

Explains organization, foresight and impulse problems in ADHD with treatments.

The ADHD e-BOOK: Living as if There Is No Tomorrow

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The
ADHD
e-Book

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Short on time?

First read the [Summary Chapter 8](#), then the [Home Chapter 2](#).

Introduction

*The winners are
the parents whose child
still loves them when the child turns 18.*

The purpose of this concise book is to be useful.

After all, there is a lot of work to be done. This thing we call “Attention Deficit Hyperactivity Disorder (ADHD)” is not just about cute, unfocused kids running around. If that were the only problem in your life, you would not be reading this. ADHD is often about overwhelmed kids who yell at their mother when she tries to help them. It is about mothers who fear that their relationship with their child is slipping away. It is about fathers who come home to find everyone at wit’s end. It is about the threat to the most important things in life.

As I hear these stories over and over again in my practice in pediatric neurology, there are so many things I want to explain to families. I want to explain that the problems they are experiencing--the disorganization, the lack of planning, the living as if only the present moment exists, the over-reactions, the screaming, the lying, the blaming others, etc.-- are usually caused biologically as part of the condition we summarize with the letters ADHD. I want to explain behavioral approaches for home and school, and the role of medications.

I wanted a book that would concisely re-enforce it all. I made many recommendations for the truly excellent books that exist. However, most times, the parent’s response at the next visit was, “No, Dr. Kutscher, I didn’t read that yet. If I had time in my life to read all of those 300 page books you recommended, I wouldn’t have needed them in the first place.” Yet, the need existed. So, I scoured through the top books, condensed the best insights of brilliant thinkers, added some of my own, and wrote this text. The idea was to be brief, but not “dumbed down.” Realistic, yet optimistic.

We begin with a discussion of the problems that we face: the full spectrum of ADHD and co-morbid symptoms. The chief difficulty is that people with ADHD cannot inhibit the present moment long enough to consider the future. ADHD behaviors make sense once we realize that they are based on reactions taking only the present moment into account.

It is not that Johnny doesn't *care* about the future; it is that the future and the past don't even exist. Such is the nature of the disability. If you want to make sense out of inexplicable behaviors by someone with ADHD, just ask yourself: "What behavior makes sense if you only had 4 seconds left to live?" For example, if you only had 4 seconds to live, it would make sense to play a videogame rather than do homework. After all, why do homework if college doesn't exist?

The rest of the book deals with solutions. First, behavioral approaches for home and school are discussed. The key to therapy is recognition that ADHD is a true disability, which requires continuous "enabling" by parents and teachers—caregivers who need to constantly defuse (not inflame) an already overwhelming situation. Then, we move on to the role of medications. We end with a summary re-cap, which can be read as a complete freestanding text. The summary chapter could be provided to spouses, teachers, etc. Finally, a pop quiz and further readings are included.

I am indebted to the original thinkers who have added so much to this field. I have cited their works when possible. I am further indebted to those in my life who have added to my understanding of the full spectrum of ADHD. I hope that you find this book useful—and brief enough for you to actually read and use. The stakes are high: nothing less than our children's success, and our relationship with our children.

Good luck to your family. It will take time, but it *can* turn out great!

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Disclaimer: This text is provided as an educational resource. It does not constitute medical advice; nor is it a substitute for discussion between patients and their doctors.

The ADHD e-BOOK

Chapter 1 The Problems:

More than We Expected

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The ADHD Iceberg: More Problems than We Expected

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We've Been Missing the Point

“Johnny is very active! He never stops moving. He gets distracted by any little noise, and has the attention span of a flea. Often, he acts before he thinks. His sister, Jill, is often in a fog. Sometimes, she’s just so spaced!”

That is how we typically consider children with Attention Deficit Hyperactivity Disorder (ADHD). OK, not so bad. But that is often only the tip of the iceberg. Here is another likely description of the whole picture for a child with ADHD:

“I can’t take it any more!! We scream all morning to get out of the house. Homework takes hours. If I don’t help him with his work, he’s so disorganized that he’ll never do well. If I do help him, he screams at me. Since he never finishes anything, everyone thinks he doesn’t care. No matter how much we beg or punish, he keeps doing the same stupid things over and over again. He never considers the consequences of his actions, and doesn’t seem to care if they hurt me. It’s so easy for him to get overwhelmed. Sometimes, he just wants to ‘turn the noise off.’ He is so inflexible, and then blows up over anything. It gets me so angry that I scream back, which makes everything even worse. Now that he’s getting older, the lies and the cursing are getting worse, too. I know he has trouble paying attention, but why does he have all of these other problems as well?”

