

ADD-vantage



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Attention Deficit/Hyperactivity Disorder Newsletter

Issue 12

Nov-Jan 2001-2

Dear Members,

I hope you all enjoyed a very Happy Christmas with your families and to those of you who did not manage to be together for whatever reason, I sincerely hope you still managed to celebrate the birth of this wonderful baby boy, Jesus Christ. New Year was another excuse for a good celebration, if you had a bad 2001 then you could wave it goodbye and if you had a good 2001 we hope 2002 will be no worse.

The Group has a lot of activities planned for the year 2002 and as usual we continue with this, our Newsletter, and our Personal and Social Educational sessions for children with AD/HD. These are held during our monthly meetings on the second Friday of every month, from 6.30 p.m. to 8 p.m. at the Gian Francisk Abela 6th Form.

It was also suggested at the Extraordinary General Meeting, that we invite a psychologist to be present during our meetings to meet with parents on an individual and private basis as the need arises. Would those parents who would like to make use of this service please phone on the above telephone number and leave their names and phone numbers so that we can get back to them. This will only be offered on an appointment basis since I am sure you will understand that we cannot afford to pay someone suitably qualified to come, on the off-chance that someone wants to talk to him, for a couple of hours.

A preoccupying situation has arisen over the granting of medication for AD/HD children on the Schedule V. Although we were advised that this had been approved and was only waiting for the Minister's signature, it now transpires that the Minister of Finance stopped the approval because word got to him that there were hundreds of children diagnosed with AD/HD who were on Ritalin.

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FUNCTIONAL BEHAVIOURAL: WHAT, WHY, WHEN, WHERE, AND WHO?

by
Stephen Starin, Ph.D.

The recent amendments to IDEA are final. School districts are now required to conduct functional behavioral analyses of problem behaviors, under certain circumstances.

Unfortunately, IDEA does not provide specific guidelines regarding the conduct of a functional behavioral assessment. Each school district is left to its own devices when interpreting the guidelines and may opt for lower quality standards. Below are my comments on conducting a functional behavioral assessment (FBA). These comments are based upon my formal training as a behavior analyst and over 20 years experience working with children, adolescents, and adults with serious problem behaviors. I've tried to avoid technical jargon for ease of discussion.

What is a "Functional Behavioral Assessment"?

The term "Functional Behavioral Assessment" comes from what is called a "Functional Assessment" or "Functional Analysis" in the field of applied behavior analysis. This is the process of determining the cause (or "function") of behavior before developing an intervention. The intervention must be based on the hypothesized cause (function) of behavior.

Why Do Functional Behavioral Assessments?

Failure to base the intervention on the specific cause (function) very often results in ineffective and unnecessarily restrictive procedures.

For example, consider the case of a young child who has learned that screaming is an effective way of avoiding or escaping unpleasant tasks. Using timeout in this situation would provide the child with exactly what he wants (avoiding the task) and is likely to make the problem worse, not better. Without an adequate functional behavioral assessment, we would not know the true function of the young child's screaming and therefore may select an inappropriate intervention.

How Do You Determine the Cause or Function of Behavior?

There are three ways of getting at the function (cause) of the behavior:

- (a) interviews and rating scales,
- (b) direct and systematic observation of the person's behavior, and
- (c) manipulating different environmental events to see how behavior changes.

The first two are generally referred to as **functional assessments** whereas the third is generally referred to as a **functional analysis**.

Several different interviews and rating scales have been developed to try to get at the function (cause) of behavior. However, reliability is usually poor and these should be used **only as a starting point** for systematic and direct observation of the person's behavior. Relying exclusively on interviews and rating scales should **never** be considered a functional assessment. Besides having poor reliability, it would never hold up in court with an expert witness.

Observe and Analyze Behavior in Natural Environment

A more **reliable method** involves directly observing the person's behavior in his or her natural environment and analyzing the behavior's antecedents (environmental events that immediately precede the problem behavior) and consequences (environmental events that immediately follow the problem behavior).

Types of Problem Behavior

Problem behavior typically falls into one or more of three general categories:

- (a) behavior that produces attention and other desired events (e.g., access to toys, desired activities),
- (b) behavior that allows the person to avoid or escape demands or other undesired events/activities, and
- (c) behavior that occurs because of its sensory consequences (relieves pain, feels good, etc.).

The antecedents and consequences are analyzed to see which function(s) the behavior fulfills. Problem behavior can also serve more than one function, further complicating the matter. The interview, combined with direct observation of the behavior is what most people use in determining the function of the behavior. This is fine when the data collected on the antecedents and consequences is

clear. Most of the time this is sufficient in determining the behavior's function(s).

Systematic Manipulation of Environment

In some cases, however, direct observation does not give a clear picture of the behavior's functions and systematically manipulating various environmental events becomes necessary. The most common way of systematically manipulating the environment is to put the person in several different situations and carefully observe how the behavior changes.

For example, to determine the function of screaming, we could arrange for attention to be given to the child each time she screams and measure how frequently screaming occurs. We could also make demands on the child, terminating them each time she screams and measure how frequently it occurs. In addition, we could leave the child alone and measure how often screaming occurs. If screaming is more frequent when attention is given, we hypothesize that it occurs to get attention. If screaming is more frequent when demands are made, we can assume that screaming has served to let the person escape or avoid demands. Finally, if screaming is more frequent when left alone, we can assume that it is occurring because of its sensory consequences. This third method should be reserved only for situations in which the functions of behavior are not clear through systematic and direct observation.

What About Qualifications and Training?

An important question is "Who should be involved in the functional behavioral assessment?" The interview is important in gathering preliminary information that will guide later direct observation. As such, it is important to talk to the people who know the child the best: parents, teachers and significant others.

Only a person who has been thoroughly trained on collecting and analyzing this type of information should carry out direct observation. Directly manipulating environment events should be conducted only by a well-trained behavior analyst or someone else with a high degree of training and experience conducting these manipulations for

they can pose danger to the person if not done correctly.

As can be seen, a functional behavioral assessment is more than a group of people sitting around a table trying to determine the cause. Although it is important to gather information from significant people in the person's life, it is not enough.

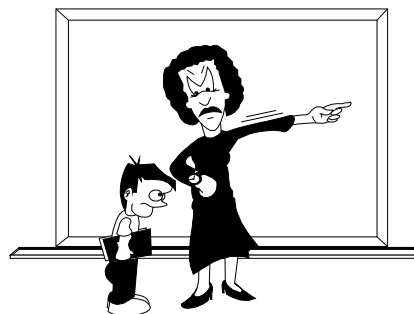
Someone knowledgeable about behavior must be in the classroom and/or family home directly observing and measuring the behavior. Although this takes time, it is usually time well spent because the intervention is more likely to be effective than one developed without careful consideration of the behavior's function(s).

