Addendum to “Suffer the Restless Children”
I wish I could say that the article you have just read is now only of historical interest. Alas, in the decade since it was written, we have witnessed an even greater tendency to throw around the ADHD label, to casually assume the existence of a biological disorder located within children’s heads, and to give kids a pill to get them to sit still. ADHD has metamorphosed from a familiar diagnostic classification into a fad, and an entire industry has grown up around it. It’s hard to go a week without running into a new book, magazine article, or talk show devoted to the topic, and nearly all are seemingly to the sort of elementary questions raised here. (One welcome exception is a recent book by Thomas Armstrong, known to many educators for his work in multiple intelligences, called The Myth of the A.D.D. Child.)[1]

In 1987, a support group called Children with Attention Deficit Disorder (CHADD) was founded. Ten years later, its name amended to include adults, the organization had 650 chapters around the country and had attracted some unwanted attention for the fact that part of its expenses are paid by Ciba-Geigy, the pharmaceutical giant that manufactures Ritalin. That company’s interest in depicting jumpy kids as having a disease (which is how most Americans already see things) is as unsurprising as its deep pockets. Based on surveys of pharmacists and doctors in 1995, Forbes magazine recently estimated that 8 million Ritalin prescriptions for children, and another 2.5 million for adults (16 and older), are written every year—although several prescriptions may be written for the same person. Measured by the number of daily doses, Ritalin use increased by an astonishing 400 percent in only five years, from 1989 to 1994, with Americans now spending more than a third of a billion dollars a year on the stuff.

The other major treatment for children diagnosed as “having” ADHD—the only alternative to drugs, as far as most people are concerned—is behavior modification. Some readers may be aware that there is a wealth of evidence showing that rewards are effective, at best, only superficially and temporarily, and at the cost of reducing interest in whatever had to be done to get the reward.[2] But several experiments have found that dangling goodies in front of children to deal with distractibility or hyperactivity in particular also doesn’t make much sense. In one study, rewards given to hyperactive children made them respond more impulsively.[3] In another, any beneficial effects of rewards (on reaction times) disappeared as soon as the rewards stopped coming, and sometimes they had the consequence of undermining performance from the beginning.[4] In yet a third study, this one with children who had short attention spans but were not hyperactive, rewards did not improve reaction time as the experimenters had expected; rather, they caused the children to make more mistakes.[5]

Whatever the limits and risks of the treatments, though, the fact remains that the status of the ADHD diagnosis itself. We live in a society where it is common to explain complicated phenomena by appealing to biological causes. On any given psychological issue, genetic factors get more attention than cultural factors do; emotional problems are likely to be investigated by looking at brains rather than at classrooms[6] or even at families. This is the research that gets funded, this is the orientation that is favored by science reporters, this is the explanation that is accepted on faith by the general public.[7] (This is also the sensibility that helps to explain the current enthusiasm among educators for “brain-based learning”: a tacit assumption that explanations for human behavior are not really scientific, and ideas for concrete practice are not truly justified, until they have been somehow grounded in biology.)[8]

Thus, it should not come as any surprise that the health columnist of the New York Times (to cite only one of hundreds of examples) declares without reservation—and without evidence—that ADHD “seems to be a neurological disorder that is often hereditary and that involves the brain mechanisms that regulate attention and impulse control.”[9] (The last assertion is certainly true, in the same sense that the anxiety experienced upon being fired from one’s job “involves” the brain mechanisms that regulate emotion, but the misleading and widely accepted implication here is that neurophysiological phenomena here is that neurophysiological phenomena are caused by a disease called ADHD.)

As it was a decade ago, most of the research on attention and hyperactivity is based on the premise that it is an organic disease. (To put this in perspective, at least three quarters of the research now conducted at the National Institute of Mental Health—that’s mental health—is biological in nature.) When something is discovered, it is cited, sometimes in exaggerated fashion, to support the medical explanation that most people accepted going in. In 1993, for example, much was made of a report in the New England Journal of Medicine that, of 49 people suffering from a rare, possibly genetic disease that involves resistance to thyroid hormone, 30 also satisfied the criteria for ADHD.[10] It was as predictable as it was foolish that this would be construed as evidence that ADHD, per se (assuming there is an ADHD, per se) is genetic.

Two years later, a study was published in the journal Child Development showing that “maternal anxiety/aggression and intrusive caregiving”—as well as other family variables such as the level of emotional support that young children receive—were significantly correlated with distractibility and/or hyperactivity.[11] That same year, a study appeared in a psychiatric journal demonstrating that children diagnosed as having ADHD “were found to be from families with higher conflict,” thus emphasizing “the importance of adverse family-environment variables as risk factors in ADHD.”[12] But neither of those studies made it into the popular press. Neither was publicized by the families in question or other members of CHADD. And neither slowed the ADHD juggernaut or the demand for Ritalin.

NOTES
6. While I have not made hyperactivity a primary area of study over the last ten years, I’m not aware of any attempts to replicate the two intriguing classroom studies mentioned in the article. Because the article was written for a popular magazine, it doesn’t include footnotes, but readers of this book might appreciate the citations for those original studies: Nona M. Flynn and Judith L. Rapoport, “Hyperactivity in Open and Traditional Classroom Environments,” Journal of Special Education 10 (1976): 285-90; and Rolf G. Jacob, K. Daniel O’Leary, and Carl Rosenblad, “Formal and Informal Classroom Settings: Effects on Hyperactivity,” Journal of Abnormal Child Psychology 6 (1978): 47-59.
8. For a critique of the tendency to make facile and unsubstantiated claims about neuroscientific “backing” for specific educational practices, see John T. Bruer, “Education and the Brain: A Bridge Too Far,” Educational Researcher, November 1997: 4-16.