It is not a coincidence that children with ADHD often manifest so much more than the classic triad of inattention, impulsivity, and hyperactivity. When we focus merely on these typically defined symptoms, we fail to deal with the whole vista of difficult problems experienced by patients and their families. This spectrum includes a wide range of “executive dysfunction” (such as poor self-control and foresight), additional co-morbid disorders (such as anxiety, depression or conduct disorders), and family stresses. These are summarized graphically in Figure 1. The Behavioral Checklist at the end of this chapter allows the parents and teachers to note which of these symptoms fit a particular child. The checklist can be discussed with the child’s doctor.

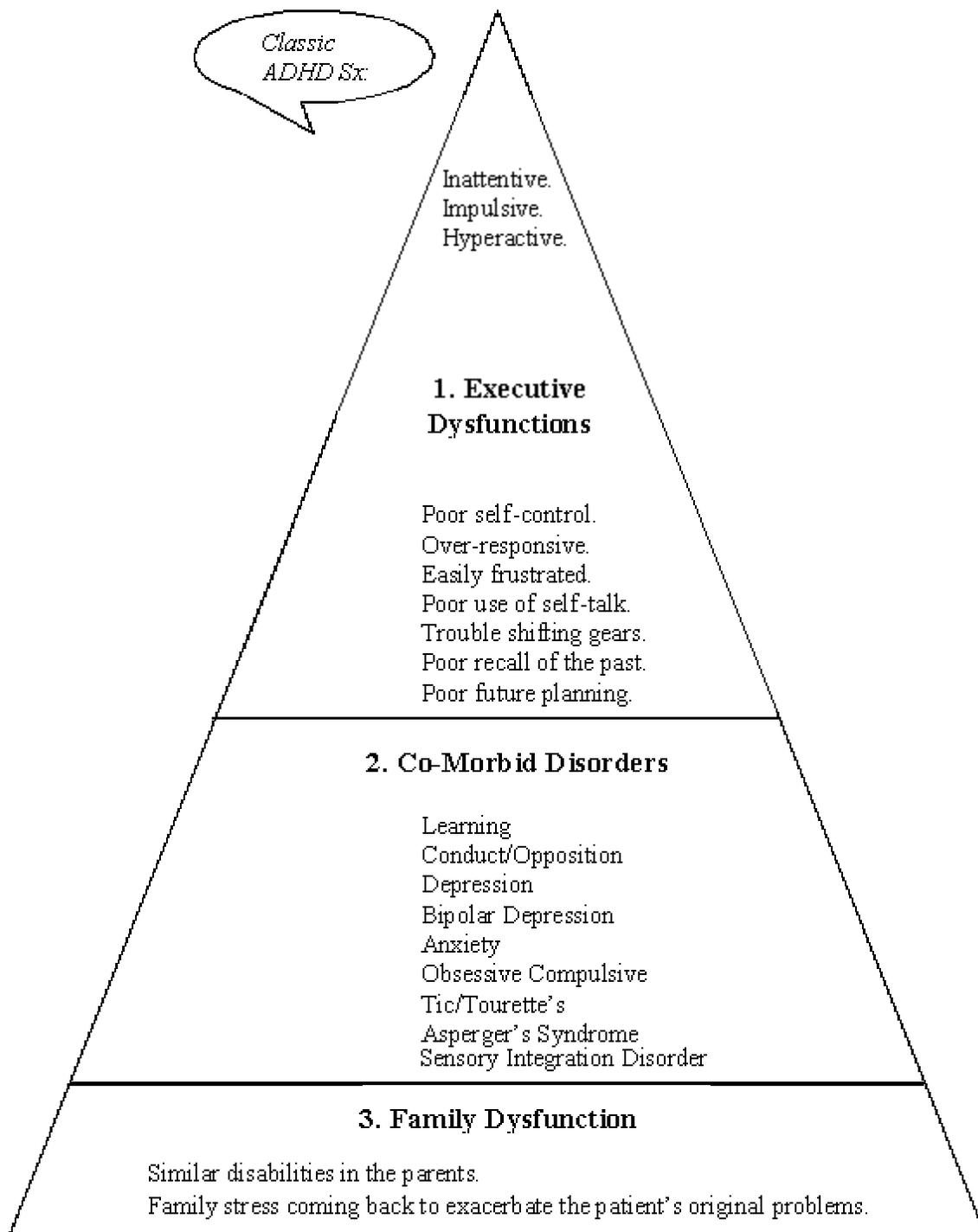


Figure 1. The extended spectrum of problems experienced by people with ADHD. The classically discussed symptoms of ADHD are only the tip of the iceberg.

Redefining ADHD to include “Executive Dysfunction”

ADHD needs to be redefined to include a wide range of “executive dysfunction.” As Russell Barkley explains (see Resources), this dysfunction stems from an inability to inhibit present behavior so that demands for the future can be met.

So, what are Executive Functions?

When you step on a snake, it bites. No verbal discussion occurs within the snake’s brain. No recall of whether striking back worked in the past. No thought as to where this action will lead in the future. No inhibition. Stepped on. Bite back. Humans, fortunately, have the option to modulate their behavior.

No single part of the human brain is solely in charge of this modulation. It does appear, however, that our frontal and pre-frontal lobes function largely as our “Chief Executive Officer (CEO).” Orchestrating language and memory functions from other parts of the brain, these frontal centers consider where we came from, where we want to go--and how to control ourselves in order to get there.

Most importantly, the ability to inhibit (“putting on the brakes”) is central to effective executive function. Successful execution of a plan largely involves putting brakes on distracting activities. These brakes--courtesy of our pre-frontal inhibitory centers--allow us the luxury of time during which we can consider our options before reacting.

This lack of inhibition is a double problem for people with ADHD. First, without these brakes, they will be viewed as unable to adequately inhibit distractions, inhibit impulsive reactions, or inhibit physically acting upon these stimuli (hyperactivity). Second, patients with ADHD do not inhibit their behavior long enough for the *other* executive functions below to adequately develop either. Executive functions identified by Barkley include:

