Diagnosing and Treating ADHD

DR. HOWARD J. FRIEDMAN, PH.D., ABPP
CLINICAL NEUROPSYCHOLOGIST and DIRECTOR, BAY AREA CHILD ASSESSMENT CLINIC

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I’m sure you are asking some of the same questions I receive about non-medication approaches to ADHD. Here is a brief summary of their current status:

NEUROFEEDBACK: Sometimes called EEG biofeedback, this treatment consists of training a person to enhance generation of brain rhythms associated with paying attention. Some research is beginning to be conducted on this approach. (see Research News)

MEDITATION: There is no standardized research relating to this as an effective treatment for ADHD. However, anecdotal comments suggest that meditation can have a calming effect, although this option likely has more appeal for adults than children.

COACHING: This approach is also more frequently applied to adults; with children, it would fit into the area of tutoring. The focus is usually on enhancing organization skills and executive functions such as self-regulation, time management, and prioritization.

DIET: There are no controlled studies supporting diet as a treatment regimen for ADHD. In fact, controlled studies have not seen significant effects. However, diet can be impacted by ADHD medications, and some attention needs to be paid to ensure a balanced diet is maintained.

EXERCISE: Exercise has a positive effect on mood, such as combating depression. John Ratey, MD, of Harvard Medical School, suggests that there is evidence of exercise also activating brain regions that impact ADHD.

The only empirically based treatments for ADHD remain medication and behavior management. Behavior management is generally preferred by parents as a treatment option. The difficulty in utilizing it relates to parents’ expectations about effectiveness, since many see it as more effective than medication. There is a problem in sustaining parental involvement because it requires long-term, active efforts to maintain improvement; this can become problematic as initial expectations meet the reality of modest improvement when medication is not also used.

By October, kids showing potential signs of ADHD may begin to present more significant problems. Children with neuropsychological problems like ADHD often display performance problems most clearly during school transition times as they find it hard to adapt, or to manage the increased level of difficulty in school demands.

Other transition issues relate to the beginning of 4th grade, middle school, or high school, due to increases in their workload and in expectations for independent functioning. This is their first major period of testing as they take midterms, and their parents attend their first meetings with teachers and participate in back-to-school nights. In addition, parents may begin logging onto school websites to check their kids’ progress, and become aware of issues including missed assignments their kids failed to mention.

Teachers discussing with parents the need for improvement may comment that their kids aren’t paying attention, their homework is incomplete, they’re starting to fall behind in class, or test performance is problematic.

A few simple questions can reveal critical answers to pursue further assessment for effective treatments: How is the child or adolescent performing in school? Are teachers complaining about them to their parents?

When parents complain about their child’s school performance difficulties and problems with attention, it can suggest ADHD; of course, other conditions may need to be screened as well.

I have found the following ADHD Rating Scale (see sidebar) to be the most efficient initial screening to assess all of the key symptoms. If the results are clearly negative, with fewer than five of the odd or even numbered symptoms, it very likely rules out ADHD and there is no need to use a more extensive questionnaire. You could then explore the possibility of Learning Disabilities or emotional issues that may be underlying the child’s performance.

The odd numbered symptoms are the Inattention components of ADHD; the even numbered symptoms are the Impulsive/Hyperactive components.

If you find positive indications from the rating scale, a more extensive medical history is warranted and a diagnosis can be confirmed in the pediatric office. Parents can then be consulted about initiating treatment. If they are concerned about medicating their child without an additional investigation, a neuropsychological evaluation would be well advised, providing quantified data to support the diagnosis and help them pursue the best treatment plan. A thorough analysis of the child’s strengths and weaknesses for treatment purposes would also enable enhanced treatment beyond medication. In particular, I have found that the medication treats only the attention problems and does not immediately eliminate the associated cognitive/academic limitations that develop as a byproduct of ADHD.

An August 2009 Consumer Reports Health study of 934 parents with children diagnosed with ADHD found that while 67% identified drug therapy as the most effective approach, they also said non-drug strategies worked very well. Their leading strategies for handling ADHD included:

• Switching to a school better suited to help with ADHD (identified as helpful by 45% of the parents)
• Giving one instruction at a time (39%)
• Having a private tutor or learning specialist work with the child (37%)
• Providing structure by maintaining a schedule of activities (35%)

In my experience, adding treatment options can enhance the effectiveness of the medication, and appeals to many parents who would prefer approaches such as school accommodations, behavioral management, tutoring strategies and psychotherapy.

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In this first issue, we explore Attention Deficit Hyperactivity Disorder (ADHD), one of the most common neurobehavioral disorders in childhood. According to the Centers for Disease Control and Prevention, nearly eight percent of youth ages 4-17 are diagnosed with ADHD throughout the U.S.—that amounts to more than 4.5 million.

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I hope to provide critical support in clinical areas that often are complex and difficult to treat with the involvement of emotional and neuropsychological conditions in conjunction with medical issues.

I consult with pediatricians, psychologists, and their patients to implement effective interventions at home and in school by clarifying neuropsychologically based issues and providing comprehensive treatment planning.

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ADHD RATING SCALE

Circle the number that best describes your patient’s home/school behavior over the past six months.

0 = Never | 1 = Very Rarely | 2 = Sometimes | 3 = Often

1. Fails to give close attention to details or makes careless mistakes in schoolwork

2. Fidgets with hands or feet or squirms in seat

3. Has difficulty sustaining attention in tasks or play activities

4. Leaves seat in classroom or in other situations in which remaining seated is expected

5. Does not seem to listen when spoken to directly

6. Runs about or climbs excessively in situations in which it is inappropriate

7. Does not follow through on instructions and fails to finish work

8. Has difficulty playing or engaging in leisure activities

9. Has difficulty organizing tasks and activities

10. “Is on the go” or acts as if “driven by a motor”

11. Avoids tasks (e.g., schoolwork, homework) that require mental effort

12. Talks excessively

13. Loses things necessary for tasks or activities

14. Blurs out answers before questions have been completed

15. Is easily distracted

16. Has difficulty waiting his/her turn

17. Is forgetful in daily activities

18. Interrupts or intrudes on others

19. Has difficulty completing tasks

20. Is impulsive

21. Has difficulty working quietly

22. Is overly active

23. Is argumentative or defiant

24. Has difficulty using imagination

25. Has difficulty solving problems

26. Has difficulty getting along

27. Has difficulty sharing

28. Has difficulty following directions

29. Is overly sensitive

30. Is too fussy

31. Has difficulty paying attention

32. Is too瞻ightful

33. Is too talkative

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