The Mental Health News

# Attention Deficit/Hyperactivity Disorders

by

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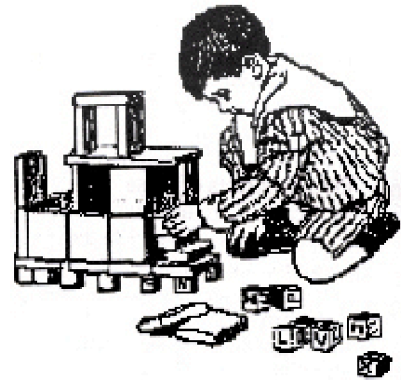
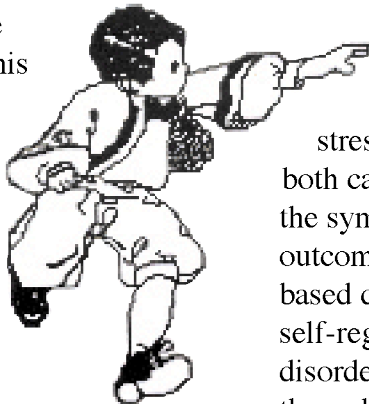


## AD/HD is an organic disorder

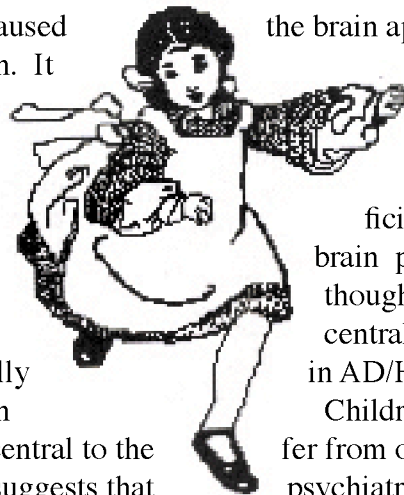
Attention Deficit Hyperactivity Disorder (AD/HD) affects approximately 3 to 5% of the children in the USA. The purpose of this newsletter is to briefly outline the central issues that pertain to AD/HD.

AD/HD is a disorder which adversely affects a child's ability to inhibit his behavior; this means the child cannot use typical environmental structures to control himself. The behavioral problems that result are often dramatic. The first symptoms of AD/HD typically begin before age seven. A child does not qualify for the AD/HD diagnosis unless his problems are atypical for his age group and cause significant impairment.



There are three subtypes of AD/HD in the current diagnostic system (i.e., DSM-IV); these subtypes incorporate a range of hyperactivity and attention problems. In order to meet the criteria for each subtype a child must show the symptom more than 93% of his or her peer group. Kids with AD/HD are also at higher risk for learning disabilities and several psychiatric disorders (particularly Oppositional Defiant Disorder, Conduct disorder, mood disorders and anxiety disorders). These children are also more likely to wet the bed, to suffer peer socialization problems, to suffer from medical problems and to be accident prone.

AD/HD is caused by brain dysfunction. It is not caused by poor parenting or stress, though both can worsen the symptoms and outcome. Biologically based deficiencies in self-regulation are central to the disorder. Research suggests that these deficiencies are usually inherited. While over 90% of AD/HD kids have not suffered a brain insult, some children who experience birth trauma,



## The frontal lobe is implicated

or other kinds of brain damage, may develop an acquired type of AD/HD.

There is much about the brain functioning of AD/HD kids that is not known. However, brain studies suggest that dysfunction exists in a specific pathway looping between the frontal portion of the brain and the thalamus. This part of the brain appears to be less active and seems to work less efficiently. These brain problems are thought to cause the central deficits seen in AD/HD.

Children who suffer from other kinds of psychiatric or medical disorders are sometimes misdiagnosed as suffering from AD/HD. In order to reduce the risk of misdiagnosis, an evaluation must be thorough, careful

and conducted by qualified professionals. Unfortunately, there is no one test which can confidently diagnose or rule out AD/HD. For this reason, an effective assessment involves the following: 1) parent and child interviews, 2) a review of school and treatment records, and 3) the completion of parent, teacher and child rating scales (if the child is old enough to read). Formal medical and psychological testing may be recommended by the evaluator in order to confirm the presence of attention problems or to rule out coexisting conditions.

The breath and severity of the symptoms which are being treated should dictate the treatment recommendations. What is described here are only some of the more commonly recommended interventions. Treatment often involves a combination of the following: medication, education, parent training and teacher consultation.

The strong efficacy of medication treatments for AD/HD has been well documented in the empirical literature. For this reason, medication is usually recommended. If well managed, the side effects of these medications are usually insignificant, especially when they are weighted against the gains incurred. Central nervous system stimulants such as Ritalin, Concerta, Dexedrine and Adderall are examples of common choices; they are effective over 90% of the time in the treatment of AD/HD. If stimulants do not work (most usually because there is a co-existing condition or because the child shows concentration problems only and is not hyper), or if stimulatnt medications are contraindicated, other agents such as Strattera or antidepressant medications may be tried. Antihypertensive medications may also play a role in some children's treatment.

**The optimal plan for AD/HD includes several interventions**

Despite the efficacy of the medications, most experts agree that treatment should incorporate educational and behavioral interventions as well.

Efforts to educate all parties regarding the nature of AD/HD is typically infused into all effective treatments. This education can also occur through reading and attending support group meetings. In addition, work with the parents consists of training in behavior management techniques. If the person with AD/HD is a teenager, the child is often included in the sessions as well.

Work with teachers includes training in behavior management and education strategies. It is always best to work collaboratively when trying to help the child. However, in instances where the school and parents disagree over what should be done, it may be appropriate to consider the federal laws which protect the education rights of AD/HD children (e.g., Part B of the Individuals with Disabilities Education Act and section 504 of the Rehabilitation Act of 1973).

Individual therapy with a child who has AD/HD, and no coexisting conditions, may not be the most critical component of the treatment plan, though it may be helpful to teach a child methods for self-control and self-organization. On the other hand, if a child suffers from depression or anxiety it may be imortant to include individual therapy in the treatment plan.

Research on adult outcome suggest that the prognosis for ADHD depends on the following variables: access to effective care as a child, the socio-economic status of the family, the intelligence of the child, the parents' mental health, the child's social skills, the presence of co-morbid conditions in the child and early detection; as many as 40% of children with AD/HD may not require medication as adults.

For referral ideas please contact one of the following websites: www.chadd.org or www.kidtherapist.com/referrals.hmtl