Self-talk refers to the ability to talk to ourselves--a mechanism by which we work through our choices using words. Toddlers can be heard using self-talk out loud. Eventually, this ability becomes internalized and automatic. However, ADHD patients have not inhibited their reactions long enough for this skill to fully develop.

Working memory refers to those ideas that we can keep active in our minds at a given moment. For example, in order to learn from mistakes, you have to be able to juggle not just the present situation, but also keep in mind past times when certain strategies did or did not work. Working memory hopefully also includes keeping future goals in mind (such as remembering that we want to get into a good college, not just do the most intriguing activity currently available). Without the ability to inhibit, people with ADHD never get to develop good function of their working memory.

Foresight (predicting and planning for the future) will be deficient when inadequate working memory teams up with a poor ability to inhibit the present distractions. People with ADHD cannot keep the future in mind. They are prisoners of the present; the future catches them off guard. In fact, surprisingly poor foresight is perhaps the greatest difficulty in their lives.

Sense of time is an executive function that is usually extremely poor in ADHD.

Shifting from Agenda A to Agenda B is a difficult task requiring good executive function. Pulling yourself out of one activity and switching to another--transitioning--is innately difficult, and requires effort and control.

Separating emotion from fact requires time to reflect. Each event has an objective reality, and an additional “emotional tag” which we attach to it. For example, a traffic jam may occur, causing us to be late for work. That is the objective fact. How we react, though, is up to the emotional tag of significance that we place on it. Do we stay calm, and make plans to finish up a little later? Or, do our emotions cause us to see the traffic as a personal, unfair attack--causing us to seethe and curse? Without the gift of time, we never get to separate emotion from fact. This leads to poor ability to judge the significance of what is happening to us.

In short, then, the ability to modulate behavior comes largely from our pre-frontal lobes, which function primarily as inhibitory centers. Without the luxury of inhibitory brakes, ADHD patients do not get to fully utilize any of their frontal lobe “executive functions.”

