

A Personal Story. When Amber was young and ran low on energy, her personality completely changed. She couldn't make a decision, cried over little things, picked arguments, and snapped at us. (Of course, I know adults who act the same way if they have to wait too long in a restaurant when they're hungry!) I easily recognized that she needed to eat or sleep, but if I said, "You're just tired" or "You are hungry" she'd yell, "No I'm not!" If I forced the issue, we'd get into a power struggle and she'd fall apart even more. I had to find a way to help **her** be more aware of her body's needs.

One night at bedtime, I explained how her body was like a car and that food and sleep are like the gasoline that gives a car the energy to go. When cars run out of energy, they stop moving until they get more gas. I described what bodies do when they run out of energy, naming the symptoms she often shows. I suggested that whenever she did those things, her body was telling her it needed more energy and she could choose what kind of energy she wanted to give her body. The fact that we discussed this when there was no problem made a big difference; she understood.

From then on, we tried preventing the problem by adding an after-school snack to her daily routine. She had to eat something before going outside to play. On the few occasions when she started falling apart, I now said, "**Is your body telling you it needs some food or sleep?**" Because I wasn't trying to force the issue and asked her to listen to her own body, she was more willing to consider the idea. If she resisted, I'd offer a choice, "Do you want a snack or to rest?" She'd usually eat a snack or do something quiet to recharge her energy. By age eight, she automatically got herself a snack when she was hungry and voluntarily took a nap.

Illness, mental retardation, autism, food allergies, or Attention Deficit Hyperactivity Disorder (ADHD) are examples of *medical conditions* that influence children's behavior. These children might truly have a limit to how much they can control their behavior when these factors are present. We can still use all the tools we've learned, but need to have realistic expectations about how long it might take to see progress. (Remember, a deeper problem is one of the five reasons the tools might not immediately work.) These tools will, at the least, not make matters worse and usually help speed progress. Read as much as you can about the disorder and specific strategies to use. Most are compatible tools to add to the Universal Blueprint (file them in the PU Toolset). If there are recommendations that go against some of the basic principles of *The Parent's Toolshop*, discuss your concerns with a trained professional who can explain whether there is a valid reason for using that approach. While we can't discuss all medical conditions in this book, it is important to focus on one—Attention Deficit Hyperactivity Disorder. Many children are labeled ADHD without proper diagnosis and quickly put on medication to "fix" them.

DIAGNOSING ADHD

True ADHD is a biological condition and there is no single method that accurately diagnoses it. ADHD children are not lazy, defiant, or bad. They often understand what they are told, but have difficulty controlling their impulses to do what they know they should do. Other medical problems (e.g., food allergies, auditory processing problems, or learning difficulties) can cause behavior that looks like ADD or ADHD. Similar behavior can also result when children haven't learned self-control, decision-making or listening skills. All these factors *must* be ruled out, before diagnosing a child with ADHD, so concerned parents want to involve a team of people from four critical areas:

1. **Parents** are a good source of diagnostic information since they are with the child the most.
2. **Teachers** can make observations of the child's behavior in large groups. Children can have a "learning disability" and not be ADHD. Some children have learning difficulties *because* their ADHD is untreated. Often, there are environmental factors (such as too much noise) that make it difficult for children to concentrate at home *or* at school, but they don't have a physical problem.
3. **Medical doctors** can rule out food allergies and hearing/visual problems, which have symptoms that mimic ADHD.

4. **Psychologists or psychiatrists** who are specially certified and trained in ADHD assessments can perform psychological testing. Parents can determine whether professional assessment might be necessary by reviewing the standard criteria for diagnosing ADHD:

Standard Criteria for Diagnosing ADHD^{1*}

A. Either (1) or (2):

- (1) *six (or more)* of the following symptoms of **inattention** have *persisted for at least 6 months* to a degree that is *maladaptive and inconsistent with developmental level*:

Inattention

- a. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- b. often has difficulty sustaining attention in tasks or play activities
- c. often does not seem to listen when spoken to directly
- d. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- e. often has difficulty organizing tasks and activities
- f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- g. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- h. is often easily distracted by extraneous stimuli
- i. is often forgetful in daily activities

- (2) *six (or more)* of the following symptoms of **hyperactivity-impulsivity** have *persisted for at least 6 months* to a degree that is *maladaptive and inconsistent with developmental level*:

Hyperactivity

- a. often fidgets with hands or feet or squirms in seat
- b. often leaves seat in classroom or in other situations in which remaining seated is expected
- c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to feelings of restlessness)
- d. often has difficulty playing or engaging in leisure activities quietly
- e. is often "on the go" or often acts as if "driven by a motor"
- f. often talks excessively

Impulsivity

- g. often blurts out answers before questions have been completed
- h. often has difficulty awaiting turn
- i. often interrupts or intrudes on others (e.g., butts into conversations or games)

- B. *Some* hyperactive-impulsive or inattentive *symptoms* that caused impairment *were present before age 7 years*.
- C. Some impairment from the symptoms *is present in two or more settings* (e.g., at school [or work] and at home).
- D. There must be clear evidence of *clinically significant impairment* in social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of . . . [another mental or physical disorder.] (*Author's paraphrasing.*)

*Diagnostic criteria is reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. copyright 1994, American Psychiatric Association.