Don't Waste Valuable Time

Time is precious. Time should not be wasted on interventions (behavioral or otherwise) when there is no evidence that this particular intervention is likely to work, for this particular child, in this particular situation.

About the Author

Dr. Stephen Starin is the Executive Director and Senior Behavior Analyst for Behavior Analysis and Therapy, Inc. He is the former Director of Behavior Analysis for the State of Florida and is a Past President of the Florida Association for Behavior Analysis. You can contact Behavior Analysis and Therapy, Inc. at (888) 423-4284 or on the Internet at <http://www.behavioranalysis.org/>



DISCIPLINE: SUSPENSIONS, EXPULSIONS & IEPs

by Robert K. Crabtree, Esq.

The Question

My daughter has a language impairment and has been on an IEP since last year. She has had a rough year and was just suspended

from school for pushing another student into a locker. This is her second suspension this year for fighting.

I think she's getting into these fights because she has so much trouble understanding how to use words in tense social situations.

Does the school have to provide her any educational services while she is suspended? The Vice Principal told us he's considering expelling my daughter. Can the school system do that?

The Answer

Your daughter's rights are governed by the 1997 amendments to IDEA concerning suspension or expulsion of children with special educational needs. (These provisions are found mostly at [20 U.S.C. § 1415\(k\)](#).)

The law states explicitly that a free appropriate public education ("FAPE") must be available to all children with disabilities, "including children with disabilities who have been suspended or expelled from school." (20 U.S.C. §1412(a)(1)(A).) Your daughter is certainly entitled under this law to continue to receive an appropriate education if she is suspended for any time beyond 10 days. See 34 CFR 300.520 in regard to "ten day" suspensions. Be sure to read the [IDEA Regulations](#) about discipline at 34 CFR 300.519-.529.

Long term Suspensions or Expulsions

Most importantly, a school system cannot impose a long-term suspension or expel a student with special educational needs if the behavior for which s/he is being disciplined was a "manifestation" of his or her disability. (§1415(k)(4)(B),(C)) IDEA provides that the IEP team must find that behavior was a manifestation of the child's disability if: the IEP was inappropriate with respect to the behavior or was not being implemented, including appropriate behavior intervention strategies; the child was unable to understand the impact and consequences of her behavior because of her disability; or the child's disability impaired her ability to control her behavior.

If any of these circumstances applies, the IEP team must correct the IEP or its implementation and, except for the 45-day provisions I described earlier, the school **cannot legally suspend the student beyond ten days**. If the team finds that the behavior is not a manifestation of the child's disability, the

school can suspend longer than ten days as it can a student without a disability, but must still provide ongoing education under his/her IEP during the suspension.

Student Rights

The rights I have discussed here apply to students who are already identified as having special educational needs.

Importantly, the law also applies to students who the school system knew or should have known have disabilities. IDEA treats a school system as "knowing" about a disability for these purposes if:

a parent expressed concern that his/her child needs special education (this must be in writing unless the parent is illiterate or unable to write because of a disability); the behavior or performance of the child shows s/he needs such services;

a parent requested an evaluation of his/her child; or

a teacher or other school employee has expressed concern about behavior or performance to other school staff. (§1415(k)(8))

Also, even if the school system is not deemed to have "knowledge" of a disability, parents can request an evaluation when their child is being suspended or expelled, which must be expedited. (§ 1415(k)(8)(C)(ii)) In that case, however, the child must remain in whatever placement is determined by the school pending the outcome of the evaluation.

These are actual excuse notes from parents (including original spelling) collected by Nisheeth Parekh, University Texas Medical Branch @ Galveston...

My son is under a doctor's care and should not take P.E. today. Please execute him.

Please excuse Lisa for being absent. She was sick and I had her shot.

Dear School: Please excuse John being absent on Jan. 28, 29, 30, 31, 32, and also 33.

Please excuse Roland from P.E. for a few days. Yesterday he fell out of a tree and misplaced his hip.

John has been absent because he had two teeth taken out of his face.

SUPPORTS FOOD ALLERGY- ADHD LINK

BEHAVIOUR PROBLEMS: WHAT SCHOOLS ARE OBLIGATED TO DO

by Pete Wright

A special educator writes, "We have a 15 year old tenth grader who is diagnosed "seriously emotionally disturbed." Academically, he is functioning at the 2nd grade level. He is placed in a self-contained classroom."

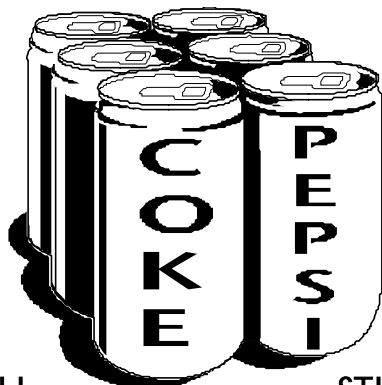
"Must we continue to provide special education services in the current setting if we believe the student is a danger to himself or others? What if the school has no alternative placement? What about the safety of other students, teachers, administrators?"

In Behavior Problems: What Schools Are Obligated to Do.

Pete describes the school's obligations to provide FAPE. He asks hard questions. What is driving the boy? Why are his skills at the 2nd grade level? Why is he not receiving remediation of academic skills? He explains that the school team needs good diagnostic testing before they can develop an appropriate educational plan.

After describing a treatment program he developed when he worked as a juvenile probation officer, Pete asks, "Why do we have to reinvent the wheel again and again."

It is important to remember that articles like the above refer to the law in the USA. Nonetheless knowing what is done in other countries helps us when it comes to pressing authorities to change the law here.



SMALL

STUDY

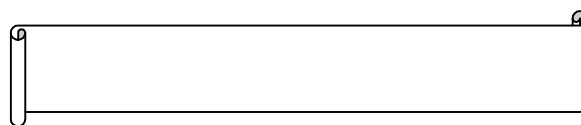
Children with attention-deficit/hyperactivity disorder (ADHD) are seven times more likely to have food allergies than children in the general population, according to the results of a small, preliminary study. <http://psychiatry.medscape.com/45586.rhtml?srcmp=psy-113001> <http://psychiatry.medscape.com/45586.rhtml?srcmp=psy-113001>">

Read it Here

CHILDHOOD METHYLPHENIDATE TREATMENT REDUCES ADULT COCAINE RESPONSE

Methylphenidate treatment early in life may blunt the pleasurable effects of cocaine in adulthood, according to findings from an animal model.

