Consultation With Pediatricians in the Management of Attention-Deficit/Hyperactivity Disorder

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In recent years, attention-deficit/hyperactivity disorder (ADHD) has become a common pediatric diagnosis. The number of affected children increases with age, most particularly during the years of schooling and academic life, and can cause significant impairment. The nature of this disorder, the challenges of properly diagnosing it, and the involvement of numerous types of health care professionals in the ongoing management of children with ADHD have resulted in a new model of collaboration between pediatricians and psychologists. This may be done in consultation or in a more interdisciplinary fashion as members of an evaluation team. ADHD assessment typically requires numerous professionals to provide information in order to reach an appropriate diagnosis and intervention plan. Therefore, regardless of which specific type of collaboration occurs (interdisciplinary or consultative), improved communication between medical professionals and psychologists is paramount for effective management of children with ADHD.

In recent years, attention-deficit/hyperactivity disorder (ADHD) has become an exceedingly common pediatric diagnosis, with an estimated 1% to 2% of the preschool population showing functional impairment due to attentional symptoms (Barkley, 2006). The number of affected children increases with age, most particularly during the years of schooling and academic life, and can result in significant impairment because of the chronicity and variability of presentation of symptoms (Riley et al., 2008). Therefore, the estimated prevalence of ADHD, based on adherence to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) diagnostic criteria, is 5% to 7% of the general school-age population.

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(Rappley, 2005). However, an epidemiological study by Scahill and Schwab-Stone (2000) suggests the prevalence of ADHD in school-age children in North America is 5% to 10%, and other estimates range as high as 12% internationally (Stein et al., 2009), which far outpaces any other single type of behavioral disorder currently identified in this age group. The nature of this disorder, the challenges in properly diagnosing it, and the involvement of numerous types of health care professionals in the ongoing management of children with ADHD has resulted in a new model of collaboration between medical professionals and mental health professionals, specifically psychologists (in the community, in schools, or from hospital-based teams). This collaboration in North America has been constantly improving, with initiatives coming from professional organizations in both psychology (Arredondo, Shealy, Neale, & Winfrey, 2004) and in pediatrics (Stein et al., 2008). Innovations in utilization of child psychology services for both inpatient and outpatient settings have led to far more contact between mental health professionals and medical specialists (Gelfand et al., 2004). The inherent link between pediatricians and psychologists sometimes may be strengthened by caregivers (Stille, Primack, McLaughlin, & Wasserman, 2007), which creates even more opportunities for collaboration. What remains scarce, however, is a truly interdisciplinary collaboration involving psychologists and physicians working synchronously and performing evaluations together. The main goal of this article is to outline current methods for assessment and management of ADHD and to explore increased collaboration between professionals from multiple disciplines.

The field of pediatrics has undergone numerous changes in the past century, some of them quite profound and fundamental. Although child health as a distinct entity or a field of inquiry has evolved over the centuries of human history, the most relevant definition of pediatric care has been in existence for less than 200 years (Colon, 1999). Similar statements can be made about recent changes in the field of psychology, and it is clear that an increasing amount of collaborative work between these two fields is taking place due to consultation and greater interprofessional exchange of ideas (Arredondo et al., 2004). Presently, a fairly well-established relationship and pattern of shared responsibility exists between pediatrics and psychology (Soons & Denollet, 2009). The elucidation of diagnoses, continued surveillance of children with behavioral issues such as ADHD, and reassessment have equal contributions from many professionals, and psychologists and pediatricians tend to be implicated as case coordinators or interpreters of information most frequently (LeBaron & Zeltzer, 1985). Thus, there is an emerging need to strengthen the bond between psychologists and pediatricians. Two significant shifts in the type of care provided by pediatricians have made the required connection more evident: (a) reduced burden of management of overwhelming acute infectious disease (e.g., smallpox, polio, measles) thanks to successful vaccination and sanitation programs throughout the world and (b) increased care for school-age children and
adolescents due to changing demographics and diminished mortality in the neonatal period (Colon, 1999).

