

Community Psychiatric Centers

Dr. Robert Lowenstein, M.D.

Dr. John Carosso, Psy.D.

ADHD – Facts and Fallacies



cpcwecare.com

1-877-899-6500

This E-Pamphlet targets and dispels the facts and fantasies regarding Attention-Deficit/Hyperactivity Disorder. Some of the common fallacies addressed include:

- 1.) Attention-Deficit/Hyperactivity Disorder is not a genuine disorder,
- 2.) medication is unsafe and causes dependency,
- 3.) Attention-Deficit/Hyperactivity Disorder is used as an excuse for underachievement,
- 4.) Attention-Deficit/Hyperactivity Disorder children just need more discipline to do better in school.
- 5.) That teachers unnecessarily try to push children onto medication when they don't need it, and that
- 6.) Behavioral interventions alone are enough.
- 7.) Children outgrow this condition at some point in their lives in all cases
- 8.) Ritalin and the other stimulant medications have increased dramatically.

However, first, let's review the primary symptoms of this condition and how it appears.

There are three types of Attention-Deficit/Hyperactivity Disorder. There is the Inattentive Type, also referred to as Attention Deficit Disorder or "ADD". There is the Hyperactive Impulsive Type and there's the Combined Type, which would be a combination of the Inattentive as well as the Hyperactive and Impulsive Type. The most commonly diagnosed types would include the Inattentive and the Combined Types, and the reason for that is it's rather rare for a child to be hyperactive and impulsive and not be inattentive at the same time.

These children tend to be fidgety, struggle to remain in their seats, they're always on the go, they have poor interpersonal boundaries at times, have trouble occupying their time appropriately and quietly, and they tend to blurt-out comments and questions in the classroom. These children tend to have difficulty waiting their turns, are inattentive, have difficulty following instructions, and have a propensity for being disorganized, losing items and being forgetful.

These signs and symptoms must be present before seven years of age. They also have to be evident in two or more settings and they have to be evident over the course of at least six months. Most importantly, the symptoms must cause significant impairment in the child's life.

Attention-Deficit/Hyperactivity Disorder occurs far more frequently in boys than in girls and it seems to run in families. Also, this is a very common condition; Attention-Deficit/Hyperactivity Disorder is present in three to five percent of all school-age children, making it a common diagnosis and problem that all children face.

Just an excuse?

We often hear from teachers and parents that children are underachieving in school, don't listen, can't pay attention, fall behind in their class work and are at risk for failure. One of the fallacies that we need to address is that ADHD diagnosis is an excuse for underachievement.

ADHD can be a challenge, but it's certainly not an excuse. At CPC, we go to great pains to work with children to help them understand that they can utilize coping strategies and teach themselves

to self-monitor, to pace themselves accordingly and use a host of other coping strategies. We also work with parents and teachers to help them utilize various accommodations in the environment so that the child can be more successful. A successful child is not looking for excuses, so in that situation, everybody wins.

Medication?

The treatment process not uncommonly includes aspects of medication management, and there are a host of fallacies and concerns about medication issues: is medication effective, is it safe? Practitioners have been treating Attention-Deficit/Hyperactivity Disorder with stimulant medications since 1938. It's probably the most studied of medications used in childhood populations. There have been no reported deaths by overdose of a stimulant medication alone. In general, this is a very safe medication. There are some side effects that need to be closely monitored, which can include decreased appetite, trouble falling asleep, some moodiness that can come and go, as well as tics that especially need to be closely monitored. These are short-acting preparations and if the child does not get that medication on the next day, most if not all of the medication is out of their system and any of the side effects are usually gone. Research has shown that this is a very safe medication in general.

To discipline or not to discipline?

Some would suggest that all these children really need is to 'lay down the law', and parents are simply being too lenient, which is why they're having the behavioral problems. This idea is misguided. Yes, these children need consistent routine, predictability, clear expectations, a firm approach. The approach needs to be based in positive reinforcement, high expectations, and lots of positive regard and patience. However, a large portion of these children's behavioral difficulties are beyond their control. They struggle with impulsivity, and need improved coping strategies and lots of extra structure and support in their environment.

