# COMMUNITY PSYCHIATRIC CENTERS

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## THE "ANSWERS" SERIES

## Attention-Deficit / Hyperactivity Disorder

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The following answers are from excerpts of the writings of Dr. Lowenstein, M.D., Dr. Carosso, Psy.D., latest research findings, the DSM-V, and from the National Institute of Mental Health (http://www.nimh.nih.gov/publicat/adhd.cfm.)

**Attention-Deficit/Hyperactivity Disorder**

Attention Deficit Hyperactivity Disorder (ADHD) is a condition that typically surfaces in the preschool and early elementary school years. It is difficult for these children to control their behavior and maintain attention. It is estimated that between three and five percent of children have ADHD, which comes to approximately two million children in the United States. This means that in a classroom of 25 to 30 children, it is estimated that at least one child will have significant signs of ADHD.

**Symptoms**

The three principal characteristics of ADHD are **inattention**, **hyperactivity**, and **impulsivity**. These symptoms appear early in a child's life. Many typical children may have these symptoms, but at a low level, or the symptoms may be caused by another disorder. Consequently, it is important that the child in question receive a thorough examination and appropriate diagnosis by a Licensed Psychologist or Board Certified Child Psychiatrist.

Symptoms of ADHD appear over the course of many months with the symptoms of impulsivity and hyperactivity preceding those of inattention, which may not surface until some time later. Various symptoms may surface in different settings depending on the demands the situation. A child who is described as "disruptive" or that "he can't sit still" will undoubtedly be noticeable in school, but the inattentive daydreamer may be overlooked. The impulsive child, who acts before thinking, may be seen as a "discipline problem," while the child who is passive or sluggish may be viewed as merely unmotivated. However, both may have different types of ADHD. All children are sometimes restless, act without thinking, and occasionally daydream. However, when the child's hyperactivity, distractibility, poor concentration, or impulsivity negatively influence performance in school, social relationships, or behavior at home, ADHD may be suspected. ADHD is not easy to diagnose because the symptoms may vary across settings, which is especially true when inattentiveness is the primary symptom.

The *Diagnostic and Statistical Manual of Mental Disorders*[2] (DSM-IV-TR), the resource used by practitioners to diagnose clinical disorders, lists three patterns of behavior that indicate ADHD. Children with ADHD may show several signs of being consistently inattentive and may have a pattern of being hyperactive and impulsive far more than others of their age. Or they may demonstrate all three types of behavior. As such, there are three subtypes of ADHD listed in the DSM-IV-TR: **predominantly hyperactive-impulsive**

**type** (child does not show significant inattention); the **predominantly inattentive type** (child does not show significant hyperactive-impulsive behavior) sometimes called ADD—an outdated term for this entire disorder; and the **combined type** (that displays both inattentive and hyperactive-impulsive symptoms).

**The Hyperactive-Impulsive Type**

**Hyperactive** children seem to be "on the go" or constantly in motion. They may dash around touching or playing with whatever is in sight, or talk incessantly. Sitting still at dinner or during a school lesson or story can be quite a challenge. These children tend to squirm and fidget in their seats or roam throughout the room. They may also wiggle their feet, touch everything, and noisily tap their pencil on the desk. Hyperactive teenagers or adults may feel internally restless and often report needing to stay busy and may try to do several things at once.

**Impulsive** children seem unable to control their immediate reactions or think before acting. They will often blurt out inappropriate comments, display emotion without restraint, and act without regard for the later consequences of their conduct. Their impulsivity may make it hard for them to wait for things they want or to take their turn in games. They may grab a toy from another child or hit when they're upset. As teenagers or adults, there may a tendency to impulsively choose endeavors have an immediate but small payoff rather than complete activities that may take more effort but provide greater albeit delayed rewards.

- Signs of **hyperactivity-impulsivity:** Feeling restless, fidgeting with hands or feet, or squirming while seated. Running, climbing, or leaving a seat in situations where sitting or quiet behavior is expected;
- Blurting out answers before hearing the whole question
- Having difficulty waiting in line or taking turns.

**Inattention**

Inattentive children have difficulty concentrating on any one thing and often get bored with a task after only a few minutes. However, if doing something enjoyable, there is far less of a tendency to have trouble paying attention while deliberate, conscious attention to organizing and completing a task or learning something new or unappealing, i.e. homework, is difficult.

Homework is particularly challenging for inattentive children. They often forget to write down an assignment or leave it at school. They forget to bring a book home, or bring the wrong one. The homework, if finished, tends to be full of errors and erasures. Homework is often accompanied by frustration for both parent and child.

The DSM-IV-TR gives these signs of

**Inattention**:

- Often becoming easily distracted by irrelevant sights and sounds

- Often failing to pay attention to details and making careless mistakes
- Rarely following instructions carefully and completely losing or forgetting things like toys, or pencils, books, and tools needed for a task
- Often skipping from one uncompleted activity to another.

Children diagnosed with the Predominantly Inattentive Type of ADHD are seldom impulsive or hyperactive but they have significant problems paying attention. They appear to be daydreaming, "spacey," easily confused, slow moving, and lethargic. They may have difficulty quickly processing information as accurately as other children. This child has a hard time understanding what he or she is supposed to do and makes frequent mistakes. Yet the child may sit quietly, unobtrusively, and even appear to be working but not fully attending to or understanding the task and the instructions.

These children don't show significant problems with impulsivity and overactivity in the classroom, on the school ground, or at home. They may get along better with other children than the more impulsive and hyperactive types of ADHD, and they may not have the same sorts of social problems so common with the combined type of ADHD. So often their problems with inattention are overlooked. But they need help just as much as children with other types of ADHD, who cause more obvious problems in the classroom.