<http://psychiatry.medscape.com/45876.rhtml?srcmp=psy-120701> <http://psychiatry.medscape.com/45876.rhtml?srcmp=psy-120701>"

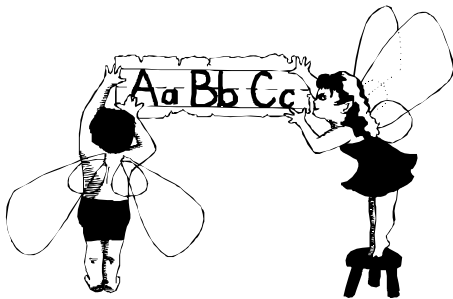


CONCERTA™ NOW AVAILABLE IN THE UK

We have just heard from B R Pharma that they are now receiving supplies of Concerta™. This will be available to people in the UK under the same conditions as Ritalin SR and ADDerall. What this means is that B R Pharma have received the licence to import the medications but they remain unlicensed as far as Doctors are concerned, i.e. they will not appear on their computer screens as medications available to prescribe. However, Concerta™ will be available to patients on a named patient basis under guidance from a consultant. If you are interested in using Concerta™ you would have to approach the consultant and make sure you can give them information about the medication and ask if they would be willing to

prescribe. Due to the cost of Concerta™ B R Pharma is only importing a limited quantity which they are doing on a supply and demand basis at present. This means that if you do have a prescription for Concerta™ the Pharmacist will have to fax a photocopy of the original prescription to BR Pharma International on (UK Only) 020-8441 0374 (Tel:020-8364 9823) who will then order from the US, this can take about 1 month for delivery. B R Pharma have told us however that as demand increases the supply will improve.

Concerta™ is an extended-release formulation of methylphenidate tablets for ADHD treatment which is designed to last throughout the day with just one dose. Methylphenidate is the most commonly prescribed medication for treating and managing ADHD. It has been used safely and successfully among children and adults for more than 25 years.



REINVENTING OUR SCHOOLS

by Thom Hartmann

This article by Thom Hartmann was prompted by an article in the New York Times science section (October 31, 2000) that clearly laid out what have become the two dominant world-views of ADD/ADHD.

The article, entitled "[Making a Plus from the Deficit in ADD](http://www.nytimes.com/2000/10/31/science/31ADD.html)" (and available on the web at <http://www.nytimes.com/2000/10/31/science/31ADD.html>), opens with the story of Michael Zane, the founder of the Kryptonite Bike Lock Corporation, who categorically says that, "I don't think I could have been as successful without it [ADHD]."

Psychologist Lynn Weiss is quoted saying, "I am so glad I have ADD!" because it gives her special skills and strengths.

Later in the article psychologist Russell Barkley is quoted as saying that the "trend" of trying to find useful or good things about ADD is "dangerous." There's nothing of value in ADD/ADHD, he says (and has said in other publications, including an editorial citing "a

failure in the evolution" as the cause for ADHD).

These are the two worldviews -- it's a difference or a disease/failure.

My take on it, which is best detailed in a book that just came out last month ("[Thom Hartmann's Complete Guide to ADHD](#)") is that it's a "context disorder."

Left-handedness is another, for example. If a left-handed person were put in a room with nothing but right-handed-required tools, she would have a problem "succeeding." In the years when my parents were in school, it was common to tie the left arm of left-handed children to their bodies, so they'd be "forced to learn to be normal" and use their right hands. Enormous psychological wounding was done in the name of enforcing "normalcy."

Similarly, I believe our assembly-line-like schools, where everybody is expected to learn the same material, in the same way, at the same time and speed, can be incredibly wounding for any children who are "different" in their learning style.

Gifted children, kinesthetic learners, ADD/ADHD children -- a whole gamut of "non-standard-factory-issue" kids are daily wounded by our schools, leading us to the point where in just the few minutes you've taken to read this email, the odds are at least one schoolchild in America has committed suicide.

Unwittingly, our schools have become an institution that is often the greatest agent of wounding for these children, which is why **Underwood Books** incorporated the entire manuscript of my unpublished book "**A Parent's Guide To Reinventing Our Schools**" into the new "[Thom Hartmann's Complete Guide](#)" book (as the "Education" section). (You can find more information about this topic in [my "online rants" from my webpage](#).)

There are huge individual variations in children and adults. For us to try to put any group into a neat little box and categorically state that they are of less function (and thus, implicitly, of less value) than "the rest of us" is to diminish all of our humanity.

Waking Kids Up In School

The most common theory about what's wrong with our schools is that there's something wrong with our kids. It's rarely stated straight-out like that, and, in fact, usually is never

stated out-loud in political debates that seem to center on standards, funding, staffing, and other peripheral issues. But when you look at what's really happening in the schools and what's being done with kids, it's quickly apparent that this is the primary theory being played out.

It's a theory particularly in favor with the medical, educational, and pharmacological establishments, and explanations range from neurological disorders such as ADD to the effect of too much television-watching. Whatever the mechanism, though, most of these theories boil down to one basic conclusion: today's kids don't have self-discipline and can't control themselves — they lack what's known in psychological circles as “executive function.”

This assumption leads to a whole range of “solutions.”

Medicate them to re-balance their neurotransmitters and thus activate their self-control centers. Use point systems to give them incentives for appropriate behavior. Put them on additive-free diets, throw out the TV, give them food supplements, or chiropractic adjustments. Discipline them more severely, perhaps even including spankings or whippings. Put them in highly structured, very quiet classrooms with few distractions.

What all of these assume is that there is some failure of inhibition on the part of the child: some inability of an unknown but presumed master-center within the brain, whose job is supposed to be to assume and maintain control.

But what if the real problem was the exact opposite of that?

Consider: any parent will agree that ADHD kids have no problem learning video games. They have no problem concentrating on them. They have no problem paying attention to them. The same goes for skateboarding, dancing, hanging out with friends, and a thousand other things that kids do outside of the classroom. Or learning to walk and speak, which are highly complex activities, with multiple levels of structure.

To use the analogy of food and eating, what if the problem is that our ADHD kids are always “hungry”?

For example, if we took 100 adults and split them into two groups, and 50 of them ate every day, all they wanted, for two weeks,

while the other 50 fasted on only water, would we see a difference in behavior between the two groups if they were both presented with tables covered with food? Of course! And would that difference be the result of the fasting group having “poor inhibitory mechanisms?” No reasoning person would think so.

So what if our kids are “getting fed” in all the things that they enjoy doing, but not “getting fed” in school? What if what we're looking at here is not a failure of self-control, but an over-intensity of hunger? That the problem is not the Executive Ego hand from above, but the viscerally craving Id from below?

The Hunger for Aliveness

When looking at psychological models such as Maslow's hierarchy of human needs or Freud's notion of the ego and its collateral parts, one question escapes answer.

Why do people take risks?

Why do skydivers jump out of airplanes?

Why do people seek out the most dangerous and difficult mountains to climb? Why do speeders drive so fast? Why do people experiment with drugs or have sexual affairs? Why does roller-coaster ridership go up whenever there's a fatal accident on one? Why do people leave secure jobs to start up businesses?