Keep in mind that this is a biological condition that a child inherits, sometimes from their parent, probably caused by a chemical imbalance in the brain that deals with dopamine or norepinephrine transmission in the brain. At Community Psychiatric Centers, we combine the use of medication with other treatment modalities, which might include individual therapy with the child, behavior modification techniques that are implemented in the home and school settings, the use of social skills training for the child to learn how to adapt and adjust to their symptoms, and the use of family support groups and family therapy to help the family deal with a child that is often quite hyperactive and sometimes 'climbing the walls', impulsive, and involved in risk-taking. Once these treatment modalities are implemented, the family stress is often greatly reduced.

Teacher feedback

Another common myth is that teachers are pushing parents to medicate their children when they see attention problems in their classroom. Maybe there are some situations where a teacher expresses concern to a parent and mentions that medication may be helpful. Of course, that shouldn't happen, as teachers are not medical practitioners and they shouldn't be making those

types of recommendations. We've found, however, typically that's rather rare. What we have found is that teachers tend to be invaluable resources in the assessment process. They tend to be excellent judges of whether a child is having genuine attention problems. Consequently, if your child's teacher expressed some concerns to you about your child being off-task or easily distracted, it's probably best not to get defensive about that but, rather, simply give us a call here at Community Psychiatric. You can catch us at cpcwecare.com. Again, teachers can be an excellent resources in this process and they tend to know what's going on with your child in terms of attention and concentration.

Is there an "ADHD test?"

There is no single test to establish a diagnosis. There is no blood test. We do know that there are factors that can help confirm the diagnosis, including the direct signs and symptoms evidenced in different settings, over a long period of time, and significantly impairing daily functioning. It also is compelling if a blood relative parent has the condition too. Another factor can include prenatal affects of drug and alcohol abuse, and trauma in a parent prenatally or problems during birth. When the child is evaluated at Community Psychiatric Centers, we take all these factors into consideration. The child is observed for a considerable length of time, objective assessment is completed from various observers, and a comprehensive history if obtained. It's also vital to rule-out other factors or conditions that might look like ADHD, including an anxiety disorder.

Grow out of it?

Another common question is "will my child grow out of this?" What does the future hold?" There are a number of quality follow-up studies that suggest that about seventy percent of children who are diagnosed with ADHD in childhood will continue to have that diagnosis in adolescence. Between fifteen and fifty percent of those adolescents will then carry the diagnosis into adulthood. What that suggests is that some kids do, in fact, grow out of it. However, there are quite a number who continue to have the signs and symptoms into adulthood, which would of course reflect the need for ongoing treatment and monitoring.

If not treated

A child who is untreated can develop problems in school, can fail in their subjects, can be labeled as a 'problem child' and experience social difficulties with their peers. Research has shown that, as they grow older, these individuals experience increasing rates of divorce, job loss, drug and alcohol abuse, and problems with driving including a greater number of accidents. It's very important to have this condition treated, sometimes for one's entire life, to avoid some of these complications. In fact, with treatment, the prognosis is quite good.

Too much of a good thing?

The last fallacy that we need to address is that Ritalin has been overproduced and that there has been a 600 percent increase in the production of this particular medication. While the production rates of this drug have increased, the question is still open as to who is getting this medication. In fact, a large portion of it is probably being administered to adults and geriatric patients, who use it for treatment of other conditions such as narcolepsy or for memory loss, and it's quite effective in that regard. Moreover, of the three and a half million children who are diagnosed with ADHD in the United States, only about half of them are being treated with medications. The number of children treated with medications is still far below what it could be. It's certainly not an overproduction of the medication or a pushing of it to children who don't need it.

Email Question

"My nine-year-old's teacher says my child is off-task, distracted and not completing schoolwork. ADD has been mentioned. However, he also seems sad, and worries about a lot of things. What do you think?"

This brings up an excellent point; we always rule out competing contributors to a child's off-task behavior and attention deficit issues. We need to rule out anxiety problems, depression, or a child who has possibly been traumatized in some way. A child who has these difficulties tends to be off-task; the child is preoccupied and, subsequently, distracted. Consequently, it's vitally important, as part of the treatment process, to rule out any other possible contributors to a child's distractibility and treat accordingly.

Children who are depressed can often appear distracted and inattentive. They can look like they have ADHD but in actuality they are depressed. A child can also have both depression and ADHD, or Bipolar Disorder and ADHD together. So those need to be ruled out and treated appropriately.

Contact us here at CPC

We hope you found this review to be helpful. Don't hesitate to call or email with any questions along the way. We're always available to answer questions, evaluate, treat, and provide ongoing consultation. Visit us at cpcwecare.com. Thanks and God bless.