**Is It Really ADHD?**

Not everyone who is overly hyperactive, inattentive, or impulsive has ADHD. Since most people sometimes blurt out things they didn't mean to say, or jump from one task to another, or become disorganized and forgetful, how can specialists tell if the problem is ADHD?

Because everyone shows some of these behaviors at times, the diagnosis requires that such behavior be demonstrated to a degree that is inappropriate for the person's age. The diagnostic guidelines also contain specific requirements for determining when the symptoms indicate ADHD. The behaviors must appear early in life, before age 7, and continue for at least 6 months. Above all, the behaviors must significantly interfere in at least two areas of the child's life such as in the schoolroom, on the playground, at home, in the community, or in social settings. Consequently, someone who displays some symptoms but whose schoolwork or friendships are not impaired by these behaviors would not be diagnosed with ADHD. Neither would a child who seems overly active on the playground but functions well elsewhere receive an ADHD diagnosis.

To assess whether a child has ADHD, specialists at C.P.C., including Dr. Lowenstein and Dr. Carosso, consider several critical questions: Are these behaviors excessive, long-term, and pervasive? That is, do they occur more often than in other children the same age? Are they a continuous problem, not just a response to a temporary situation?

Do the behaviors occur in several settings or only in one specific place like the playground or in the schoolroom? The person's pattern of behavior is compared against a set of criteria and characteristics of the disorder as listed in the DSM-IV-TR.

**Diagnosis**

Some parents see signs of inattention, hyperactivity, and impulsivity in their toddler long before the child enters school. The child may lose interest in playing a game or watching a TV show, or may run around completely out of control. However, because children mature at different rates and are very different in personality, temperament, and energy levels, it's useful to obtain an evaluation by a Licensed or Board Certified practitioner of whether the behavior is appropriate for the child's age.

A formal diagnosis of ADHD is made from an evaluation by a Licensed Psychologist or Psychiatrist. There is no one specific "test" for Attention-Deficit/ Hyperactivity Disorder (ADHD) but, rather, a comprehensive evaluation will include obtaining a thorough history, discussing his current behavior, and assessing your child during a clinical interview. Behavior rating scales will also be used to assess rates, severity, and frequency of behaviors in the home, school, and community. It is important to rule-out other possibilities including an anxiety disorder that, in children, can mimic signs of ADHD. If the problematic behavior, including hyperactivity, impulsivity, distractibility, and inattentiveness, is of significant severity and interfering with his daily functioning, then an ADHD diagnosis may be warranted at which time there are numerous treatment

**What Causes ADHD?**

Parents often ask "why? What went wrong?" or "did I do something to cause this?" There is little compelling evidence at this time that ADHD arises purely from social factors or child-rearing methods. Most substantiated causes appear to fall in the realm of neurobiology and genetics. This is not to say that environmental factors may not influence the severity of the disorder, and especially the degree of impairment and suffering the child may experience, but that such factors do not seem to give rise to the condition by themselves.

The parents' focus should be on looking forward and finding the best possible way to help their child. Scientists are studying causes in an effort to identify better ways to treat, and perhaps someday, to prevent ADHD. They are finding more and more evidence that ADHD does not stem from the home environment, but from biological causes. Knowing this can remove a huge burden of guilt from parents who might blame themselves for their child's behavior.

Over the last few decades, scientists have come up with possible theories about what causes ADHD. Some of these theories have led to dead ends, some to exciting new avenues of investigation.

**Environmental Contributors.**

Studies have shown a possible correlation between the use of cigarettes and alcohol during pregnancy and risk for ADHD in the offspring of that pregnancy. As a precaution, it is best during pregnancy to refrain from both cigarette and alcohol use.

Another environmental agent that may be associated with a higher risk of ADHD is high levels of lead in the bodies of young preschool children. Since lead is no longer allowed in paint and is usually found only in older buildings, exposure to toxic levels is not as prevalent as it once was. Children who live in old buildings in which lead still exists in the plumbing or in lead paint that has been painted over may be at risk.

**Brain Injury.**

One early theory was that attention disorders were caused by brain injury. Some children who have suffered accidents leading to brain injury may show some signs of behavior similar to that of ADHD, but only a small percentage of children with ADHD have been found to have suffered a traumatic brain injury.

**Food Additives and Sugar.**

It has been suggested that attention disorders are caused by refined sugar or food additives, or that symptoms of ADHD are exacerbated by sugar or food additives. In 1982, the National Institutes of Health held a scientific consensus conference to discuss this issue. It was found that diet restrictions helped about 5 percent of children with ADHD, mostly young children who had food allergies.[3] A more recent study on the effect of sugar on children, using sugar one day and a sugar substitute on alternate days, without parents, staff, or children knowing which substance was being used, showed no significant effects of the sugar on behavior or learning.[4]

In another study, children whose mothers felt they were sugar-sensitive were given aspartame as a substitute for sugar. Half the mothers were told their children were given sugar, half that their children were given aspartame. The mothers who thought their children had received sugar rated them as more hyperactive than the other children and were more critical of their behavior.[5]

**Genetics.**

Attention disorders often run in families, so there are likely to be genetic influences. Studies indicate that 25 percent of the close relatives in the families of ADHD children also have ADHD, whereas the rate is about 5 percent in the general population.[6] Many studies of twins now show that a strong genetic influence exists in the disorder.[7]

Researchers continue to study the genetic contribution to ADHD and to identify the genes that cause a person to be susceptible to ADHD. Since its inception in 1999, the Attention-Deficit Hyperactivity Disorder Molecular Genetics Network has served as a way

for researchers to share findings regarding possible genetic influences on ADHD.