What are the different kinds of problems in ADHD?

Redefining ADHD as inadequate inhibition explains a wide spectrum of difficulties experienced by people with the syndrome. This expanded spectrum of symptoms can create an environment of havoc. For more details, the reader is referred to the important and inspired works by Barkley, Greene, and Silver listed under Resources.

1. Symptoms of Executive Dysfunction

In the previous section, we defined the components of executive dysfunction. Now, we will translate problems in these areas into real life symptoms.

a. Classical Symptoms of ADHD

ADHD is typically defined as a triad of inattention, impulsivity, and hyperactivity. Figure 2 (at the end of this chapter) is a simplified version of the

official DSM-IV criteria for ADHD. These are the symptoms that receive the most attention from doctors, and all come from an inability to inhibit.

- *Distractible* <=Inadequate inhibition of extraneous stimuli.
- *Impulsive* <=Inadequate inhibition of internal stimuli.
- *Hyperactive* <=Physically checking out those stimuli.

b. Other Symptoms of Executive Dysfunction

If we do not address the following resulting executive function issues, we are only dealing with a small part of the problem. These are not just “incidental” symptoms. They are hard to live with—ask either the patient or his family.

- *Lack of foresight!!!* (“Johnny, you’ll never get into a good college if you all you do is play videogames. Why do you keep shooting yourself in the foot?”) Foresight--the ability to predict the results of our behaviors--is a major adaptive ability of humans. We can run imaginary simulations of the future on our brain’s computer. Lack of use of this ability can be the most devastating part of ADHD. Mothers--often endowed with great foresight-- are crushed as they watch their child repeatedly head down counter-productive paths.
- *Poor hindsight/Trouble learning from mistakes* (“Johnny, how many times do you have to be punished for the same thing.”) Unable to inhibit the present, Johnny cannot stop to consider lessons from the past.
- *Live at the “mercy of the moment.”* (“Johnny is always swept away by whatever is happening to him right then and there.”) ADHD behaviors make sense once we realize that they are based on reactions taking only the present moment into account. It is not that Johnny doesn’t *care* about the future; it is that the future and the past don’t even exist. Such is the nature of the disability. By way of analogy, imagine riding down a river with a leaking canoe. You would be so overwhelmed by the need to bail out water that you would not see the upcoming cliff. It’s not that you don’t “care” about falling over a cliff--it’s that you don’t even get to consider it. If you want to understand the ADHDer’s actions, simply ask yourself: “What behavior makes sense if you feel like you only have 4 seconds left to live?”
- *Poor organization* (“Johnny, you never told me that there is a paper due tomorrow! And, “Why do I have to keep going back to school for your books?”)
- *Trouble returning to task* (“Johnny, you never complete anything. You get distracted and don’t bother finishing. You just don’t care.”)

- *Poor sense of time* (“Johnny, what have you been doing all afternoon? You can’t spend one hour on the first paragraph!”)
- *Time moves too slowly* (“Mommy, you are taking forever to go shopping!”)
- *Poor ability to utilize “self-talk”* to work through a problem (“Johnny, what were you thinking?! Did you ever think this through?”)
- *Poor sense of self awareness* (Johnny’s true answer to the above question is probably “I don’t have a clue. I guess I wasn’t actually thinking.”)
- *Poor internalization and generalization of rules* (“Johnny, why do I need to keep reminding you that playing videogames comes *after* you finish your homework?”)
- *Poor reading of social clues* (“Johnny, you’re such a social klutz. Can’t you see that the other children think that’s weird?”)
- *Inconsistent work and behavior.* (“Johnny, if you could do it well yesterday, why is today so horrible.) With 100% of their energy, they may be able to control the task that most of us can do with 50% of our focus. But who can continually muster 100% effort? As the joke goes: ADHD children do something right once, and we hold it against them for the rest of their lives.
- *Trouble with transitions* (“Johnny, why do you curse at me when I’m just calling you for dinner?”)
- *Hyper-focused at times* (“When Johnny is on the computer, I can’t get him off. And once his father gets his mind on something, off he goes!”)
- *Poor frustration tolerance* (“Johnny, why can’t you even let me help you get over this?”)
- *Frequently overwhelmed* (“Mommy, just stop. I can’t stand it. Just stop. Please!”)
- *Gets angry frequently and quickly* (“Johnny, you get flooded with emotion so quickly. Why are you always angry with me? Even though you usually apologize, it still hurts me.”)
- *Push away those whose help they need the most* (“Mommy, stop checking my assignment pad. Get out!”).
- *“Hyper-responsiveness”* (“Mommy, you know I hate sprinkles on my donuts! You never do anything for me! I hate you!”) Barkley uses the term hyper-responsiveness to indicate that people with ADHD have excessive