Due to these changes in the practice of the profession, pediatric care has needed to increase focus on psychosocial difficulties related to academic performance. Pediatric training has also metamorphosed in recent decades, with more emphasis on subspecialty instruction and greater competency in the developmental and behavioral issues arising in childhood (Olson et al., 2001). Initial efforts from the 1930s to integrate more psychology instruction into the teaching of pediatrics, which were mildly successful at best (LeBaron & Zeltzer, 1985), slowly progressed to a more successful collaborative method of consultation with pediatricians (Kagan, 1965). In the present context of child health care, there is an emerging trend toward shared expertise between pediatricians and psychologists (Foy & Earls, 2005).

DEFINING ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder that has significant impact on behavioral functioning and on domains of attention and executive function. According to the *DSM-IV-TR* (American Psychiatric Association, 2000), the core behavioral features of ADHD include inattention, hyperactivity, and impulsivity. The theoretical and research literature support the assumption that ADHD is a multidimensional rather than a unitary disorder. This has led to the inclusion of three diagnostic subgroups in the *DSM-IV-TR*: ADHD, Combined Type (ADHD-C); ADHD, Predominantly Inattentive Type (ADHD-IA); and ADHD, Predominantly Hyperactive-Impulsive Type (ADHD-HI). These diagnostic subgroups differ in symptom criteria based on the severity and duration of symptoms. Children with significant levels of inattention, hyperactivity, and impulsivity over a 6-month period meet the *DSM-IV-TR* diagnostic criteria for the ADHD-C. Likewise, ADHD-HI is diagnosed in children who present with significant levels of hyperactivity and impulsivity lasting for a period of 6 months but may either manifest lesser level of inattention or for a lesser duration of time. Children with ADHD-IA present with significant levels of inattention for a period of 6 months but do not meet the same criteria for symptoms of hyperactivity and impulsivity (Williams, Klinepeter, Palmes, Pulley, & Foy, 2004).

TOOLS USED FOR DIAGNOSIS OF ADHD

The behavioral symptoms of ADHD are assessed using parent, teacher, and self-report behavioral rating scales. There are numerous common scales, and most clinicians are readily able to use the results of any of these to
identify at-risk children and adolescents. Those who meet diagnostic criteria based on these questionnaires often do not require significant amounts of further testing or observation. The most widely known and standardized ADHD rating scales that are familiar to professionals from various disciplines include the Conners Rating Scales-Revised (CRS-R; Conners, 1997), ADHD Rating Scale-IV (ADHD-IV; DuPaul, Power, Anastopoulos, & Reid, 1998), the Attention Deficit Disorder Evaluation Scales (ADDES; McCarney, 1995), the Brown Attention-Deficit Disorder Scales (T. E. Brown, 1996, 2001), ADD-H: Comprehensive Teacher’s Rating Scale (ACTeRS; Ullmann, Sleator, & Sprague, 2000), Attention Deficit/Hyperactivity Disorder Test (ADHDT; Gilliam, 1995), the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983), and the Behavior Assessment Scale for Children (BASC; Reynolds & Kamphaus, 1998). In a recent comparative evaluation, Demaray, Schaefer, and DeLong (2003) recommend the CRS-R, the ADDES, and the ADHD-IV as psychometrically sound rating scales to assess for DSM-IV behavioral symptoms of ADHD across home and school settings. In conjunction with these rating scales, parent and teacher interviews and classroom observations are standard practice in most mental health settings and part of the multimethod assessment protocol.

Alongside behavioral rating scales, clinicians also use neuropsychological batteries that commonly include the Conners Continuous Performance Test (CPT; Conners, 1994), Test of Every Day Attention (TEA-Ch; Manly, Robertson, Anderson, & Nimmo-Smith, 1999), and the Developmental NEuro PSYchological Assessment, 2nd ed. (NEPSY-II; Korkman, Kirk, & Kemp, 2007a). There is little research to support the diagnostic utility of neuropsychological tests in ADHD, and their clinical application mainly assists in obtaining further information about a child’s attentional and executive function impairments.