**Disorders that Sometimes Accompany ADHD**

**Learning Disabilities.**

Many children with ADHD—approximately 20 to 30 percent—also have a specific learning disability (LD). In preschool years, these disabilities include difficulty in understanding certain sounds or words and/or difficulty in expressing oneself in words. In school age children, reading or spelling disabilities, writing disorders, and arithmetic disorders may appear. A type of reading disorder, *dyslexia*, is quite widespread. Reading disabilities affect up to 8 percent of elementary school children.

**Tourette Syndrome.**

A very small proportion of people with ADHD have a neurological disorder called Tourette syndrome. People with Tourette syndrome have various nervous tics and repetitive mannerisms, such as eye blinks, facial twitches, or grimacing. Others may clear their throats frequently, snort, sniff, or bark out words. These behaviors can be controlled with medication. While very few children have this syndrome, many of the cases of Tourette syndrome have associated ADHD. In such cases, both disorders often require treatment that may include medications.

**Oppositional Defiant Disorder.**

As many as one-third to one-half of all children with ADHD—mostly boys—have another condition, known as oppositional defiant disorder (ODD). These children are often defiant, stubborn, non-compliant, have outbursts of temper, or become belligerent. They argue with adults and refuse to obey.

**Conduct Disorder**

About 20 to 40 percent of ADHD children may eventually develop conduct disorder (CD), a more serious pattern of antisocial behavior. These children frequently lie or steal, fight with or bully others, and are at a real risk of getting into trouble at school or with the police. They violate the basic rights of other people, are aggressive toward people and/or animals, destroy property, break into people's homes, commit thefts, carry or use weapons, or engage in vandalism. These children or teens are at greater risk for substance use experimentation, and later dependence and abuse. They need immediate help.

**Anxiety and Depression.**

Some children with ADHD often have co-occurring anxiety or depression. If the anxiety or depression is recognized and treated, the child will be better able to handle the problems that accompany ADHD. Conversely, effective treatment of ADHD can have a positive impact on anxiety as the child is better able to master academic tasks.

**Bipolar Disorder.**

There are no accurate statistics on how many children with ADHD also have bipolar disorder. Differentiating between ADHD and bipolar disorder in childhood can be difficult. In its classic form, bipolar disorder is characterized by mood cycling between periods of intense highs and lows. But in children, bipolar disorder often seems to be a rather chronic mood dysregulation with a mixture of elation, depression, and irritability. Furthermore, there are some symptoms that can be present both in ADHD and bipolar disorder, such as a high level of energy and a reduced need for sleep. Of the symptoms differentiating children with ADHD from those with bipolar disorder, elated mood and grandiosity of the bipolar child are distinguishing characteristics.[11]

**The Treatment of ADHD**

The results of numerous and extensive research studies suggest that long-term behavioral treatments and medication-management, together, are optimal intervention strategies.

**Which Treatment Should My Child Have?**

For children with ADHD, no single treatment is the answer for every child. A child may sometimes have undesirable side effects to a medication that would make that particular treatment unacceptable. And if a child with ADHD also has anxiety or depression, a treatment combining medication and behavioral therapy might be best. Each child's needs and personal history must be carefully considered.

**Medications.**

For decades, medications have been used to treat the symptoms of ADHD.

The medications that seem to be the most effective are a class of drugs known as stimulants. Following is a list of the stimulants, their trade (or brand) names, and their generic names. "Approved age" means that the drug has been tested and found safe and effective in children of that age.

| Trade Name | Generic Name | Approved Age |
|---|---|---|
| Adderall | amphetamine | 3 and older |
| Concerta | methylphenidate (long acting) | 6 and older |
| Cylert* | pemoline | 6 and older |
| Dexedrine | dextroamphetamine | 3 and older |
| Dextrostat | dextroamphetamine | 3 and older |
| Focalin | dexmethylphenidate | 6 and older |
| Metadate ER | methylphenidate (extended release) | 6 and older |
| Metadate CD | methylphenidate (extended release) | 6 and older |
| Ritalin | methylphenidate | 6 and |

| | | |
|---|---|---|
| | | older |
| Ritalin SR | methylphenidate (extended release) | 6 and older |
| Ritalin LA | methylphenidate (long acting) | 6 and older |

*Because of its potential for serious side effects affecting the liver, Cylert should not ordinarily be considered as first-line drug therapy for ADHD.

The U.S. Food and Drug Adminstration (FDA) approved a medication for ADHD that is not a stimulant. The medication, Strattera®, or atomoxetine, works on the neurotransmitter norepinephrine, whereas the stimulants primarily work on dopamine. Both of theses neurotransmitters are believed to play a role in ADHD. More studies will need to be done to contrast Strattera with the medications already available, but the evidence to date indicates that over 70 percent of children with ADHD given Strattera manifest significant improvement in their symptoms.

Some people get better results from one medication, some from another. It is important to work with the prescribing physician to find the right medication and the right dosage. For many people, the stimulants dramatically reduce their hyperactivity and impulsivity and improve their ability to focus, work, and learn. The medications may also improve physical coordination, such as that needed in handwriting and in sports.