emotions. Their responses, however, are appropriate to what they are actually feeling. So next time you see someone “over-reacting,” realize that they are actually “over-feeling,” and must feel really awful at that moment.

- *Inflexible/explosive reactions* (“Johnny, you’re stuck on this. No, I can’t just leave you alone. Johnny, now you’re incoherent. Johnny, just stay away. I can’t stand it when you break things!”) Greene (see Resources) goes into extensive explanation about the inflexible/explosive child.
- *Feels calm only when in motion* (“He always seems happiest when he is busy. Is that why he stays at work so late?”)
- *Thrill seeking behavior* (“He seems to crave stimulation at any cost. In fact, he feels most ‘on top of his game’ during an emergency.”)
- *Trouble paying attention to others* (“My husband never listens when I talk to him. He just cannot tolerate sitting around with me and the kids. He doesn’t “pay attention” to his family any more than he “paid attention” in school.”) As the patient gets older, people in his life will increasingly expect more time and empathy to be directed their way. Yet, the behaviors above of ADHDers may interfere with their demonstration of these traits, despite their passions.
- *Trouble with mutual exchange of favors with friends.* Without establishing a reliable “bank account” of kept promises, friendships can be hard to make.
- *Sense of failure to achieve goals* (“Somehow, I never accomplished all that I thought I could or should have.”) This deep disappointment is commonly what brings adults with ADHD to seek help.
- *Lying, cursing, stealing, and blaming others* become frequent components of ADHD; especially as the child gets older. According to some particularly depressing data by Russell Barkley, here is how ADHD children compare to typical children:

Symptom	ADHD Children (%)	Typical Children (%)
Argues with adults	72	21
Blames others for own mistakes	66	17
Acts touchy or easily annoyed	71	20
Swears	40	6
Lies	49	5
Stealing (not involving threats)	50	7

[Barkley RA, Fischer M, et al. The Adolescent outcome: An 8-year prospective follow up. Journal of the American Academy of Child and Adolescent Psychiatry, 29, 546-557.]

- In short, the symptoms of ADHD become less “cute” as the children switch from elementary to secondary schools. The “good” news comes from understanding that these problems are commonly part of the syndrome we call ADHD. They are nobody’s fault--not yours, and not your child’s. This understanding points the way towards coping with these issues.

2. Co-Morbid Disorders Associated with ADHD

In addition to the executive dysfunctions above, there are a myriad of co-morbid disorders which frequently accompany the diagnosis of ADHD in the patient and/or her family. These disorders may often be *misdiagnosed as* ADHD, or they may *co-exist with* true ADHD. In addition, many people are “subsyndromal,” and have just parts of the following diagnosis. John Ratey (see Resources) refers to these as “shadow syndromes.” The presence of these disorders must be investigated whenever the diagnosis of ADHD is being considered.

[Medications for the co-morbid disorders in children are used frequently “off-label,” and information is quite limited. Recommendations need to be taken as subject to change and debate. Full discussion of the usefulness, monitoring, drug interactions, etc. of these medications is beyond this paper. The reader is referred to ADHD with Comorbid Disorders by Pliszka (see Resources), which forms the basis for the following medication assessments. Medical treatment of the associated disorders is perhaps best done in consultation with a neurologist or psychiatrist.]

a. Learning Disabilities (LD)

Twenty to thirty percent of patients with ADHD have LD. A review of the diagnostic criteria for ADHD (figure 2) will show that an Organizational Disability is virtually built into the syndrome of ADHD by definition. Following directions, sequencing problems and dysgraphia are also particularly common. Learning disabilities should be suspected whenever a student does not “live up to his/her potential.” They are identified with history, exam and psycho-educational testing. As well explained by Larry Silver (see Resources), learning disabilities can either exacerbate or mimic ADHD. After all, how long can someone focus on something that she does not understand?