PROFESSIONALS INVOLVED IN THE DIAGNOSIS OF ADHD

Although several types of mental health professionals may be involved in the assessment, treatment, and management of ADHD (e.g., school psychologist, neuropsychologist, speech and language therapist, occupational therapist, social worker), typically psychiatrists, neurologists, and developmental pediatricians will diagnose the disorder (Witko, Bernes, & Nixon, 2005). This demonstrates the need for subspecialty care in the identification of children with ADHD and underscores the essential nature of collaborative communication between primary care pediatricians and school psychologists in follow-up. In recent years, there has been interest among health care professionals to increase involvement of school psychologists and educators in diagnostic assessment of these children.
The Psychology Perspective

Overview. Collaboration among interdisciplinary mental health care professionals such as psychologists and pediatricians has become necessary because there is an overlap in providing mental health care for children (Watson, Heppner, Roos, Reid, & Katz, 2005). Efforts continue to maximize efficiency in interprofessional communication and to improve the scope of such interaction (Arrendondo et al., 2004). Such collaboration among mental health care professionals is crucially important when a child is referred for a formal assessment to rule out ADHD (M. B. Brown, 2002) given the heterogeneous and chronic nature of this disorder. Considering the high incidence of ADHD, successful collaboration among interdisciplinary mental health care professionals is important for appropriate management of ADHD.

Very frequently, a referral for assessment of ADHD is made by the teacher of a school-age child. In the academic setting it is the teacher or teacher’s aide who may observe that the child is consistently off task, easily distracted, hyperactive, fails to complete assignments, and is performing poorly in academic work. Following such observations, and in consultation with the school personnel and the child’s parents, a formal referral is then made to the school psychologist to psychometrically assess for ADHD. School psychologists are often qualified to conduct evidence-based assessments to rule out childhood disorders such as ADHD (Koonce, 2007; Shapiro & Manz, 2004). However, depending on the amount of time before a child gains access to a school psychologist, a formal referral for assessment of ADHD may also be made to a psychologist in a community mental health setting or hospital (e.g., child psychology/psychiatry outpatient department). Alternatively, a referral may be initiated by a child’s pediatrician, and consultation with a psychologist is requested to clarify the child’s strengths and weaknesses as well as to determine the finer details of ADHD subtype.

What is done to evaluate a child for ADHD. Properly evaluating for ADHD requires a multimethod assessment protocol. This includes obtaining information about the child’s functioning across multiple settings. As a first step, it is best practice to obtain information about the child’s functioning at home and school through parent and teacher interviews and behavioral rating scales. Direct classroom observation is also considered an essential, or at least highly useful, component of ADHD evaluation because it provides an objective measure of the child’s problem behavior within the classroom settings (Nock & Kurtz, 2005). Barkley (2006) and Anastopoulos and Shelton (2001) assert that a comprehensive evaluation to rule out ADHD should focus on assessing for the presence of DSM-IV symptoms of ADHD. Furthermore, because ADHD is often comorbid with learning disabilities, an assessment of the child’s intellectual and academic functioning using psychometric tests is useful.
Despite these general guidelines, implementing appropriate services to assess for ADHD varies across settings. It is not uncommon to find variability in the methods and assessment tools used to rule out ADHD (Demaray, Elting, & Schaefer, 2003). School psychologists often include clinical interviews, behavioral rating scales, conduct classroom observations, and use psychometric tests (Koonce, 2007). Community mental health settings and hospitals, on the other hand, may eschew classroom observations and clinical interviews but use neuropsychological tests such as the CPT, the TEA-Ch, or the NEPSY-II. There are some professionals who argue that the use of psychometric tests and neuropsychological tests is not useful in diagnosing ADHD (e.g., Barkley, 2006; Robin, 1998) but rather merely provide information about other problem areas of functioning. Furthermore, there are little data to support which of the commonly used behavioral rating scales truly serve as gold standard diagnostic assessment tools for ADHD. However, Demaray, Schaefer, et al. (2003) recommend the CRS-R, the ADDES, and the ADHD-IV as psychometrically sound rating scales to assess for DSM-IV behavioral symptoms of ADHD across home and school settings. Koonce (2007) asserts that assessment methods vary across mental health settings mainly because there is a lack of consensus as to which assessment instruments and methods constitute gold standard tools to diagnose ADHD. He recommends that a psychologist’s decision about the choice of assessment instruments should depend on whether unique information would be obtained from that instrument to rule out ADHD.