If you were to ask one of those skydivers or mountain climbers why they take the risks they do, you'd probably hear an answer along the lines of: “When I do that, I feel the most totally and completely alive.”

Apparently, to judge from the hundreds of thousands of testimonies in life and literature of people who take risks or live high-stimulation lives, the need to feel alive is a very real and important need.

Yet some people seem not to experience this need as strongly as others. Some take risks only rarely, keep the same job for 40 years, live in the same house, and prefer a life of quiet and predictable stability. This spectrum of behavior, from risk-seeking to risk-avoiding (or novelty-seeking to novelty-avoiding), shows us that there is a spectrum of “hunger” among people for “the experience of aliveness.”

This is what I believe many of our school-misfit children are experiencing: the need for aliveness. It's a real and visceral and powerful need, and one that isn't being met in the

classroom. So they misbehave, act out, become the class clown, or give up altogether — all as ways of getting this primordial need met.

Low-stimulation Classrooms

Understanding this tells and shows us why the conventional wisdom of putting such kids into highly structured and very quiet, no-distraction “special classrooms” or “resource rooms” doesn’t work. In such an environment, they only become more hungry for the stimulation which evokes the feeling of aliveness they crave.

It explains why stimulant drugs — which chemically induce a stimulating experience that’s internally and neurologically similar to riding in a roller coaster — have the effect of calming these kids down. Their need for stimulation is being met, albeit chemically.

It explains why kids who “can’t learn and can’t focus” can become experts at multi-level video games or complex skateboarding tasks: those are filled with stimulation, causing them to feel very much alive.

It explains why there are so many bright people who never were able to complete high school, yet “unconventional” private schools or home-schooling parents are so often able to educate the very kids the public schools have given up on.

It explains why many kids who struggled with the boredom of primary school are able to do well in college, where they can pick and choose for themselves the most stimulating and exciting topics and teachers.

It explains why both types of ADD — the “dreamy, inattentive” form most often seen in girls and the “hyperactive” form most often seen in boys — are identical in their root causes. While boys are obtaining their stimulation from manipulating the world (as they’re taught to do by our culture), girls more often get their stimulation internally, by having raging conversations in their own minds or creating exciting fantasy worlds into which they can escape.

It explains why the “failure of executive function” explanation is a misguided view of symptom and not cause, and why so many of the “therapies/solutions” suggested by proponents of that model don’t work over the long-term, and why even when they do work they often leave children wounded.

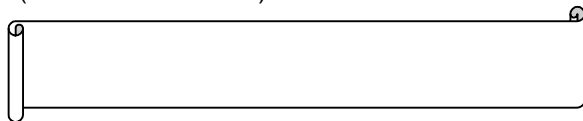
And it explains a large part of why threats of expulsion, point systems, or resource rooms with one-on-one instruction do seem to work for a short time — they’re stimulating. (Although it’s a stimulation that fades quickly once the negative consequence is experienced: like the junkie with his heroin, ever-increasingly-larger doses are necessary to produce the same result.)

Dr. John Ratey of the Harvard Medical School often refers to “the sleepy cortex” of learning-disabled, and, particularly, hyperactive or ADD children. “They need arousal,” he said in a seminar we taught together in Jerusalem. “They need stimulation to keep their brains awake and functioning.”

High-stimulation Classrooms

Viewed from this perspective, we can see why the character Robin Williams played in *Dead Poet’s Society* was able to captivate and motivate an entire classroom full of jaded and bored kids with something as seemingly arcane as 18th century poetry. Williams’ character was, himself, “on fire” for the topic, and that enthusiasm came across to his kids in the form of a wildly stimulating teacher and classroom.

It also explains the mechanism of the **“on fire” principle**: when a child is interested in something, he finds it stimulating, almost regardless of what it is. No point system, threats of expulsion, medication, or time-outs will ever come even close to the power to capture a child’s interest that’s contained in these two simple concepts: “fire” (interest/enthusiasm) and stimulation.



MISTAKES PEOPLE MAKE - PARENTS

by Robert K. Crabtree

Because the stakes are so high, it is difficult for parents of children with special educational needs to advocate calmly and objectively for the educational and related services their children need.

Here are some common mistakes that undermine parents’ ability to obtain appropriate services:

1. Viewing the special education process as the moral equivalent of war, fighting that war with a "scorched earth" approach, and letting personal animosity toward administrators and/or teachers distort one's judgment about what is best for the child and what is realistic to accept;

2. The opposite mistake: trusting administrators and teachers too uncritically; assuming that if they are "nice" they are also competent and interested in serving the child's best interest; not questioning slow, or nonexistent progress as long as the child, parent and teacher have a cordial relationship;

3. Taking an "all or nothing" approach: waiting too long before getting good independent advice, then insisting on instant delivery of needed services rather than steady progress toward the right program;

4. Failing to understand that the special education process sometimes requires that the parent educate the child's special education team about the child's disabilities and needs (the school system may not be willfully refusing to meet the child's needs; they may simply not understand those needs);

5. Not trying a program or added services, even on a temporary basis, when they are offered by the school system -- holding out for an alternative program only to have a hearing officer decide the untried program might have worked;

6. Attempting to "micro-manage" the details of a child's life in school; even if parents don't feel things are going well, their efforts to control the child's day usually backfire when the hearing officer concludes that the parents were over-protective and didn't let the school professionals do their job;

7. Focusing on minor, nonprejudicial procedural missteps by the school (e.g., the parent who already knows her rights who says, "Aha! Gotcha! School district forgot to give me the rights brochure!") instead of focusing on the substantial issues in the case;

8. Not consenting to school evaluations;

9. Choosing the wrong independent evaluators: e.g., "hired guns" who only say what the parents want them to say, and have a reputation for doing so; those who will not follow through by observing programs, attending team meetings, etc.; those who do

not have training or experience to evaluate a child like yours;

10. Not providing copies of independent evaluations to the school, or not providing them in a timely way;

11. Not responding in a timely way to proposed IEPs;

12. Not documenting issues with the school; not sending letters to confirm agreements with the school or to record important conversations with school personnel.

13. Seeing the school system as a monolith ("All those teachers are incompetent [or wonderful!]); failing to look carefully at alternatives within the system for this year and at next year's teacher possibilities.



LEARN TO ASK QUESTIONS, GET SERVICES

By Laurie from New York

When I began to advocate for my daughter, I felt insecure when I requested services or supports for her.

Because I felt insecure, I supported my requests with lots of documentation --articles, reports and recommendations from experts, test results, and information about specialized equipment. I was calm, polite, and in control.

I was surprised to find that the "powers that be" would not provide the services and supports that I requested for my daughter.