There are actually three types of attention deficits: (1) Inattentive (ADD), (2) Hyperactive/Impulsive, and (3) Combined type (ADHD). ADHD can also appear in children who have other neurological (brain and nervous system), psychological, and learning disorders, so **a thorough diagnosis process is vital.**

TREATING ADHD

No one approach can “cure” ADHD and treatment must be long-term. Therefore, effective treatment plans should address all the possible factors that influence ADHD. The best treatment plan uses the first four interventions at the same time and may or may not include the last (medication).

- A. **Parent education is the most important part of treating ADHD.** *The Parent’s Toolshop* includes every parenting skill that ADHD experts recommend. Most of the strategies are adaptable to school and other settings. If a child does *not* have true ADHD, just problem behavior that mimics it, it is important for parents to spend time teaching children important behavioral skills.
- *ADHD children have a high degree of variability—they are consistently inconsistent.* These children *do* have good days—and it can be their undoing—because the adults around them may expect them to have good days every day.
 - *Teach children organizational techniques*, such as making lists, using self-reminders, using a planning calendar, and making desk, drawer, or closet organizers. These skills are also important to teach children who do not have ADHD, but have similar behavior problems.
- B. **Consistent behavior management.** Parents, educators, and others who work with ADHD children should not feel inadequate for having difficulty managing ADHD children. They must repeat themselves often to make progress or just keep situations from getting worse.
- *ADHD children have a hard time being self-motivated toward long-term goals.* They have difficulty paying attention or sticking with tasks unless the tasks provide instant gratification, or are novel, stimulating, and fun. This is why they have no difficulty playing video games for long stretches of time. Use positive, creative teaching methods that will maintain their interest. Teach children how to remind themselves to stay on track and find their own way to get the job done. (It is important to consider whether excessive TV viewing and video games have conditioned the child to only pay attention to stimulating events.)
 - *ADHD children respond well to external rewards, but also get quickly addicted to them.* Provide frequent, positive feedback, such as nods, descriptive encouragement, smiles, pats, and high-fives. Only add external motivators *if* the internal rewards are long-term. ***If you use external rewards*** (such as extra privileges, games, computer time, or free time), ***always comment on the long-term, internal rewards of a task or behavior and teach children how to set up self-rewards.*** This reduces children’s dependency on rewards and praise from others.
 - *Effective reprimands are immediate, brief, unemotional, and consistent.* Reprimands are ineffective when they are delayed, long-winded, harsh, critical, or emotional. Selectively ignore attention-seeking, minor behavior that is not aggressive or disruptive.
- C. **Effective classroom environment.** There are *many* small changes teachers can make in the school environment that greatly benefits ADHD children. Many of these changes will help *every* child’s ability to concentrate. For example, face children away from windows and stand in one location when speaking, so all the children can see *and* hear the instructions. Unfortunately, we can’t list all the ideas in this resource. (See the list of recommended reading at the end of this chapter.) Parents and educators should at least know about the following factors and incorporate them in their teaching style.

- *There are three steps to the learning process (learning, understanding, and remembering) and four ways people learn best (seeing, hearing, doing, and teaching).* Education commonly presents information through visual aids (books) and uses discussion to explain and practice the information. Some teachers add hands-on learning. If a child cannot learn or understand information until they have an opportunity to do hands-on activities, they may be behind other students who primarily learn through sight and hearing. This is only one example of how someone's learning style affects their ability to learn and retain information. The most effective teaching approach, however, incorporates *all* four learning styles at *each* step of the learning process, to account for the various combinations of learning styles.
- *In addition, **everyone** uses eight different areas of the brain² at each step of the learning process, but each person is stronger in some areas than others.*
 1. Words (written or spoken), songs.
 2. Numbers, patterns, and other logical strategies.
 3. Music, sound, rhythm.
 4. Pictures, visualizing, building structures, drawing, doodling.
 5. Physical movement, sports, dance, repetitive movements.
 6. Socializing with others, reading body language.
 7. Internalizing, imagination, self-discipline.
 8. Nature, plants, animals, and outdoors.

If a child is particularly strong in areas that schools don't happen to use and weak in areas they do use, the child might have difficulty learning. ***Parents and teachers can help children learn by incorporating all three learning styles and a variety of the eight learning centers of the brain.*** It takes far more creativity, time, and energy, but helps *all* children learn.