Interpretation of information and further consultation with a pediatrician/medical professional. After completing a satisfactory assessment process, identifying the symptomatology and behavior patterns consistent with a diagnosis of ADHD, the psychologist will usually synthesize the findings from the assessment in a summary report. The primary purpose of this report is to describe the child’s attentional functioning and any relevant information about academic performance or other behavioral parameters worth considering as comorbidities of ADHD. As such, the assessment data obtained from multiple sources are crucial components of making a clinical decision as to whether the child meets the criteria for a diagnosis of ADHD. In order to make this clinical decision, the assessment data must collectively support the DSM-IV criteria for ADHD. If these criteria are met, but there remains some need to clarify underlying issues, then the psychologist may make a consultative referral to a psychiatrist to confirm the behavioral diagnosis. In most cases where pharmacotherapy is considered as a treatment for ADHD, the child is referred to his or her pediatrician.

What is shared with school/parents. The psychologist will share results of assessment with both the parents and the school. The report will provide parents with information regarding ways to manage their child’s ADHD behavior at home such as creating a structured home environment, encouraging attentiveness and concentration, and praising and reinforcing
positive behavior. The psychologist will further make recommendations to the parents to seek support resources within their community to gain skills in managing and coping with their child’s ADHD behavior. At the academic level, a child with ADHD will require school-based accommodations to lessen the impact of the disorder on the child’s school functioning. Thus, the report will outline the child’s areas of academic and behavioral strengths and weaknesses and what type of accommodations are required for the child to successfully function at school. For example, if the child is found to have a comorbid learning disability, then recommendations might be made to the school to formulate an individualized education plan to monitor the student’s progress in areas of academic difficulties.

The Pediatric Perspective

*Overview.* Generally pediatricians tend to inquire about ADHD as a routine part of health maintenance for school-age children (Stein et al., 2009). The likelihood for detailed inquiry increases when any behavioral issues are raised by parents, and certainly if there are reports from school or community-based psychologists suggesting the diagnosis, more specific history is obtained during a clinical visit. Interestingly, many primary care pediatricians diagnose and treat ADHD based on office visits (McKenzie & Wurr, 2004), and there is wide variation in the methodology used for assessment of diagnostic criteria. The literature suggests that pediatricians would like much more aid in making the diagnosis of ADHD (Stein et al., 2009) and that best practices ought to be applied even to initial evaluation of the behavioral symptoms consistent with underlying ADHD (McGough & McCracken, 2000). Some studies indicate that up to 50% of children with ADHD are not assessed or managed by a child mental health specialist and do not necessarily receive tailored intervention as a result (Leslie, Weckerly, Plemmons, Landsverk, & Eastman, 2004). Historically, consultation between pediatricians and psychologists used to take place unidirectionally, with pediatricians receiving requests from parents or school officials for further assessment of a child with suspected ADHD. Such children and their families would be referred to a psychologist for more intensive testing of academic and attentional skills. More recently, thanks to some of the changes in practice described earlier, this consultation has grown more bidirectional. In addition, the presence of psychologists on multidisciplinary teams in developmental pediatric clinics has allowed for effective communication on a more regular basis when patients are evaluated in primary care and then sent for team assessment. Further, this type of collaborative consultation allows for parental mediation as another means of verifying information between professionals (Stille et al., 2007).

*Acquiring appropriate information for assessment.* When the diagnosis of ADHD is suggested by a school and confirmed with psychological testing
that shows a child meets the *DSM-IV* criteria for one of the subtypes of ADHD, the pediatrician is often asked to participate in the management of the disorder (Committee on Quality Improvement, Subcommittee on Attention-Deficit/Hyperactivity Disorder, 2000). In order to participate as a member of the child's intervention team, most pediatricians prefer to have a clear description of the behaviors observed at home and school (Stein et al., 2009) as well as more detailed reports from all professionals involved, beyond the history and physical examination they routinely perform. Although a number of primary care pediatricians have begun to use behavioral rating scales as part of their evaluation of children with attentional difficulties, making full use of standardized scales and questionnaires remains mainly the domain of subspecialist pediatricians such as developmental-behavioral pediatricians or adolescent medicine specialists as well as child psychiatrists and child neurologists (Stein et al., 2009).