How Do They Perceive Me?

Why was I having this problem? What could I do?

It seemed that when I made a request, the educational experts viewed me as a "Know it All Parent" who thought she knew more about

my child's needs than they did. I realized that they felt threatened.

Now when I go to an IEP meeting, I have a mental list of the accommodations my child needs. What took me so long to do – to ask for what my child needs – I NEVER do! Now I ask questions so the educators come up with the desired solution, NOT me.

Strategies: Asking Questions to Identify Solutions

My child Susie has a hearing loss. I want Susie to sit near the teacher OR have a speakerphone in the classroom. I won't ask that Susie sit near the teacher or have a speakerphone.

Instead, I will say, "Gee, Susie really loves her teacher, Mrs. Smith. It's sad that Susie can't hear much that Mrs. Smith says. You know Susie has a hearing loss? (submit medical report) Susie really wants to do well on the new state tests. I wonder what we can do . . . At this point, someone is likely to say, "Let's have her sit by the teacher" or "Let's get a speakerphone for her."
I say, "That's a wonderful idea. I'm so glad you thought of it."

Strategies: Saying "Thank You"

I thank the team members for letting Susie sit near Mrs. Smith, the teacher she likes so much. I know this sounds crazy but I found it works most of the time. Educators/experts are happy when THEY come up with the way to meet the child's needs! Sometimes, they have ideas that I had not considered either!

I decided it doesn't matter who comes up with the solution as long as my child's needs are met!

Last year, we moved to a new school district in a different part of the state. We had a "clean slate." I had a chance to try out my techniques with a new group of educators. I gave them my child's IEP and told them about the equipment our former school used (the former school was willing to sell the stuff to them).

I could tell them everything they needed to know about my daughter but until they met her and got to know her for themselves, I was just another "yappy" parent.

I learned another lesson: our children often win over people on their own!

IEP Day: My Child Has Many Advocates

When IEP day came, more people were advocating for my daughter than I could imagine. I sat there feeling stunned, not saying much.

I heard, "We need to base her services on what she needs, NOT the availability of a TVI (Teacher of the Visually Impaired)" and "We need to have some training in this area" and "We must order these Braille books immediately."

They had already purchased the equipment from the old school – it was sitting on the table!

When I meet or talk with school staff, I explain that my daughter needs access to the general curriculum. She must have instructional materials in Braille, services from a teacher of the visually impaired, and orientation and mobility instruction.

I also explain that she wants to be like other kids. I do not expect the school to cartwheels just for her! When they realized that I do not want to break their budget or create unnecessary extra work for them, they've been great. I can honestly say that I don't feel that I'm an at odds with them! (But I still don't let down my guard.)

I look at it this way: If an educator came into my home and told me how to decorate the rooms and what color to paint my walls, I would not be very happy!

I can't say that everything has been smooth sailing – we have had some glitches and are getting some things in place for next year. I think this is the case whenever people with different interests work together for a common goal.

Parents need to figure out how to get the educators to come up with what our children need. My strategies are one approach. I'll bet other parents have ideas too!

It's sort of silly when you think about it -- like a game!

ANSWER; From Wrightslaw

You're right, it's like a game. And you hit a home run!

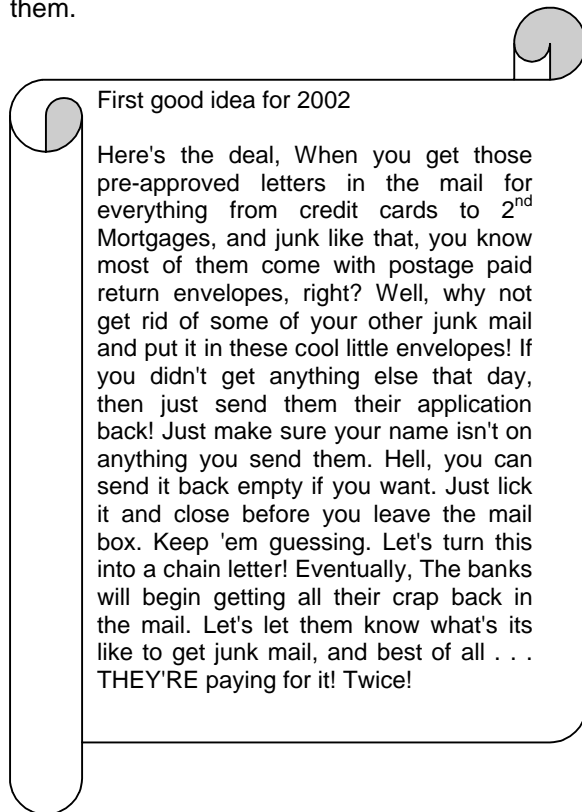
If a parent asks for a specific service or support, this generally ensures that the school will not provide that service or support.

After you struck out, you spent time thinking about the meetings. You thought about how you were perceived by school people (a Know-it-All or "yappy parent). You understood that if you took over the role of "Expert," you would leave no role for the educators.

If school people feel threatened or disrespected by you, they will look for a way to shoot you down. This is human nature - it is not specific to special education.

Many parents do not understand these issues. Since many parents feel insecure in their dealings with school people, it's hard for them to put their egos on the back burner.

In our new book, [Wrightslaw: From Emotions to Advocacy](#), we describe these issues and provide strategies to deal with them.



First good idea for 2002

Here's the deal, When you get those pre-approved letters in the mail for everything from credit cards to 2nd Mortgages, and junk like that, you know most of them come with postage paid return envelopes, right? Well, why not get rid of some of your other junk mail and put it in these cool little envelopes! If you didn't get anything else that day, then just send them their application back! Just make sure your name isn't on anything you send them. Hell, you can send it back empty if you want. Just lick it and close before you leave the mail box. Keep 'em guessing. Let's turn this into a chain letter! Eventually, The banks will begin getting all their crap back in the mail. Let's let them know what's its like to get junk mail, and best of all . . . THEY'RE paying for it! Twice!

THE AD/HD CRITICS: MORE PASSION THAN SCIENCE

Sam Goldstein, Ph.D.

This month's article may read more like an editorial than a review of research, set of clinical guidelines or treatment practice. Though I have made a point to avoid using my

monthly article as an editorial forum, my daily mailbag led me to change my mind, at least for this month.

In last week's mail I received a correspondence containing four documents. The return address was someone in Honolulu whom I do not know nor did that person make any effort to identify him/herself within the correspondence.

The first was a copy of a number of recent editorial cartoons sarcastically addressing the issue of psychiatric medications for children. These were from major media such as Newsweek and the New York Times. The second was two pages of short quotes by many well-respected professionals concerning ADHD. The title of this sheet was ADHD: Fact, Fiction or Fraud? Most of the quotes were taken out of context. Most reflected opinion not necessarily scientific fact.