b. Disruptive Behavioral Disorders

50% of ADHD children have Disruptive Behavioral Disorders. Even in the absence of a full diagnosis, the lives of many (if not most) children with ADHD are afflicted by lying, cursing, taking things that do not belong to them, blaming others, and being easily angered. This frequency is not surprising given the executive dysfunction hypothesis. Full definitions can be found in the Diagnostic and Statistical Manual-IV. Medications such as mood stabilizers (eg. Depakote), Catapres, and Risperdal can sometimes help with impulsivity and aggression.

- Oppositional Defiant Disorder (ODD). Whereas ADHD children do not comply because of inattention or impulsivity, ODD children are unwilling to conform (even with an intriguing task). They may be negative, deliberately annoying or argumentative, angry and spiteful.
- Conduct Disorder (CD). Children with CD are more frequently overtly hostile and law breaking, with lack of remorse, not seen in ADHD alone. These people violate the rights of others, such as with physical cruelty to others or animals, stealing, etc.
- Antisocial Personality Disorder. People with Antisocial Personality Disorder have a pervasive pattern of severe violation of the rights of others, typically severe enough to merit arrest.

c. Anxiety Disorder

Anxiety Disorder occurs in up to 30% of children with ADHD, but half of the children never tell their parents! Patients are beset most days by painful worries not due to any imminent stressor. Children may appear edgy, stressed out, tense, or sleepless. There may be panic attacks or an incomplete (or negative) response to stimulants.

Treatments include:

- Change of environment; behavioral approaches; exercise; meditation.
- buspirone (Buspar)—helps anxiety but not panic attacks.
- Selective Serotonin Uptake Inhibitors (SSRIs) such as Luvox, Paxil, Prozac, and Zoloft.
- clonazepam (Klonopin)—helps anxiety.
- Tricyclics—help some with anxiety; great for panic attacks.
- Stimulants may help if anxiety is a secondary problem, but may also worsen anxiety.

d. Obsessive Compulsive Disorder (OCD)

Obsessive thoughts and compulsive actions may occur in up to one third of ADHD patients. If ADHD is living in the present, then OCD is living in the future. Although difficult to live with, the future goal directed behavior of OCD might help overcome the organizational problems of ADHD. SSRI's are the current mainstay of medical treatment.

e. Major Depression

Depression occurs in 10-30% of ADHD children and in 47% of ADHD adults. Although pure ADHD patients get depressed briefly, they flow with the environment (changing within minutes). In contrast, depressed children stay depressed for long periods. The symptoms include loss of joy, sadness, pervasive irritability (not just response to specific frustrations), withdrawal, self-critical outlook, and vegetative symptoms (abnormal sleep or appetite).

Treatment:

- Counseling; adjusting environment.
- Selective Serotonin Uptake Inhibitors (SSRIs) such as Luvox, Paxil, Prozac, and Zoloft.
- bupropion (Wellbutrin)—helps depression and ADHD.
- venlafaxine (Effexor)—helps depression and maybe ADHD.
- Tricyclics (such as Tofranil and Pamelor) do not appear to work in children for depression in controlled clinical trials.

f. Bipolar Depression

Bipolar depression occurs in up to 20% of ADHD children. These children show depression cycling with abnormally elevated, expansive, grandiose, and pressured moods. Children may cycle within hours. Other hallmarks include severe separation anxiety and often precociousness as children; extreme irritability; extreme rages that last for hours; very goal directed behavior; and little sleep requirement. They may demonstrate hypersexuality; gory dreams; extreme fear of death; extreme sensitivity to stimuli; often oppositional or obsessive traits; heat intolerance; craving for sweets; bedwetting; hallucinations; possible suicidal tendencies or substance abuse. Often

symptoms are shown only at home. See The Bipolar Child by Papolos (under Resources)

Consider bipolar when a diagnosis of “ADHD” is accompanied by above symptoms or:

- strong family history of bipolar disorder or substance abuse.
- *prolonged* temper tantrums and mood swings. Sometimes the angry, violent, sadistic, and disorganized outbursts last for hours (vs. less than 30 minutes in ADHD).
- bipolar rages are typically from parental limit setting; in ADHD, rages are from overstimulation.
- oppositional/defiant behaviors.
- explosive and “intentionally” aggressive or risk seeking behavior.
- substance abuse.
- separation anxiety, bad dreams, disturbed sleep; or fascination with gore.
- morning irritability which lasts hours (vs. minutes in ADHD).
- symptoms worsen with stimulants.

