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### New Guidelines on How to Accurately Convey ADHD Information

te Meerman, Sanne

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## New Guidelines on How to Accurately Convey ADHD Information

By **Sanne te Meerman** - October 17, 2024

**W**hen it comes to information on ADHD, there are no rules on what are considered good and bad practices. To this day, this results in websites, news messages and even academic textbooks that are very unbalanced and filled with fallacies.

Unbalanced, for instance, in the sense that much emphasis is placed on brain and genetic studies that to this day have cost billions of dollars, while showing only very small associations—not providing any basis for biological screening. At the same time, correlations that are much stronger often go unmentioned. A vivid example is that healthcare professionals tend to classify the youngest in a classroom as having ADHD up to twice as often as their older classmates—due to their normal age-appropriate behavior: a stunning but long-known research finding that has insufficiently found its way to a broader audience. [Fallacies are also very common](#), an important one being the 'nominal fallacy': thinking that by naming behaviors using denominators like ADHD and autism, we have explained them.

Now there is a new set of guidelines ([available here](#)) on how to talk about ADHD. The guidelines are meant for mental health professionals and journalists who write about ADHD, clinicians who explain ADHD to their clients and their families, and those who have the experiences that have been labeled as ADHD. The guidelines are meant to help explain what research on ADHD has actually found, its strengths and limitations, and more accurate ways to express what the classification means.



The creation of the guidelines began in 2018, when the Dutch research collective 'Druk & Dwars' (Wild and Willful) initiated a taskforce for their development. The project was funded by ZonMW, an independent government body that finances research in health, healthcare and well-being. I chaired the project, which was closely [related to my research on reification](#). A variety of healthcare professionals participated, including professors in pedagogy, psychiatry (neuro)psychology, policymakers in the healthcare domain, those experienced with ADHD, and many more.

The group did have a somewhat difficult start. Soon enough however, it became clear that none of the taskforce's members denied the phenomenon of people feeling restless, having trouble concentrating, for whatever reason or by whatever causes. Most in the taskforce also agreed that the criteria for the ADHD construct to be used are highly subjective and contextually situated and there is a risk of pathologizing normal (or often functional) behavior. Additionally, the discourse is too biologically oriented and often insufficiently acknowledges the influence of environmental and societal factors.

Fortunately, studies show that there are also many good practices available, explaining the outcomes of ADHD research very well. This led the group to choose a comparative approach, juxtaposing and comparing more and less desired examples to explain how and why one example is better and why the other examples may give a skewed/false perception of research outcomes.

Receiving a slow but positive reception in the Netherlands in 2022 and 2023, several additional practitioners in the field of psychiatry and psychology committed to translating the guidelines to English, resulting in the current revised and stylized version. Many topics are covered in the guidelines, mostly relating to causes and motives for the behaviors that fall under the ADHD umbrella. Topics include societal norms and contextual factors but also genetics, brain anatomy/physiology/chemistry, course over the lifetime, and more.

Although many subjects are discussed, some fallacies seem particularly important in perpetuating a flawed narrative that not only plagues ADHD, but many more of the

classifications defined in the DSM. These fallacies are, first and foremost the ‘ecological fallacy’: [the fact that average\(!\) group outcomes are used to justify categorically naming ADHD](#), a ‘neurobiological’ or even ‘neurological disorder’ while—by far—not every individual with ADHD has any neurobiological difference. This happens for instance in relation to anatomical brain studies—that indicate that those with ADHD slightly more often have a delayed brain maturation. Just as women have smaller brains than man on average, this is not true for every woman, and there are women with larger brains than the average man.

Furthermore, a smaller brain is not indicative of a brain condition. This issue, known in moral philosophy as the ‘fact-value’ distinction is also brought to the fore: *differences* (by whatever definition considered *factual*) are not *disorders* (as this is a statement of *value*, not of *fact*). The contemporary neurodiversity debate also relates to this subject and the guidelines provide concrete examples on how to avoid the trap of pathologizing what research can only show to be differences between people.

Genetic studies are also the cause of many misunderstandings. Mad in America printed [an article on an earlier study](#) on how many academic textbooks leave readers in the dark about the fact that genetic differences can hardly explain any of the ADHD behaviors. Those genetic variants that do contribute appear far more often in ‘normal’ people in absolute terms.

These and many other flaws in sources on ADHD are discussed in the guidelines. This gives everyone, especially website editors, journalists and informed parents an opportunity to improve information or talk back to sources that falsely suggest that those classified as having ADHD children and adults alike suffer from a brain condition in most cases. Other factors than dysfunctional brains, like schools being underfunded or our culture not being well-adapted to individual differences, are often overlooked. The predominantly biomedical narrative puts children at risk of being unnecessarily medicated and pathologized, can lead to despair and prognostic pessimism and [hinders parents and teachers to make an informed decision](#) to help their child or pupil.

This is, to our knowledge, the first set of guidelines on information about any of the disorders defined by the DSM. Many of the fallacies and imbalances also occur in relation to others classifications such as autism, depression and bipolar disorder—increasingly echoed by influencers on social media and resulting in an increasing burden on healthcare systems globally. Yet beyond the stigma and despair that individuals can experience due to the skewed and often misleading information, we have built a resource-spending institutional world that [depends on the revenues based on the narrative of medically treatable individual disorders](#). As these institutions have little incentive for change, it is time governments step up and start investing in more research into the medicalized narrative and push for more market control and guidelines on psycho-education.

For questions or feedback on these guidelines, you can contact the editor and co-author dr. Sanne te Meerman, University of Groningen. [S.te.meerman@rug.nl](mailto:S.te.meerman@rug.nl)

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*Mad in America hosts blogs by a diverse group of writers. These posts are designed to serve as a public forum for a discussion—broadly speaking—of psychiatry and its treatments. The opinions expressed are the writers' own.*



### **Sanne te Meerman**

After an unsettling encounter with the just released DSM-IV as a psychology freshman, Sanne switched to Sociology. 10+ years after graduating he returned to study [the DSM's influence](#) from a sociological perspective as a PhD. Together with his co-promotor Laura Batstra he founded [www.drukendwars.nl](http://www.drukendwars.nl) (Wild and Willful). The organisation aims, amongst others, to help parents and teachers deal with challenging interactions without the use of disorder classifications. This approach, called 'stepped diagnosis' was developed by Laura and Allen Frances, the DSM IV's former chair (turned DSM critic).