The stimulant drugs, when used with medical supervision, are usually considered quite safe. Stimulants do not make the child feel "high," although some children say they feel different or funny. Such changes are usually very minor. Although some parents worry that their child may become addicted to the medication, to date there is no convincing evidence that stimulant medications, when used for treatment of ADHD, cause drug abuse or dependence. A review of all long-term studies on stimulant medication and substance abuse, conducted by researchers at Massachusetts General Hospital and Harvard Medical School, found that teenagers with ADHD who remained on their medication during the teen years had a lower likelihood of substance use or abuse than did ADHD adolescents who were not taking medications.[13]

The stimulant drugs come in long- and short-term forms. The newer sustained-release stimulants can be taken before school and are long-lasting so that the child does not need to go to the school nurse every day for a pill. The doctor can discuss with the parents the child's needs and decide which preparation to use and whether the child needs to take the medicine during school hours only or in the evening and on weekends too.

If the child does not show symptom improvement after taking a medication for a week, the doctor may try adjusting the dosage. If there is still no improvement, the child may be switched to another medication. About one out of ten children is not helped by a stimulant medication. Other types of medication may be used if stimulants don't work or if

the ADHD occurs with another disorder. Antidepressants and other medications can help control accompanying depression or anxiety.

Sometimes the doctor may prescribe for a young child a medication that has been approved by the FDA for use in adults or older children. This use of the medication is called "off label." Many of the newer medications that are proving helpful for child mental disorders are prescribed off label because only a few of them have been systematically studied for safety and efficacy in children. Medications that have not undergone such testing are dispensed with the statement that "safety and efficacy have not been established in pediatric patients."

**Side Effects of the Medications.**

Most side effects of the stimulant medications are minor and are usually related to the dosage of the medication being taken. Higher doses produce more side effects. The most common side effects are decreased appetite, insomnia, increased anxiety, and/or irritability. Some children report mild stomach aches or headaches.

Appetite seems to fluctuate, usually being low during the middle of the day and more normal by suppertime. Adequate amounts of food that is nutritional should be available for the child, especially at peak appetite times.

If the child has difficulty falling asleep, several options may be tried—a lower dosage of the stimulant, giving the stimulant earlier in the day, discontinuing the afternoon or evening dosage, or giving an adjunct medication such as a low-dosage antidepressant or clonidine. A few children develop tics during treatment. These can often be lessened by changing the medication dosage. A very few children cannot tolerate any stimulant, no matter how low the dosage. In such cases, the child is often given an antidepressant instead of the stimulant.

When a child's schoolwork and behavior improve soon after starting medication, the child, parents, and teachers tend to applaud the drug for causing the sudden changes. Unfortunately, when people see such immediate improvement, they often think medication is all that's needed. But medications don't cure ADHD; they only control the symptoms on the day they are taken. Although the medications help the child pay better attention and complete school work, they can't increase knowledge or improve academic skills. The medications help the child to use those skills he or she already possesses.

Behavioral therapy, emotional counseling, and practical support will help ADHD children cope with everyday problems and feel better about themselves.

**Facts to Remember About Medication for ADHD.**

- Medications for ADHD help many children focus and be more successful at school, home, and play. Avoiding negative experiences now may actually help prevent addictions and other emotional problems later.

- About 80 percent of children who need medication for ADHD still need it as teenagers. Over 50 percent need medication as adults.

**The Family and the ADHD Child**

Medication can help the ADHD child in everyday life. He or she may be better able to control some of the behavior problems that have led to trouble with parents and siblings. But it takes time to undo the frustration, blame, and anger that may have gone on for so long. Both parents and children may need special help to develop techniques for managing the patterns of behavior. In such cases, mental health professionals can counsel the child and the family, helping them to develop new skills, attitudes, and ways of relating to each other. In individual counseling, the therapist helps children with ADHD learn to feel better about themselves. The therapist can also help them to identify and build on their strengths, cope with daily problems, and control their attention and aggression. Sometimes only the child with ADHD needs counseling support. But in many cases, because the problem affects the family as a whole, the entire family may need help. The therapist assists the family in finding better ways to handle the disruptive behaviors and promote change. If the child is young, most of the therapist's work is with the parents, teaching them techniques for coping with and improving their child's behavior.

Several intervention approaches are available. Knowing something about the various types of interventions makes it easier for families to choose a therapist that is right for their needs.

**Psychotherapy** works to help people with ADHD to like and accept themselves despite their disorder. In psychotherapy, clients talk with the therapist about upsetting thoughts and feelings, explore self-defeating patterns of behavior, and learn alternative ways to handle their emotions. As they talk, the therapist tries to help them understand how they can change or better cope with their disorder.

**Behavioral therapy (BT)** helps people develop more effective ways to work on immediate issues. Rather than helping the child understand his or her feelings and actions, it helps directly in changing their thinking and coping and thus may lead to changes in behavior. The support might be practical assistance, like help in organizing tasks or schoolwork or dealing with emotionally charged events. Or the support might be in self-monitoring one's own behavior and giving self-praise or rewards for acting in a desired way such as controlling anger or thinking before acting.

**Social skills training** can also help children learn new behaviors. In social skills training, the therapist discusses and models appropriate behaviors important in developing and maintaining social relationships, like waiting for a turn, sharing toys, asking for help, or responding to teasing, then gives children a chance to practice. For example, a child might learn to "read" other people's facial expression and tone of voice in

order to respond appropriately. Social skills training helps the child to develop better ways to play and work with other children.

**Support groups** help parents connect with other people who have similar problems and concerns with their ADHD children. Members of support groups often meet on a regular basis (such as monthly) to hear lectures from experts on ADHD, share frustrations and successes, and obtain referrals to qualified specialists and information about what works. There is strength in numbers, and sharing experiences with others who have similar problems helps people know that they aren't alone. National organizations are listed at the end of this document.

