynamics and intersects with class, sexual orientation, and gender. But, its relationship to ability and neurodivergence is underexplored. This leaves Black families who are navigating neurodivergence vulnerable to racism and ableism with limited support.

Black Neurodivergence in a White World

Dr. Cassandra Raphael, M.D., MPH, a board-certified psychiatrist, mental health, and public health researcher and educator serving adults and children in New York City says neurodivergence is an umbrella term for various diagnoses, including dyslexia and other specific learning disorders. It also includes epilepsy, obsessive-compulsive disorder (OCD), and Tourette's syndrome. But most commonly, the term is used to describe autism spectrum disorder, sensory processing disorder, or ADHD. Most research focuses on ADHD and autism.

"It is difficult to determine exactly how many Black families are diagnosed as neurodivergent as it is a collection of diagnoses, and these numbers are dynamic," says Dr. Raphael, who notes the barriers to diagnosis and treatment in Black communities.

Autism and ADHD are often narrowly depicted as conditions that only impact white males. Black neurodivergent people, especially Black women and girls, are often identified and diagnosed late, if ever, and experience higher misdiagnosis rates for nearly all conditions. Nelson wasn't diagnosed until 31.

According to Dr. Raphael, support can be delayed because of structural factors, like schools being underfunded and understaffed. In turn, Black caretakers of neurodivergent children struggle to have their concerns taken seriously. They may also fear that a diagnosis labels children and will be used to justify their mistreatment or will limit their chances for success later in life, as Nelson described. The effects of both structural factors and familial concerns can leave Black children struggling alone while needing support.

Freedom Through Diagnosis

Dazmine Manns, a Black, 26-year-old mother of three who lives in Tulsa, Okla., describes living with undiagnosed ADHD as "fighting against a current that almost had you underwater a few times."

"I found myself getting overwhelmed by small or big noises, crying and this would cause panic and nervousness," says Manns, describing what would eventually be revealed to be sensory overload. She sought help after her third child was born and finally understood she wasn't the problem. "I am more patient and not as frustrated, because I also talk to my children when I need personal time or begin getting overwhelmed" she says. "Receiving my diagnosis helped me realize my daughter's difficulties were undiagnosed ADHD."

Nelson says clear communication and boundaries are foundational to positive parenting, as is beginning to see mistakes as learning opportunities. "Being imperfect, honest, and having boundaries with your children allows them to see an example of how to be imperfect and make mistakes and recover and focus on solutions." Because of this, neurodivergent parents are perfectly situated to show their children that neurodivergent people can thrive. She recommends boundaries like "I understand you want to cuddle with Mommy. But right now, Mommy needs space for (length of time). What can you snuggle or play with instead while Mommy gets space?"

Abandoning "Good" and "Bad" Labels

Black autistic children are twice as likely to be misdiagnosed with conduct disorder, a highly stigmatized behavioral disorder, and five times as likely to be misdiagnosed with adjustment disorder, a prolonged response to a stressful or traumatic event. Tamara Rachelle, a content creator and disability advocate from Los Angeles with four daughters, witnessed how unidentified Black neurodivergent children were mischaracterized as "bad" or "disruptive" in her childhood neighborhood. "The children weren't bad," she says. "Just were parts of marginalized groups where the system failed them, and their community didn't have the resources to help them."