The third was a copy from an occupational therapy weekly newsletter. It was a one-page viewpoint titled ADHD is Biopsychiatric Social Control. The author, an occupational therapist, cited a number of authors of recent texts critical not only of ADHD but of psychiatry in general. Absent any substantive fact, this author suggested that "ADHD is biopsychiatric social control under the guise of therapeutic intervention. It gives permission to parents and professionals to micro manage a child's life. This may ultimately create a helpless and dependent individual rather than in independent and resilient person" (Parry, 10/8/98, OT Week). Ms. Parry is certainly entitled to her opinion. It would be nice if she provided some facts to support her inflammatory statements. Her statements in general reflect pseudo science and a lack of understanding on her part of the current state of science in psychiatry and psychology.

Finally, the last document was an article titled ADHD: An Educational, Cultural Model from the December, 2001 issue of the Journal of School Nursing. The authors, Jane Lundholm-Brown and Mary E. Dildy, offer an interesting overview of ADHD, from the perspective of the "traditional medical model" versus what they define as an Educational Cultural Model (ECM). They cite themselves as the authors of this alternate model, suggesting that "in the ECM the child is not considered physiologically disordered. Instead, children are recognized as individuals with varying levels of energy who differ in temperament, attention span, intensity, mood, distractibility,

intelligence, talent and personal interests. Additional consideration will be given to the potential effects of family dynamics and societal influences on the behavior and attentiveness of children" (pg. 307). Ironically, this purported new model is not so new nor is it theirs except by title. What they describe is in fact the current standard of care in the evaluation of emotional, behavioral and developmental problems in childhood. Well over twenty-five years ago, pioneering researcher, Dr. Keith Conners, referred to the assessment and treatment of ADHD as a biopsychosocial phenomena that can only be understood by taking into account not only genetics and biology but environment and experience as well.

Lundholm-Brown and Dildy then go on to describe a very narrow, rather antiquated view of the "medical model of ADHD." Their description has long since been abandoned by researchers and most mainstream clinicians. They suggest that the medical model of ADHD places "little emphasis on the educational and cultural factors that may contribute to the cause of behavioral and attention problems in children" (pg. 310). I am not sure what resource or authoritative volume they relied on for their definition of a medical model but this certainly is not the current state of affairs in the science of ADHD. A review even of my previous monthly articles stands testament to the recognized complexity of this condition and the multiple forces that ultimately shape and determine a child's behavior in any given setting.

It is unfortunate my mysterious correspondent was willing to take the time to provide information and attempt to shift what he/she perceived to be my opinion yet was unwilling to reveal his/her identity. I can only assume that this person identified me as one of those professionals who rigidly adheres to the "medical model of ADHD" and is on a quest to diagnose as many children in the population as possible, handing them off to the pharmaceutical industry for a life-time of medications. Unfortunately, this could not be further from the truth.

Perhaps the practices of some professionals in the field contributes to the misguided views of the public or other professionals? In the very same day's mail, I also received a set of records to review of an unfortunate eight-year-old child with a history of significant behavioral and emotional problems beginning at a very young age. Despite the efforts of caring,

conscientious parents, parents raising three other children who in fact were doing quite well, this child was struggling. He had been evaluated a number of times. His parents had attempted a number of behavioral, educational and medical interventions. In fact, I was not surprised to note that this child had been treated with multiple psychiatric medications in the past with mixed results. These included medications in multiple classes from the anti-convulsants to the anti-depressants. Included were Seroquel, Depakote, Tenex, Clonidine, Zyprexa, Ritalin, Adderall and Wellbutrin. They had been attempted in various combinations following a diagnosis of early onset bipolar disorder and ADHD. Did this child have ADHD or bipolar disorder? It was difficult to tell from the records. Certainly this child was struggling. Had these medications been beneficial? Once again it was difficult to tell from the records as specific targets for medication treatment or careful monitoring of medication response had not been completed.

Unfortunately, I am seeing more and more children coming in to our tertiary care, university affiliated neuropsychology clinic with similar behavioural and medical histories. As Dr. Robert Brooks and I have noted in our work, especially in the area of resilience, a review of all sources of childhood data suggests that children are finding it increasingly more difficult to meet the expectations and demands of our culture. In response, more and more are experiencing problems. More and more of them come into our clinics and offices taking multiple medications, sometimes for problems that medicines have yet to be demonstrated as effective for in children.

How are these two items in my mail related? They both reflect actions based more on passion than science. Try as I might, I can't find an extensive literature of editorials, articles or opinions raising questions about this increasing trend. I also cannot find scientific research supporting this increasing pattern of prescribing and the prescription of multiple psychiatric medications to children simultaneously. I am not questioning the good work of many of the medical clinicians with whom I interact, I am just suggesting for example there is scant scientific literature to support the 300,000 plus children receiving anti-hypertensives such as Tenex and Clonidine or the over one million children receiving SSRI's such as Prozac and Zoloft let alone polypharmacy. Ironically, there is a very solid research base concerning the immediate

symptom relief offered by the stimulant medications for children with impaired self-control leading to inattentive, hyperactive and impulsive behavior. I also cannot find an extensive literature questioning the existence conditions other than ADHD that present in childhood such as anxiety, depression or learning disability.

What is it about ADHD that has created such a backlash among some professionals as well as the community at large? Why is it that ADHD so routinely stirs controversy based more on philosophy than fact? Why is it that many professionals can't seem or are unwilling to take the time to read, review and understand the scientific literature, that very clearly demonstrates the physical and genetic bases for children at risk to receive diagnoses of ADHD? Why is it that these people have so much difficulty understanding that ADHD is not an "it" but a reflection of the pace at which a child develops self-regulation and self-control. Thus, increased cultural demands upon children increases the number struggling to meet the expectations of the culture. This acts as but one more force leading children to the doorsteps of physicians and psychologists. Why is it that many of these individuals choose to close their eyes to fact, arguing that ADHD is a condition invented by pharmaceutical companies to sell pills, a means to micro manage children's behavior, an excuse for bad parenting or poor education or a problem caused by a variety of mysterious phenomena? Perhaps in the end it comes down to the fact that opinion is cheap and easy. It is easy to blame parents as inadequate when their children struggle to develop effective self-control. It is easy to point a finger of guilt at a parent who struggles to help a child learn to sustain attention or sit still only to find the child experiencing increasing problems. It is easy to blame professional organizations, support groups or drug companies.