**Parenting skills training**, offered by therapists or in special classes, gives parents tools and techniques for managing their child's behavior. One such technique is the use of token or point systems for immediately rewarding good behavior or work. Another is the use of "time-out" or isolation to a chair or bedroom when the child becomes too unruly or out of control. During time-outs, the child is removed from the agitating situation and sits alone quietly for a short time to calm down. Parents may also be taught to give the child "quality time" each day, in which they share a pleasurable or relaxing activity. During this time together, the parent looks for opportunities to notice and point out what the child does well, and praise his or her strengths and abilities.

This system of rewards and penalties can be an effective way to modify a child's behavior. The parents (or teacher) identify a few desirable behaviors that they want to encourage in the child—such as asking for a toy instead of grabbing it, or completing a simple task. The child is told exactly what is expected in order to earn the reward. The child receives the reward when he performs the desired behavior and a mild penalty when he doesn't. A reward can be small, perhaps a token that can be exchanged for special privileges, but it should be something the child wants and is eager to earn. The penalty might be removal of a token or a brief time-out. *Make an effort to find your child being good*. The goal, over time, is to help children learn to control their own behavior and to choose the more desired behavior. The technique works well with all children, although children with ADHD may need more frequent rewards.

In addition, parents may learn to structure situations in ways that will allow their child to succeed. This may include allowing only one or two playmates at a time, so that their child doesn't get overstimulated. Or if their child has trouble completing tasks, they may learn to help the child divide a large task into small steps, then praise the child as each step is completed. Regardless of the specific technique parents may use to modify their child's behavior, some general principles appear to be useful for most children with ADHD. These include providing more frequent and immediate feedback (including rewards and punishment), setting up more structure in

advance of potential problem situations, and providing greater supervision and encouragement to children with ADHD in relatively unrewarding or tedious situations.

Parents may also learn to use stress management methods, such as meditation, relaxation techniques, and exercise, to increase their own tolerance for frustration so that they can respond more calmly to their child's behavior.

**Some Simple Behavioral Interventions**

Children with ADHD may need help in organizing. Therefore:

- **Schedule.** Have the same routine every day, from wake-up time to bedtime. The schedule should include homework time and playtime (including outdoor recreation and indoor activities such as computer games). Have the schedule on the refrigerator or a bulletin board in the kitchen. If a schedule change must be made, make it as far in advance as possible.
- **Organize needed everyday items.** Have a place for everything and keep everything in its place. This includes clothing, backpacks, and school supplies.
- **Use homework and notebook organizers.** Stress the importance of writing down assignments and bringing home needed books.

Children with ADHD need consistent rules that they can understand and follow. If rules are followed, give small rewards. Children with ADHD often receive, and expect, criticism. Look for good behavior and praise it.

**Your ADHD Child and School**

**You are your child's best advocate.** To be a good advocate for your child, learn as much as you can about ADHD and how it affects your child at home, in school, and in social situations.

If your child has shown symptoms of ADHD from an early age and has been evaluated, diagnosed, and treated with either behavior modification or medication or a combination of both, when your child enters the school system, let his or her teachers know. They will be better prepared to help the child come into this new world away from home.

If your child enters school and experiences difficulties that lead you to suspect that he or she has ADHD, you can either seek the services of an outside professional or you can ask the local school district to conduct an evaluation. Some parents prefer to go to a professional of their own choice. But it is the school's obligation to evaluate children that they suspect have ADHD or some other disability that is affecting not only their academic work but their interactions with classmates and teachers.

If you feel that your child has ADHD and isn't learning in school as he or she should, you should find out just who in the school system you should contact.

Your child's teacher should be able to help you with this information. Then you can request—in writing—that the school system evaluate your child. The letter should include the date, your and your child's names, and the reason for requesting an evaluation. Keep a copy of the letter in your own files.

Until the last few years, many school systems were reluctant to evaluate a child with ADHD. But recent laws have made clear the school's obligation to the child suspected of having ADHD that is affecting adversely his or her performance in school. If the school persists in refusing to evaluate your child, you can either get a private evaluation or enlist some help in negotiating with the school. Help is often as close as a local parent group. Each state has a Parent Training and Information (PTI) center as well as a Protection and Advocacy (P&A) agency. (For information on the law and on the PTI and P&A, see the section on support groups and organizations at the end of this document.)

Once your child has been diagnosed with ADHD and qualifies for special education services, the school, working with you, must assess the child's strengths and weaknesses and design an Individualized Educational Program (IEP). You should be able periodically to review and approve your child's IEP. Each school year brings a new teacher and new schoolwork, a transition that can be quite difficult for the child with ADHD. Your child needs lots of support and encouragement at this time.

Never forget the cardinal rule—**you are your child's best advocate**.

**Your Teenager with ADHD**

Your child with ADHD has successfully navigated the early school years and is beginning his or her journey through middle school and high school. Although your child has been periodically evaluated through the years, this is a good time to have a complete re-evaluation of your child's health.

The teen years are challenging for most children; for the child with ADHD these years are doubly hard. All the adolescent problems—peer pressure, the fear of failure in both school and socially, low self-esteem—are harder for the ADHD child to handle. The desire to be independent, to try new and forbidden things—alcohol, drugs, and sexual activity—can lead to unforeseen consequences. The rules that once were, for the most part, followed, are often now flaunted. Parents may not agree with each other on how the teenager's behavior should be handled.

Now, more than ever, rules should be straightforward and easy to understand. Communication between the adolescent and parents can help the teenager to know the reasons for each rule. When a rule is set, it should be clear *why* the rule is set. Sometimes it helps to have a chart, posted usually in the kitchen, that lists all household rules and all rules for outside the home (social and school). Another chart could list household chores

with space to check off a chore once it is done.