- ADHD children often participate in special programs, such as tutoring and reading groups, that take place during school hours away from the classroom. While they learn important skills in these programs, they also lose the extra time they need to complete schoolwork, absorb and process information, or simply get a mental break. They may get farther behind in their work and have difficulty adjusting to the transitions.
- D. ***Psychological Treatment.*** Locate a psychologist, psychiatrist, or therapist who is knowledgeable and experienced in treating ADHD. They can address the following special issues of ADHD:
- Treat depression and anxiety.
 - Explain how the mind/brain works and doesn't work.
 - Teach anger control, social, self-motivation, self-reminding, and relaxation techniques.
 - Build self-esteem, since ADHD children are often discouraged.
 - Provide marital and family therapy. ADHD affects the whole family (the ripple effect). ADHD children should not be labeled "problem children" or blamed for other family problems.
- E. ***Medication therapy***
- *Medication is only **one** type of treatment and should **only** be used as a last resort.* Some medications have negative side-effects and most are considered "controlled substances." Some employers (the military for example) will not hire adults who used these "drugs" in childhood. Given these risks, parents must seriously consider whether medication is really necessary. ***Above all, never use medication alone or as a replacement for any of the other treatments.***
 - *Medication will not **fix** ADHD; it only manages it.* Medication for ADHD works like eye-glasses on vision problems; glasses don't fix the eyes, they simply help people see better. Poor vision and ADHD are both lifelong problems. As children mature and master self-regulating skills, they can often reduce or eliminate the need for medication.

ADDITIONAL RESOURCES

In addition to the books mentioned in this and other chapters, there are other resources that address the causes of PU behavior. Here are some possible topics and recommended resources:

Young children:

- *Parenting Young Children*, with James S. Dinkmeyer (American Guidance Service, 1989).
- *Tantrums: Secrets to Calming the Storm*, Ann E. LaForge, (Pocket Books, 1996).
- Any book or resource by Doctors T. Berry Brazelton or William Sears.
- *The First Three Years of Life*, Burton L. White, M.D., (Fireside Books, 1995).

Puberty:

- *Changes in You & Me*, by Paulette Bourgeois and Martin Wolfish, M.D. (Somerville House, 1994). A book written for children nearing puberty. There is one book for boys and one for girls.
- *Created by God: About Human Sexuality for Older Girls and Boys*, by Dorlis Brown Glass with James H. Ritchie, Jr. (Graded Press, United Methodist Church, 1989).

Teens:

- *The Parent's Handbook: S.T.E.P./TEEN, Systematic Training for Effective Parenting of Teens*, Donald Dinkmeyer, Sr. and Gary McKay, (American Guidance Service, 1983).
- *Between Parent and Teenager*, Haim G. Ginott, (MacMillan, 1969).
- *Positive Discipline for Teenagers : Resolving Conflict With Your Son or Daughter in an Atmosphere of Mutual Respect*, Jane Nelsen, with Lynn Lott, (Prima Publishing, 2000).

All ages:

- *Creative Parenting*, William Sears, M.D., (Everest House, 1982). Explains several developmental issues of all ages, including medical advice.
- *Childswork/Childsplay*, a catalog of therapeutic games/books for parents, teachers, and therapists. An excellent resource for teaching emotional and behavior skills. Call 1-800-962-1141 or write 135 Dupont St., P.O. Box 760, Plainview, NY, 11803. Website: <http://childswork.com>

Bedtime/Sleep problems:

- *The Family Bed*, by Tine Thevenin. (Avery Publishing Group Inc., 1987).
- *Nighttime Parenting*, by Dr. William Sears (La Leche League International, 1985).

Learning styles:

- *Seven Kinds of Smart: Identifying and Developing Your Many Intelligences*, Thomas Armstrong, (Plume, 1993).
- *How Your Child Is Smart: a Life-Changing Approach to Learning*, Dawna Markova, Ph.D., (Conari Press, 1992).

Personality traits (also called “temperaments”):

- *Raising Your Spirited Child*, by Mary Sheedy Kurchinka (HarperCollins, 1991).

Food allergies:

- *Is this Your Child? Discovering and Treating Unrecognized Allergies*, Doris Rapp, (W. Morrow, 1991).

Attention Deficit Hyperactivity Disorder:

- *The Myth of the ADD Child: 50 Ways to Improve Your Child's Behavior and Attention Span Without Drugs, Labels, or Coercion* Thomas Armstrong, (Dutton, 1995).
- CH.A.D.D. National Headquarters, 8181 Professional Place, Suite 201, Landover, MD, 20785, 301-306-7070, fax 301-306-7090. CH.A.D.D. has parent support groups throughout the United States (call to inquire about international resources) and publishes an “educator’s manual” for teachers. For more information, check the CH.A.D.D. Web site, home page address: <http://www.chadd.org/>