Typical recommendations made by pediatricians. As the overall evaluation of behavioral disorders has matured, attempts have been made to expand the methods of intervention for children with ADHD. The American Academy of Pediatrics, the Canadian Pediatric Society, and other pediatric organizations have developed several unique algorithms leading to appropriate recommendations (Leslie et al., 2000). Most of these do try to follow current standards of care arising from evidence-based approaches to ADHD diagnosis and management (Barkley, 2006), which suggests that treatment with psychostimulant medication with or without behavior modification is the optimal treatment modality for most children who have the disorder. Current guidelines tend to outline a set of pediatric recommendations as follows:

- If the diagnosis of ADHD is confirmed using rating scales, then treatment with medication is favored, and specific medication algorithms exist for the use of psychostimulants and other psychopharmacologic therapy for ADHD. Although follow-up care is required, there is a substantive amount of this performed within the context of the pediatric clinic (Leslie et al., 2000).
- If ADHD is diagnosed with suspicion of significant comorbidities or psychosocial issues (e.g., family stressors, any discrepant results in rating scales between school and family), then more in-depth evaluation with a psychologist is suggested.
- If there is some suspicion of a learning disability based on history and concerns of the family or school, then an academic evaluation is required to explore the possibility of this important comorbidity.
- If there are organic concerns or dysmorphic features noted at the time of evaluation for ADHD, or if there are behaviors inconsistent with a pure ADHD diagnosis, then a referral by the primary care pediatrician to either neurology, genetics, or developmental pediatrics is warranted.
This is particularly true for those children whose inattentive behaviors may be similar to absence seizures or consistent with an underlying neuroanatomic or neurophysiologic problem (tumor, increased intracranial pressure, neurodegenerative disease process) that cannot be ignored (Leslie et al., 2000).

A major purpose of pediatric consultation for these children is to rule in or rule out any number of associated conditions. ADHD tends to be a diagnosis accompanied by a number of associated symptoms and even associated disorders (Barkley, 2006), such as Gilles de la Tourette Disorder, behaviors that can lead to Oppositional Defiant Disorder, and dyslexia, to name a few.

Challenges in consultation. Apart from the initial steps in evaluation, psychologists are often asked to take on the role of case coordination in the academic setting as a recommended medication trial and titration take place (Bray & Rogers, 1995). As mentioned earlier, there is ample evidence for highly effective and consistent contact between pediatricians and psychologists who are both involved in the care of a child with ADHD, but much of this is anecdotal. In fact, there is growing concern that many pediatricians are actually taking on too many responsibilities and possibly presuming diagnoses in the absence of extremely necessary information at the time of evaluation (Stein et al., 2009). Additionally, there are few formal guidelines as to the best means to facilitate collaboration without confusing professional roles. Recent studies have also shown that pediatricians themselves are not always able to elicit all pertinent information when communicating with patients and parents (Burstein, Bryan, Chao, Berger, & Hirsch, 2005). Indeed, it appears that the parents of children with special health needs such as ADHD are often the most important cog in the system of effective, efficacious, and efficient communication with health professionals, without whom collaborative efforts between psychologists and pediatricians would be largely fruitless (Stille et al., 2007).

This manner of findings is indicative of a more nuanced difficulty in interprofessional communication that has yet to be fully examined and resolved (Arredondo et al., 2004). Much of the practical, day-to-day communication that occurs between members of a child’s management team (including the pediatricians, psychologists, teachers, tutors, speech-language pathologists, occupational therapists, resource aides, social workers, nurses, school administrators, and any other hospital or clinic-based professionals who find themselves implicated in care) takes place through written documents and is not done in real time (Bergman & Fritz, 1985). Reliance on written information results in two obvious, major pitfalls for many such consultations: (a) highly important observations are missed because they are not always quickly transcribed into reports and surveillance is thus weakened and (b) lingering questions or suggestions often go undiscovered for weeks at a time, resulting
in less-than-optimal care for the child and for the management of ADHD symptomatology.