Medical treatment:

- valproate (Depakote).
- carbamazepine (Tegretol) clearly helps bipolar and aggressive symptoms at least in adults (no controlled studies in children).
- lithium (not clear that it works in children who cycle so rapidly; does not help ADHD).
- Plus cautious use of stimulants or antidepressants for ADHD symptoms.
- Stimulants and antidepressants may trigger mania.
- Plus risperidone (Risperdal) for psychotic symptoms and aggression.

g. Tics and Tourette's (motor & vocal tics)

Seven percent of ADHD children have tics; but 60% of Tourette's patients have ADHD.

Medical treatments include:

- clonidine (Catapres) / guanfacine (Tenex)—help impulsivity & tics.
- bupropion —helps ADHD but might worsen tics.
- stimulants—helps ADHD but often worsen (or improve) tics.
- tricyclics—mild ADHD help but tic “neutral.” Cardiac concerns.

h. Asperger's Syndrome

ADHD and Asperger's syndrome can cluster together. Symptoms include impaired ability to utilize social cues such as body language, irony, or other “subtext” of communication; restricted eye contact and socialization; limited range of encyclopedic interests; perseverative, odd behaviors; didactic, monotone voice; “concrete” thinking; over-sensitivity to certain stimuli; and unusual movements.

See Attwood's book (Resources).

i. Sensory Integration (SI) Dysfunction

SI dysfunction is the inability to process information received through the senses. The child may be either oversensitive or undersensitive to stimuli. Or, the child may not be able to execute a coordinated response to the stimuli. SI may mimic or co-exist with ADHD. SI is typically evaluated by an occupational therapist. See Kranowitz's book (Resources). Some types of SI include:

- Hypersensitive to touch: sensitive to clothes or getting dirty; withdraw to light kiss.
- Hyposensitive to touch: wallow in mud; rub against things; unaware of pain.
- Hypersensitive to movement: avoid running, climbing, or swinging.
- Hyposensitive to movement: rocking; twirling; unusual positions.
- May also respond abnormally to sights, sounds, smells, tastes or textures.

- May be clumsy; have trouble coordinating (bilateral) movements; or have poor fine motor skills.

3. Familial Issues.

This can be of two categories:

a. Family members with their own neuro-psychiatric problems

Family members may have their own ADHD, OCD, depression, anxiety, etc. In fact, a child with ADHD has a forty percent chance that one of his parents has ADHD. Such difficulties affect the family's ability to cope with the ADHD child, and may need to be addressed independently.

b. Stress--created by the child--cycling back to further challenge the patient.

Children or adults with ADHD can create chaos throughout the entire family, stressing everyone in the process. The morning routine and homework are frequent (and lengthy!) sources of dissension. Other siblings are often resentful of the time and special treatment given to the ADHD child. Mothers, who frequently consider their child's homework to be their own, find it stressful that "their" homework never seems to get completed. Fathers come home to discover a family in distress, and that they are expected to deal not only with a child who is out of control, but also with the mother who is understandably now losing it, too. Parents may argue over the "best strategy," a difficult problem since no strategies are even close to perfect. The unpleasantness of life around someone with ADHD leads to a pattern of avoidance that only furthers the cycle of anger. *In turn, all of this family turmoil creates a new source of pressures and problems for the already stressed ADHD patient to deal with.*

“Will it be okay?” Onward to therapy for ADHD.

In summary, we miss the point when we address only the triad of inattention, impulsivity, and hyperactivity. These symptoms are only the tip of the iceberg. Much greater problems have usually been plaguing the family, but often no one has understood that the associated symptoms described above are part and parcel of the same neurologically based condition. Without this recognition, families have thought that their ADHD child also was "incidentally" uncooperative and apparently self-absorbed. Unless we recognize that these extended symptoms are part of the same spectrum, parents will not mention them; and doctors will never deal with them.