Why is it that people have so much trouble understanding that ADHD is not a diagnosis based purely on symptoms but on impairment as well? The diagnosis of ADHD is made not to categorize, pathologize, moralize or demonize human beings but to assign risk and to gaze into the future through the eyes of the diagnosed child. By comparing that child to other children with a similar pattern of symptoms and impairment, other children for whom future risks and outcome are known, we can plan and more effectively work with the diagnosed child. By doing so, we well

understand the risks children who fail to develop self-discipline and self-control face academically, emotionally, behaviorally, vocationally and even in the lifestyle choices they make. What is it about these critics that blinds them to recognizing the common sense that in every classroom worldwide some children struggle with developing self-control? Even if it is one out of twenty, that is five percent of the population. That is five percent of all children who simply struggle to sustain effort, and require more time, patience and support to develop the self-discipline necessary to deal with life's daily requirements.

In my work with parents, I often provide the analogy of teaching children to swim or ride a bicycle. We all accept that based on the underlying skills necessary to master these abilities, children will vary in their progress. We accept that balance and coordination make a difference in the pace at which children learn to swim or ride a bicycle. Some will achieve quickly. Most will require some assistance but some, despite our assistance, will continue to struggle. When they struggle, as long as they get on the bicycle or into the water, we are very encouraging. We don't ask them to try harder. We don't question their effort or motivation. We don't ask how many times do we have to tell or show you? We are supportive and empathic. We recognize that the acquisition of these abilities for some children is difficult and that our role as parents and professionals is to provide sufficient opportunity, patience, encouragement and support to allow mastery of these abilities. I strongly believe that children with ADHD need the same empathy and support. Their only "crime" is that they are delayed in the development of self-control. These children require more time to master the self-regulatory skills necessary for success in every day life. I am not suggesting that practice will make perfect, just that there is enough scientific evidence to recognize that repeated practice over time enhances performance. Our mindset with children struggling to develop self-control is not to just provide a diagnostic label, a prosthetic environment and a prescription, but to find a way to facilitate the development of self-regulation and self-control. Keep in mind that while the medicines we provide children for ADHD offer strong symptom relief, we have not demonstrated that they change long-term outcome. As I have noted, the day a child with ADHD stops taking medicine usually looks like the day before they ever started, regardless of how long they have been taking the

medication. The same outcome holds true for behavior management as well. Symptom relief is not synonymous with changing long-term outcome. To help children with ADHD, we must find ways to strengthen and enhance their self-discipline. In the January, 2002 issue of the Journal of the American Academy of Child and Adolescent Psychiatry, Dr. Joseph Strayhorn provides two excellent articles reviewing the strong relationship of faulty self-control, not just to ADHD but to a host of other emotional, behavioral and adjustment problems. Dr. Strayhorn offers a model to begin a concerted effort to enhance the development of self-control in children at risk.

In the final analysis , I am not so much annoyed by the critics , but perplexed as to what we as a professional and scientific field can do to help the public understand the nature of ADHD and the truth about what we know. I believe that most professionals want to do the right thing. Certainly there are some with their own agendas for whom belief and rhetoric are the only "facts" they will ever rely upon. But by far the majority, my mysterious correspondent and the authors of those pieces I received in the mail, mean well and truly want to help children. I remain optimistic and confident that eventually the goal of helping children, one that we all share regardless of our opinions and ideas, will bring us together. The events of 2001 argue strongly that we must find a way to do so, not just for the increasing number of children experiencing problems fitting into the world we have designed, but for all children. I invite each of you to consider your opinions and beliefs. Examine the science of those opinions and recognize that the goal of helping all children develop self-discipline and other resilient qualities and ensuring stress hardiness must be first on all of our "to do" lists.

Dr. Sam Goldstein is on the faculty at the University of Utah and Clinical Director of the Neurology, Learning and Behavior Center. His articles and other information appears on his website, <http://www.samgoldstein.com>.

Fire authorities in California found a corpse in a burned out section of the forest. While assessing the damage done by a forest fire. The deceased male was dressed in a full wet suit, complete with scuba tanks on his back, flippers, and facemask. A post-mortem revealed that the person died, not from the burns but from massive internal injuries. Dental records provided a positive identification. Investigators then set about to determine how a

fully clad diver ended up in the middle of a forest fire. It was revealed that on the day of the fire, the person went for a diving trip off the coast some 20 miles from the forest. The fire fighters, seeking to control the fire as quickly as possible, called in a fleet of helicopters with very large dip buckets. Water was dipped from the ocean and then flown to the forest fire and emptied. You guessed it. One minute our diver was making like Flipper, in the Pacific, the next he was doing the breaststroke in a fire dip bucket, 300 feet in the air. Apparently, he extinguished exactly 5'10" of the fire. Some days, it just doesn't pay to get out of bed.

This article was taken from the California Examiner, March 20, 1998

Still Think You're Having a Bad Day????:

A man was working on his motorcyle on his patio and his wife was in the kitchen. The man was racing the engine on the motorcycle when it accidentally slipped into gear. The man, still holding onto the handle bars, was drug through the glass patio doors and along with the motorcycle, dumped onto the floor inside the house. The wife, hearing the crash, ran into the dining room and found her husband lying on the floor, cut and bleeding, the motorcycle lying next to him and the shattered patio door. The wife ran to the phone and summoned the ambulance. Because they lived on a fairly large hill, the wife went down the several flights of stairs to the street, to escort the paramedics to her husband. After the ambulance arrived and transported the man to the hospital, the wife up-righted the motorcycle and pushed it outside. Seeing that gas was spilled on the floor, the wife got some paper towels, blotted up the gasoline, and threw the towels in the toilet. The man was treated and released to come home. Upon arriving home, he looked at the shattered patio door and the damage done to his motorcycle. He became despondent, went to the bathroom, sat down on the toilet and smoked a cigarette. After finishing the cigarette, he flipped it between his legs, into the toilet bowl while seated. The wife, who was in the kitchen, heard the loud explosion and her husband screaming. She ran into the bathroom and found her husband lying on the floor. His trousers and been blown away and he was suffering burns on the buttocks, the back of his legs, and his groin. The wife again ran to the phone to call the ambulance. The very same paramedic crew was dispatched and the wife met them at the street. The paramedics loaded the husband on to the stretcher and began carrying him to the street. While they were going down the stairs to the street, accompanied by the wife, one of the paramedics asked the wife how the husband had burned himself. She told them and the paramedics started laughing so hard, one of them slipped and tipped the stretcher, dumping the husband out. He fell down the remaining stairs and broke his arm.

.....taken from a Florida Newspaper

Having a bad day??? Just remember, it could be worse.....

1. A woman came home to find her husband in the kitchen, shaking frantically with what looked like a wire running from his waist towards the electric kettle. Intending to jolt him away from the deadly current, she whacked him with a handy plank of wood by the back door, breaking his arm in two places. Until that moment, he had been happily listening to his Walkman.

2. Two animal rights protesters were protesting at the cruelty of sending pigs to a slaughter house in Bonn, Germany. Suddenly the pigs, all two thousand of them, escaped through a broken fence and stampeded, trampling the two hapless protesters to death.