When rules are broken—and they will be—respond to this inappropriate behavior as calmly and matter-of-factly as possible. Use punishment sparingly. Even with teens, a time-out can work. Impulsivity and hot temper often accompany ADHD. A short time alone can help.

As the teenager spends more time away from home, there will be demands for a later curfew and the use of the car. Listen to your child's request, give reasons for your opinion and listen to his or her opinion, and negotiate. *Communication, negotiation, and compromise* will prove helpful.

**Your Teenager and the Car.**

Teenagers, especially boys, begin talking about driving by the time they are 15. In some states, a learner's permit is available at 15 and a driver's license at 16. Statistics show that 16-year-old drivers have more accidents per driving mile than any other age. In the year 2000, 18 percent of those who died in speed-related crashes were youth ages 15 to 19. Sixty-six percent of these youth were not wearing safety belts. Youth with ADHD, in their first 2 to 5 years of driving, have nearly four times as many automobile accidents, are more likely to cause bodily injury in accidents, and have three times as many citations for speeding as the young drivers without ADHD.[14]

Most states, after looking at the statistics for automobile accidents involving teenage drivers, have begun to use a graduated driver licensing system (GDL). This system eases young drivers onto the roads by a slow progression of exposure to more difficult driving experiences. The program, as developed by the National Highway Traffic Safety Administration and the American Association of Motor Vehicle Administrators, consists of three stages: learner's permit, intermediate (provisional) license, and full licensure. Drivers must demonstrate responsible driving behavior at each stage before advancing to the next level. During the learner's permit stage, a licensed adult must be in the car at all times.[15] This period of time will give the learner a chance to practice, practice, practice. The more your child drives, the more efficient he or she will become. The sense of accomplishment the teenager with ADHD will feel when the coveted license is finally in his or her hands will make all the time and effort involved worthwhile.

Note: The State Legislative Fact Sheets—Graduated Driver Licensing System can be found at web site http://www.nhtsa.dot.gov/people/outreach/safesobr/21qp/html/fact_sheets/Graduated_Driver.html, or it can be ordered from NHTSA Headquarters, Traffic Safety Programs, ATTN: NTS-32, 400 Seventh Street, S.W., Washington, DC 20590; telephone 202-366-6948.

**Attention Deficit Hyperactivity Disorder in Adults**

Attention deficit hyperactivity disorder is a highly publicized childhood disorder that affects approximately 3 percent to 5 percent of all children. What is much less well known is the probability that, of children who have ADHD, many will still have it as adults. Several studies done in recent years estimate that between 30 percent and 70 percent of children with ADHD continue to exhibit symptoms in the adult years.[16]

The first studies on adults who were never diagnosed as children as having ADHD, but showed symptoms as adults, were done in the late 1970s by Drs. Paul Wender, Frederick Reimherr, and David Wood. These symptomatic adults were retrospectively diagnosed with ADHD after the researchers' interviews with their parents. The researchers developed clinical criteria for the diagnosis of adult ADHD (the Utah Criteria), which combined past history of ADHD with current evidence of ADHD behaviors.[17] Other diagnostic assessments are now available; among them are the widely used Conners Rating Scale and the Brown Attention Deficit Disorder Scale.

Typically, adults with ADHD are unaware that they have this disorder—they often just feel that it's impossible to get organized, to stick to a job, to keep an appointment. The everyday tasks of getting up, getting dressed and ready for the day's work, getting to work on time, and being productive on the job can be major challenges for the ADHD adult.

**Diagnosing ADHD in an Adult.**

Diagnosing an adult with ADHD is not easy. Many times, when a child is diagnosed with the disorder, a parent will recognize that he or she has many of the same symptoms the child has and, for the first time, will begin to understand some of the traits that have given him or her trouble for years—distractibility, impulsivity, restlessness. Other adults will seek professional help for depression or anxiety and will find out that the root cause of some of their emotional problems is ADHD. They may have a history of school failures or problems at work. Often they have been involved in frequent automobile accidents.

To be diagnosed with ADHD, an adult must have childhood-onset, persistent, and current symptoms.[18] The accuracy of the diagnosis of adult ADHD is of utmost importance and should be made by a clinician with expertise in the area of attention dysfunction. For an accurate diagnosis, a history of the patient's childhood behavior, together with an interview with his life partner, a parent, close friend, or other close associate, will be needed. A physical examination and psychological tests should also be given. Comorbidity with other conditions may exist such as specific learning disabilities, anxiety, or affective disorders.

A correct diagnosis of ADHD can bring a sense of relief. The individual has brought into adulthood many negative perceptions of himself that may have led to low esteem. Now he can begin to

understand why he has some of his problems and can begin to face them. This may mean, not only treatment for ADHD but also psychotherapy that can help him cope with the anger he feels about the failure to diagnose the disorder when he was younger.

**Treatment of ADHD in an Adult.**

**Medications.** As with children, if adults take a medication for ADHD, they often start with a stimulant medication. The stimulant medications affect the regulation of two neurotransmitters, norepinephrine and dopamine. The newest medication approved for ADHD by the FDA, atomoxetine (Strattera®), has been tested in controlled studies in both children and adults and has been found to be effective.[19]

Antidepressants are considered a second choice for treatment of adults with ADHD. The older antidepressants, the tricyclics, are sometimes used because they, like the stimulants, affect norepinephrine and dopamine. Venlafaxine (Effexor®), a newer antidepressant, is also used for its effect on norepinephrine. Bupropion (Wellbutrin®), an antidepressant with an indirect effect on the neurotransmitter dopamine, has been useful in clinical trials on the treatment of ADHD in both children and adults. It has the added attraction of being useful in reducing cigarette smoking.