Given all of this, it is reasonable to ask: "Will this go away?" Personally, I would rephrase the question as, "Will it be OK?" The answer can be "yes," but we must

recognize that this is often the “fifty year plan.” In other words, these children can be wonderfully successful adults, while they continue to work on these issues over their lifetime. Meanwhile, we “just” need to patiently steer them in the positive direction. That is what the rest of this book is all about.

Finally, we must also keep in mind that some of the iceberg is fantastic and enviable. While the rest of us are obsessing about the future, or morosing about the past, people with ADHD are experiencing the present. ADHDers can be a lot of fun; dullness is never a problem. Their “Why not?” attitude may free them to take chances that the rest of us may be afraid to take. Their flux of ideas may lead to creative innovations. And most importantly, their extreme passion can be a source of inspiration and accomplishment to the benefit of us all.

It’s going to be quite a ride.

Figure 2. Simplified DSM-IV criteria for ADHD

A. Either (1) or (2)

(1) Six or more symptoms of **inattention**

- (a) fails to give close attention; careless mistakes
- (b) difficulty sustaining attention
- (c) does not seem to listen when spoken to directly
- (h) easily distracted by extraneous stimuli
- (e) difficulty organizing tasks*
- (d) fails to follow through (not volitional or incapable)*
- (f) avoids tasks requiring sustained organization*
- (g) loses things needed for tasks*
- (i) often forgetful in daily activities*

(2) Six or more symptoms of **hyperactivity-impulsivity**

Hyperactivity

- (a) fidgets/squirms
- (b) leaves seat
- (c) runs or climbs excessively
- (d) difficulty playing in leisure activities quietly
- (e) “on the go” or “driven by a motor”
- (f) talks excessively

Impulsivity

(a) blurts out answers before questions completed

(b) difficulty waiting turn

(c) interrupts or intrudes

B. Some symptoms present before 7 y.o.

C. Symptoms in two or more settings

D. Interferes with functioning

E. Not exclusively part of other syndrome

[The symptoms of inattention have been grouped together and placed in italics by the author to demonstrate how much disorganization is built into the definition of ADHD.]

Using these criteria, DSM-IV defines three subtypes of ADHD:

ADHD, Predominantly Inattentive Type.

ADHD, Predominantly Hyperactive-Impulsive Type.

ADHD, Combined type.

[Note, that by current terminology, your diagnosis will be “ADHD” even if you don’t have hyperactivity.]

Behavioral Checklist

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Child's Name:

Date:

Your Name:

Subject (if teacher):

Please rate the severity of each problem listed.

(0)none (1)slight (2)moderate (3)major

Please add comments below!

Trouble attending to work that child understands well _____

Trouble attending to work that child understands poorly _____

Requires one-to-one attention to get work done _____

Impulsive (trouble waiting turn, blurts out answers) _____

Hyperactive (fidgety, trouble staying seated) _____

Disorganized _____

Homework not handed in _____

Inconsistent work and effort _____

Poor sense of time _____

Does not seem to talk through problems _____

Over-reacts _____

Easily overwhelmed _____

Blows up easily _____

Trouble switching activities _____

Hyper-focused at times _____

Poor handwriting _____

Certain academic tasks seem difficult (specify) _____

Seems *deliberately* spiteful, cruel or annoying _____

Anxious, edgy, stressed or painfully worried _____

Obsessive thoughts or fears; perseverative rituals _____

Irritated for hours or days on end (not just frequent, brief blow-ups) _____

Depressed, sad, or unhappy _____

Extensive mood swings _____

Tics: repetitive movements or noises _____

Poor eye contact _____

Does not catch on to social cues _____

Limited range of interests and interactions _____

Unusual sensitivity to sounds, touch, textures, movement or taste _____

Coordination difficulties _____

Other (specify) _____

If the child is on medication, please answer the following questions:

Can you tell when the child is on medication or not?

Does the medication work consistently throughout the day?

Does the child appear to be on too much or too little medication?

Explains organization, foresight and impulse problems in ADHD with treatments.

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