**DISCUSSION AND RECOMMENDATIONS**

There are many perspectives on the most useful means of consulting pediatric services and collaboration interprofessionally for the management of children with ADHD. From the context of a psychologist who identifies a child with attentional problems, particularly in the academic context, the most pressing practical need is assistance with potential medical intervention. The pediatrician receiving such a consultation request is then likely the one to provide access to psychopharmacologic therapy but may or may not be involved in long-term care of the child. In the inverse scenario, a psychologist who receives a request to perform specific attentional testing for a child with ADHD symptoms is equally vulnerable to an isolated consultation for clarification of the diagnosis and then may not participate in further treatment or care of the child (Forrest et al., 1999; McGough & McCracken, 2000).

The optimal approach to pediatrician-psychologist consultation for children with ADHD should be modeled more closely after the kind of management that occurs with other chronic psychosocial diagnoses requiring closer surveillance (e.g., mood disorders) that by necessity create numerous opportunities for discussion and regular contact between medical professionals and mental health professionals (Olson et al., 2001). However, it is worth commenting on the fact that the literature seems to point to the fact that there remains some degree of discomfort on the part of general pediatricians when dealing with child mental health problems of any kind (Stein et al., 2008). Although this sense of awkwardness on the part of some pediatricians cannot be completely alleviated, there are means to address this issue while keeping in mind that the it is essential to find recommendations that are useful to families and can be implemented by all members of the child’s health care team. This team can be quite small in some instances but is often quite large and includes a variety of allied health professionals and medical specialists. Perhaps the clearest path to recommendations that are helpful for all professionals involved in the care of children with ADHD as well as for the family is directive subspecialty consultation (Egger, Kondo, & Angold, 2006). In this approach, consultation to a child neurologist or developmental pediatrician implies not only a request for an ancillary treatment plan but also for collaborative and ongoing management in conjunction with psychological services and school adaptations. This may be a way avoid the discomfort that some generalists continue to feel regarding developmental diagnoses such as ADHD (Stein et al., 2008). Further, it is a way to build a cohesive team that will establish rapport and work together toward common,
shared goals for intervention, ultimately benefiting the child and family enormously.

To build a truly interdisciplinary and collaborative model of consultation, which moves beyond the typical interrupted means of communication that tends to occur in ADHD management, it is apparent that a new perspective on relevant teams is necessary. It is apparent from the previous discussion that it is essential to build teams including psychologists and pediatricians/family doctors who work synchronously and participate in real-time discussions with each other (Grenier, Chomienne, Gaboury, Ritchie, & Hogg, 2008). Current interprofessional consultation for ADHD often takes place within the context of multiple individuals who may not share a perspective or who experience very different facets of a child’s life. Although it is important to use direct observation of behavior in different milieus in order to properly assess ADHD, a more consolidated team with increased opportunities for communication and interaction is necessary to move beyond the current compartmentalized method of assessment and management (Heneghan et al., 2008).

Although there are certainly obstacles to this consolidative approach, it would appear that the long-standing rapprochement between the fields of psychology and pediatrics creates a milieu that is conducive to increasing shared responsibilities and management (Kates, 2002). Given the high prevalence of ADHD there is every reason to believe that an effective strategy implemented for this disorder could be a template for appropriate management of other behavioral issues in childhood. If pediatric consultation takes place in the appropriate context and with the recognition that ensuing consultative communication with psychologists and other professionals is mandatory as part of the follow-up process, then it is likely that the single most important facet of the entire diagnostic, management, and surveillance process will not be overlooked: the provision of individualized, highly appropriate interventions for the child with ADHD that can be undertaken by the family and school. Although there is undoubtedly great value in improving collaboration between psychologists and pediatricians for the sake of academic and professional facilitation, optimizing patient care must remain the focus and will surely be best served by continued efforts to communicate effectively when formulating management plans (Pace, Chaney, Mullins, & Olson, 1995). Including everyone involved in the care of a child with ADHD is a long-term goal and is a logical outcome when pediatric-psychologic consultation takes place in a highly effective manner. If increased education and effort is undertaken toward true team building, then it is likely that interdisciplinary teams will arise naturally and optimize evaluation and ongoing care of children with ADHD. Involvement of school-based professionals in a hospital-based or community-based team, although logistically difficult, is another way to significantly improve collaboration.
REFERENCES


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