And finally,

3. Iraqi terrorist, Khay Rahnajet, didn't pay enough postage on a letter bomb. It came back with "return to sender" stamped on it. Forgetting it was the bomb, he opened it, and was blown to bits.

Your day's not so bad after all, is it !!!!!!! Have a good one.

THE WAYS IN WHICH PARENTS THINK ABOUT PARENTING, THEMSELVES, AND THEIR CHILD MAY AFFECT TREATMENT OUTCOMES FOR CHILDREN WITH AD/HD

David Rabiner, Ph.D.

Although numerous studies on the treatment of ADHD have been conducted, most have been limited to examining the effectiveness of particular treatments (e.g. medication, behavioral therapy, neurofeedback, dietary interventions, etc.) without regard to how aspects of parents' thinking may impact treatment outcome. Because parents are ultimately responsible for implementing prescribed treatments, it is possible that how parents think about themselves and their child could influence children's outcomes through the influence these beliefs have on parents' willingness/ability to consistently implement the treatments that have been recommended.

It is not difficult to imagine examples of how this could occur. Parents who believe their child has no control over non-compliant behavior may feel that imposing limits and consequences is pointless. They may, therefore, be unwilling to comply with

recommendations that are part of behavioural treatment. Similarly, parents who lack confidence in their parenting ability, or who have low self-esteem in general, may find it difficult to enforce consequences or consistently administer medication when faced with resistance from their child. In other families, parents who believe the problematic behavior of their ADHD child is always deliberate and willful, and are unwilling to consider that ADHD symptoms are a contributing factor, may frequently react with anger and punitive discipline, and be unwilling to implement the kind of parenting strategies that can be more helpful for many children with ADHD.

Despite these reasons for hypothesizing that parents' thinking about their child, themselves, and their parenting may influence children's treatment outcomes, there has been virtually no research conducted on this important topic. A study published in the December 2000 issue of the Journal of Abnormal Child Psychology (Hoza, B. et al. Parent cognitions as predictors of child treatment response in ADHD, 28, 569-583), however, provides an interesting initial look at this understudied area.

This study was conducted in conjunction with the MTA study, the largest treatment study of ADHD ever conducted. In the MTA study, 579 6-12 year-old children with the combined type of ADHD were randomly assigned to one of four different treatment conditions -- careful medication management; intensive behavioral treatment, the combination of careful medication management and intensive behavioral treatment; and routine community care. (You can find a thorough discussion of this study here:

<http://www.attention.com/library/articles/article.jsp?id=145&parentCatId=6&categoryId=37>.

The current study included 105 children and parents from 2 of the 6 MTA study sites who agreed to participate in an "add-on" investigation to the main study. These parents completed a number of measures designed to assess their self-esteem, their feelings of parenting efficacy (i.e. how confident they felt about their parenting skills), the adaptiveness of their discipline strategies, and the types of attributions they made about their child's behavior (i.e. did they consistently blame their child's non-compliant behavior problems on lack of effort and/or poor mood as opposed to recognizing that such behavior could also reflect other factors, including the impact of

ADHD).

These aspects of parents thinking and disciplinary strategies were collected separately for mothers and fathers prior to any child receiving treatment. Fourteen months later, parent and teacher reports of children's ADHD symptoms and oppositional/defiant behaviors were collected. The authors could then examine whether parental thinking and disciplinary strategies influenced children's outcome even after treatment benefits had been taken into account. They predicted that regardless of which treatment a child received, the outcome would be better when parents had higher self-esteem, reported more adaptive disciplinary strategies, and held more adaptive attributions about themselves and their child.

Results

For mothers, self-esteem and self-report of dysfunctional discipline both had a significant impact on child outcome. Across all 4 treatment groups (i.e. medication management, behavioral intervention, combined treatment, and community care) children whose mothers had higher self-esteem and who used fewer dysfunctional disciplinary strategies were doing better (i.e. their parents and teachers reported they were showing fewer ADHD symptoms and less oppositional behavior).

For fathers, the use of fewer dysfunctional disciplinary strategies also predicted more positive outcomes. In addition, children did better when their fathers were less likely to "blame" their child's non-compliance on lack of effort and/or bad mood. Finally, there was a strong trend indicating that high parenting efficacy for fathers (i.e. having confidence in one's ability to handle the demands of parenting) predicted more positive child outcomes.

In addition to examining how aspects of parental thinking and disciplinary style related to children's outcomes, it is also interesting to look at the relationship between these variables. For mothers and fathers, higher self-esteem was associated with a more positive disciplinary style. And, parents who felt more confident in their parenting ability (i.e. higher parental efficacy scores) were less likely to endorse dysfunctional disciplinary strategies or blame their child's non-compliance on lack of effort.

Summary and Implications

The major findings of this study: parental cognitions and parental reports of dysfunctional disciplinary strategies predicted children's treatment outcomes 14 months later. It is important to emphasize that these factors had a significant impact on children's outcomes even after all gains associated with treatments received in the MTA study had been taken into account.

For mothers, self-esteem emerged as a significant predictor of child treatment response. The authors speculate that perhaps mothers with low self-esteem experience doubts about their parenting ability, thus making them prone to engage in dysfunctional disciplinary practices which have a negative affect on child outcome. Among fathers, those with higher feelings of parental efficacy, and were less prone to blame children's non-compliance on poor effort and/or bad mood, had children who were doing better. The authors suggest that this may occur because feelings of efficacy in fathers encourage more positive involvement with their child and fewer dysfunctional disciplinary practices.

Although the exact mechanisms by which these aspects of parental thinking influence treatment outcome cannot be determined from this study alone, the results provide strong evidence that such factors can play an important role. The authors argue that, because parents are the implementers of treatment for children with ADHD, parental factors such as those examined here should be considered as possible targets for treatment. As was demonstrated here, even when children are receiving the most careful medication treatment and/or the most systematic behavioral treatment available, certain aspects of parental thinking can still have an important influence on treatment success.

An encouraging aspect of these results is that they underscore the critical role parents play in the development of children with ADHD. For parents who question whether they can play an important role in promoting their child's healthy development above and beyond making sure their child takes the right medication, these data clearly indicate they can. How parents think about themselves, and how confident they feel in their role as parents, may have a meaningful impact on the success of whatever treatment(s) their child is receiving. This paper will hopefully stimulate additional work in this important area.

Cont. from front page..../

A number of people have still not paid their membership subscription for the year 2002. Please remember that if these are not received by the AGM you will not be allowed to vote and thereafter will not be receiving our circulars or newsletters. **During the month of April the office will be opening on a Thursday instead of a Friday. The hours are 09.30 – 12.30 as usual.**

The Editor