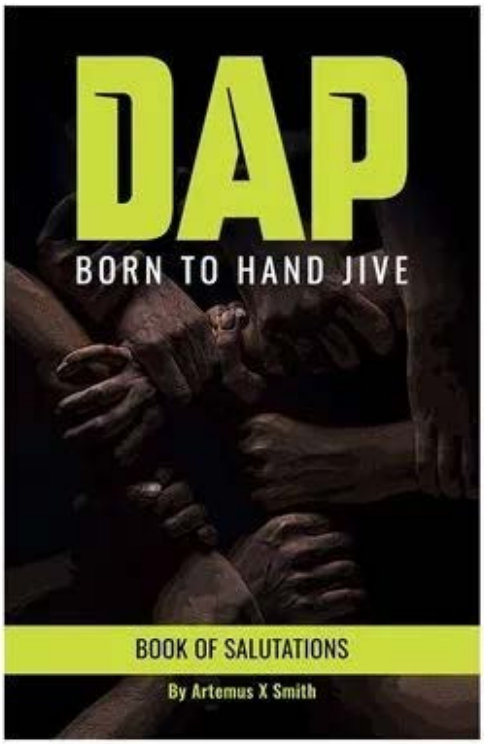
When her now 12-year-old daughter Lilac was diagnosed with autism and an intellectual disability, and her twin Leone was diagnosed with ADHD, Rachelle abandoned labels like "good" and "bad." Instead, she focused on developing an intersectional understanding of disability that honors the nuance of Lilac's experience as someone Black, female, and disabled. "Unfortunately, Lilac is non-verbal. So as her mother and caretaker, I try to represent her the best way I can," Rachelle says.

Preserving Expression

Supporting children who are non-speaking, or have limited communication, involves paying attention to the same cues and following up by helping them express themselves to the world. "If your child has no voice, they can't tell you the way they diverge, and you're not able to know their triggers and support them," says Nelson.

Rachelle's videos show that neurodivergent people may communicate differently, can experience discomfort through disrupted routines or policies made without consideration for intellectually disabled individuals, and finances can limit access to support. For Black families, there can be additional pressure to hide these struggles from the public for fear of consequence and also concern that support resources overlook how race shapes efforts to navigate support services.

Psychiatrist Cassandra Raphael says it's important to learn children's triggers and remember the importance of praise to reinforce positive behaviors. She says all Black children—whether neurotypical or neurodivergent—require affirmation and thoughtful parenting to survive. "I think of the high-profile case of Elijah McClain and similar young people who were targeted ostensibly for being Black and 'different.' They are at greater risk if their actions or intentions are misunderstood," says Dr. Raphael. "Early understanding and inclusion of neurodivergent Black youth fosters early self-esteem and collaboration, while also eliminating stigma that disconnects parts of the community from mental wellness."



Our CEO, Artemus X. Smith wrote and published, DAP, Born to Handjive.

In African-American culture, "giving Dap" is a unique form of non-verbal communication, featuring intricate handshakes and gestures that symbolize camaraderie and unspoken bonds. Its origins can be traced back to West African traditions brought to the Americas by enslaved Africans, offering a way to express affirmation, congratulations, or agreement through physical contact. During the 1970s, the Dap represented "Dignity And Pride" among African-American soldiers in the Vietnam War and has evolved into a selective and secretive form of greeting, emphasizing belonging and trust.

Book can be found on Barnes + Noble and Amazon

National Suicide Prevention Hotline: 1-800-273-8255

National Domestic Violence Hotline: 1-800-799-7233

Runaway and Homeless Teen Hotline Help: 1-800-246-4646

Coalition for the Homeless: 212-776-2000

Drug and Alcohol Hotline: 800-622-2255

Food and Hunger Hotline: 866-888-8777

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Rape Crisis Hotline: 212-227-3000

National Child Abuse Hotline: 1-800-422-4453

National Teen Dating Abuse Helpline: 1-866-331-9474

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American Pregnancy Helpline: 866-942-6466

Behavior Management Consultants believes that, “No Child is Born Bad”. Our mission is to educate, mentor, and assist parents, caregivers, and professionals to cope with, socialize, and identify values important to today’s youth.

The goal is to serve public and private social service organizations including, but not limited to:

- Residential Treatment Facilities (RTFs)
- Juvenile Detention Centers
- Residential Treatment Centers (RTCs)
- Public Schools
- Community Based Organizations (CBOs)

We are confident that we will meet our goals thereby ensuring that our clients are being kept abreast in the ever-changing landscape of Human/Social Services.

Quote of the Month

“Whatever is bringing you down, get rid of it. Because you’ll find that when you’re free . . . your true self comes out.”

Tina Turner

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