In prescribing for an adult, special considerations are made. The adult may need less of the medication for his weight. A medication may have a longer "half-life" in an adult. The adult may take other medications for physical problems such as diabetes or high blood pressure. Often the adult is also taking a medication for anxiety or depression. All of these variables must be taken into account before a medication is prescribed.

**Education and psychotherapy.** Although medication gives needed support, the individual must succeed on his own. To help in this struggle, both "psychoeducation" and individual psychotherapy can be helpful. A professional coach can help the ADHD adult learn how to organize his life by using "props"—a large calendar posted where it will be seen in the morning, date books, lists, reminder notes, and have a special place for keys, bills, and the paperwork of everyday life. Tasks can be organized into sections, so that completion of each part can give a sense of accomplishment. Above all, ADHD adults should learn as much as they can about their disorder.

Psychotherapy can be a useful adjunct to medication and education. First, just remembering to keep an appointment with the therapist is a step toward keeping to a routine. Therapy can help change a long-standing poor self-image by examining the experiences that produced it. The therapist can encourage the ADHD patient to adjust to changes brought into his life by treatment—the perceived loss of impulsivity and love of risk-taking, the new sensation of thinking before acting. As the patient begins to have small

successes in his new ability to bring organization out of the complexities of his or her life, he or she can begin to appreciate the characteristics of ADHD that are positive—boundless energy, warmth, and enthusiasm.

**My child, who is diagnosed with A.D.H.D, always fights with his sister. What can I do?**

Try not to take sides or figure out "who started it" both of which is futile. Instead, encourage your kids to problem-solve on their own. Anything short of bodily injury and destruction of property can be considered minor. The goal is for your children to realize that name-calling, and related minor nuisances, is to be managed by "brushing it off" and not becoming defensive or angry, which only adds fuel to the conflict. Moreover, parent intervention too, ironically, tends to only add fuel to sibling's bickering especially if you "take sides." Rather, limit intervention to giving the child the "words" to help problem-solve and/or "divide and conquer" (separate the siblings) if the children are unable to resolve in timely manner. If a punishment is necessary, implement the consequence equally on both kids.

**My child has A.D.H.D. and is always being teased and rejected. What do you suggest?**

Teach social skills, as described above, to improve the extent to which your child is accepted by peers. Moreover, to address bullying or child being teased, teach your child any number of simple and easy-to-use diffusing strategies to avoid worsening the situation. In that regard, it tends to be counter-productive for child to become defensive or argumentative when teased but, rather, it's often best for child to respond to the teasing in an unemotional, nonchalant, and agreeable manner. A sense of humor also tends to be quite helpful. Clearly, the child becoming emotional and upset only 'adds fuel to the fire.' It can 'take the wind out of the sails' of the teaser if there is no subsequent argument or emotionality from the would-be "victim" of the teasing. It will also be important to work with school staff to ensure that, while they protect all students from physical danger, they do not take sides when faced with accusations of minor teasing. In that regard, taking sides and punishing only worsens the subsequent teasing given that, after being punished, the "bully" tends to seek revenge on the "victim." However, if the minor teasing is managed effectively by the child and teacher, the situation can be easily diffused and future teasing averted. Please contact the C.P.C. office for more information about specific techniques and/or review the resources listed below.

**My child is really tough during the bedtime routine, what can I do?**

Utilize two minute warning prior to beginning of bedtime routine

Keep the lights dim as bedtime approaches. Maintain a quite environment by turning the television down, or off. Create an environment, as bedtime

approaches, of quiet, peacefulness, and that things are "winding down."

Use a visual schedule to emphasize routine. Utilize a favored activity as the last activity prior to going to sleep and reinforce adherence to the routine prior to going to sleep. However, the activity should be relaxing, not stimulating.

At the end of the routine, refuse to attend to questioning or stalling.

Utilize a time bank with an earlier bed-time the following night if the routine is not followed.

If child frequently leaves bedroom after going to bed, may help to provide up to three "passes" that can be used per night to leave bedroom and ask parent for something such as a drink of water (research has shown that this technique often results in only one or none of the passes being used and the child more readily staying in bed)

**I heard that offering praise is more important than punishment for treating children with A.D.H.D.?**

Yes, that is true. It is vital to provide high levels of reinforcement for compliance and pro-social behavior, and meaningful consequences for being oppositional. While redirecting misbehavior, keep statements brief and rely on fair, firm and consistent limit-setting based in logical consequences. Remain calm and mention the child's strengths and accomplishments ("I know you can do a nice job cleaning your room because you've done it before… this is not your best effort but we can work together to make it better…"). Rely more on praise and reinforcement than punishment (10/1 ratio: ten comments offering praise and reinforcement ("I like the way you cleaned-up, nice job…") for every one negative comment or reprimand.

A consistent daily routine is also advised during which unfavored tasks (clean-up) are completed before favored activities (watching television).

**I learn better by being shown something and then doing it myself, as opposed to only having something being explained to me. Is that typical? Is that also true for my child?**

Yes, that is a great point. It is important for professionals, when teaching problem-solving and task completion, to rely on "experiential" approaches (literally walking the child through the activity) as opposed to explaining and using only "words." The same is true for teaching parents new strategies; rely on actual "hands-on" and experiential strategies as opposed to only teaching in a didactic manner.

**Please describe 'token economy systems'.**

A token economy system, consisting of a point or sticker chart, is very helpful. Daily/Weekly responsibilities (included as tasks on the chart) can include: cleaning room, taking care of belongings, helping to launder, fold, and/or put away clothes,

doing family chores in timely manner, completing homework, and proper grooming and dressing.

**What about exercise and diet?**

A consistent exercise regimen can be very helpful including involvement in sports/gross-motor activities and/or a specific aerobic exercise regimen
It would likely be helpful to implement a healthy diet of fruits, lean proteins and vegetables, void of excessive additives, caffeine, and refined sugars.

**How do I manage negative-attention-seeking?**

Ignore attention-seeking behavior, walk away and take time-out to gather thoughts. If you're followed by your child so it's difficult to "escape", express that you won't argue and offer a designated time-out area to cool down.

**My child always wants to watch TV before chores, what should I do?**

Enforce what is known as the "Premack Principle": First you do this (un-favored activity) and then you can do that (favored activity). Example: "First pick-up your stuff in the living room and then you can watch television."

**Is Time-Out helpful?**

Time-out is a traditional and often-times helpful technique. Use of a timer may be helpful. Time-out can be preceded by use of the 1-2-3 Magic System (please see C.P.C. professional for full description of the 1-2-3 Magic Program).

**Is my voice tone important?**

Yes, it is. Model an appropriate tone of voice (calm and reassuring) and offer praise when you hear an appropriate tone of voice.

**What should I focus on in terms of social skill development?**

Skills that will need to be emphasized include (Attwood & Gray) Entry: how to join-in with a group of children and how to welcome a child who wants to join-in; Assistance: recognizing when and how to provide and accept help from others; Compliments: providing compliments at appropriate times and knowing how to respond to a friend's compliment; Criticism: knowing when criticism is appropriate and inappropriate, how it is given and the ability to tolerate criticism; Accepting Suggestions: incorporating the ideas of others in the activity; Reciprocity and Sharing: a "back and forth" sharing of conversation and resources (toys…); Conflict Resolution: working through disagreements with compromise, accepting opinion of others; Monitoring and Listening: learning to observe peer's body language and monitor their contribution to the activity. Monitor one's own body language to reflect interest in peer and activity; Empathy: recognizing when appropriate comments and actions are required in response to peer's circumstances and the feelings of others; Avoiding and Ending: teach the

appropriate comments and behavior to maintain, end, or avoid an interaction.

Also emphasize the potential benefits of associating with peers who a good influence as opposed to those who are not. Encourage opportunities for involvement with such peers and reinforce that choices in that regard can result in increased privileges.

Use social stories, role playing, and rehearsal of social situations.

Utilization of feedback, i.e. videotape or audio recording may also be helpful.

Introduce child to peers, or structure social opportunities, with peers who have similar interests.

Explain why a particular behavior is necessary; don't assume an understanding of the reasoning behind the pro-social behavior.

**What do I do if my child becomes aggressive?**

When faced with aggression, refer to the pre-established Crisis Plan (professional from C.P.C. will develop, with you, a comprehensive Crisis Plan addressing aggressive behavior) that may include immediate time-out with gentle physical prompts if not compliant in going to the time-out area. After time-out, review posted house rules. After a period being calm, ask what *could have been done* to express feelings rather than being physically aggressive or destroying property. For property destruction, after presenting as calm, direct to clean-up area and "pay back" what was destroyed by doing extra chores. Utilized logical consequences such as losing, for a pre-established period of time, a valued item that was thrown or broken.

**Helpful resources found at your local C.P.C. office:**

***To address attention-deficit/hyperactivity:***

- Childswork-Childsplay (www.childswork.com): quality resource for counseling games and books for children
- Taking Charge of ADHD (Barkley)
- Various workbooks including: The "Putting On The Breaks" Activity Book For Young People With ADHD; and The Best of "Brakes" (Quinn & Stern)
- Getting a Grip on ADD: A Kid's Guide to Understanding and Coping with Attention Disorders (Frank and Smith)
- ADD/ADHD Behavior Change Resource Kit (Flick)

***Improving relationship between parent and child***

How To Talk So Kids Will Listen and Listen So Kids Will Talk (Faber & Mazlish)

***Addressing Teenagers' Issues***

- STEP (Systematic Training for Effective Parenting): Parenting Teenagers (Dinkmeyer and McKay)
- Parents, Teens, and Boundaries: How to Draw the Line (Bluestein)

- Brief Adolescent Therapy Homework Planner (Jongsma, Peterson, and McInni

***To address behavioral issues***

- STEP (Systematic Training for Effective Parenting): Parenting Young Children Under the age of six (Dinkmeyer and McKay)
- 1-2-3 Magic System (Phelan)
- How to Behave So Your Child Will Too (Sal Severe)
- Parenting with Love and Logic (Fay and Cline)
- Skills Training for Children with Behavioral Disorders (Bloomguist)
- Defiant Children: A Clinician's Manual for Assessment and Parent Training (Barkley)

***Developing friendships***

- Good Friends are Hard to Find: Help Your Child Find, Make and Keep Friends (Wetmore)
- Social Stories and More Social Stories (Gray)
- The New Social Story Book, Illustrated Edition (Gray)

***Information about medication***

- Straight Talk About Psychiatric Medications For Kids (Wilens)
- Medications for School-Age Children: Effects on Learning and Behavior (Brown and Sawyer)

***Sleep problems***

- Solve your Child's Sleep Problems (Ferber)

***Sibling issues:***

- Siblings Without Rivalry (Faber & Mazlish)
- Bullies to Buddies: How to Turn Your Enemies into Friends (Kalman, I)
- www.Bullies2Buddies.com

***Information about medication***

- Straight Talk About Psychiatric Medications For Kids (Wilens)
- Medications for School-Age Children: Effects on Learning and Behavior (Brown and Sawyer)

***Additional Internet Resources***

- communitypsychiatriccenters.com (Website provides dozens of links for information on many childhood disorders and related resources)