

# ADD-vantage



## Attention Deficit/Hyperactivity Disorder

### Newsletter

*Issue 15*  
*Spring 2005*

Dear Members,

This Newsletter comes to you from our new premises c/o the Malta Resource Centre at 33 Cannon Road, Hamrun. These are the old premises of Multigas and the owners of this company are very kindly allowing them to be used for philanthropic purposes for now.

Unfortunately, this means that we have had a lot of unnecessary expenses. As you all know we tried to rent our own premises after the promise of support from a particular government department but when this wasn't forthcoming, we realised that we could not realistically continue spending such a large portion of our meagre income in this manner. Now we can look to the future and concentrate our efforts on activities that will best benefit our members.

First and foremost is our Information and Guidelines booklet, which is being distributed as this Newsletter is being finalised. It goes out to all schools in Malta and Gozo and has been financed by means of donations from various people sympathetic to our cause. Please make sure that your child's teacher has a copy and if not, tell her to approach her Head of school or us direct. 3000 copies have been distributed and we hold 1000 in reserve so there is no reason why anyone should be left out. Our grateful thanks go to all those out there who helped in any way to realise the fulfilment of this goal.

We are also trying to set up courses for Social Skills and or Behaviour Modification. These courses would involve either children on their own or children and their parents. Both areas are of great importance and we urge you to apply to join before the course is full.

As parents of AD/HD children, or indeed adults with AD/HD, we all need a boost now and again to keep up our spirits and thanks to the many e-mails I receive daily (some of which are a real pain in the neck) I have included a few choice comments with this Newsletter and leave you now with one final one, Working for God on earth does not pay much, but His Retirement plan is out of this world. Please bear this in mind at next month's AGM when we call for volunteers for the Committee. ☺

## **\*\*BRAIN POWER\*\***

Research confirms that omega-3 supplements can boost brain function in young and old.

## **FISH OIL SCORES WITH SCHOOL CHILDREN**

Presented by Professor Winston, one of the UK's foremost and best known scientists, the British Broadcasting Corporation's The Human Mind TV series (October 2003) featured dramatic evidence that supplementation with fish oils can boost children's reading, writing and concentration skills.

Results of the experiment conducted in twelve Durham schools strengthen the connection between fish oils, the brain and mental health.

Primary school children with learning difficulties were selected for the trial. Aged between six and eleven, the 120 children who participated all showed some evidence of problems with concentration, coordination, reading, handwriting or spelling. During the first three months of the trial the children were divided into two groups and given either a supplement or placebo. As the improvements in the children taking supplements were so marked, all the children received supplements for the second three months.

Overall, more than 40% of the children improved their scores in intelligence tests. A quarter showed reading age improvements of between 18 months and 4.5 years. After only three months of taking the supplements, one child's reading age improved by four years, and others showed a two-year leap in learning ability.

Over half the brain consists of fat and of that, polyunsaturates form the biggest component. It is known that the omega-3 fatty acids are essential for infant brain development both before and after birth and more recent research has positively linked the omega-3s with dyspraxia, dyslexia, ADHD (attention deficit hyperactivity disorder), dementia, schizophrenia, bipolar disorder and depression.

Fish consumption in the general UK population is well below desired levels. In addition, it is thought that some children are deficient in fatty acids, not because of their diet but because their body fails to make proper use of the fatty acids they are getting. Regular supplementation may help bridge the gap.

**Don't go for looks; they can deceive.  
Don't go for wealth; even that fades away. Go for someone who makes you smile, because it takes only a smile to make a dark day seem bright.  
Find the one that makes your heart smile.**

## **\*\*RECOGNISING STRENGTHS AND AFFINITIES\*\***

By Dr. Mel Levine

Sometimes in our haste to help children and adolescents overcome their weaknesses, we neglect the careful detection and cultivation of their strengths. Yet, in the adult world what counts most is the strength of an individual's strengths. Therefore, any student's educational planning needs to include measures to mobilize and enhance individual assets of the mind. And every kid has these! They await discovery.

Different forms of strength can be found. A child may reveal certain highly developed neuro-developmental functions. For example, she or he may be particularly effective with language, motor coordination, or certain aspects of memory. Other children show very advanced higher thinking, as revealed in their creativity, the way they form concepts, or the astute quality of their critical thinking. There are students who exhibit remarkable strengths in their social cognition; they are true "people persons," which will carry them far in any career they select as an adult.

It is up to teachers and parents to make sure that students with good language skills get plenty of opportunities to develop verbally through public speaking and writing. Kids with great spatial capacities need opportunities to advance their artistic or mechanical aptitudes. Highly creative children must never have their original thinking stifled in any way - to the contrary, they deserve many opportunities to pursue their uniqueness and dream up novel ideas. Finally students with great social skills need opportunities to become leaders.

Some children display strengths in specific skill areas, such as sports, music, writing, or mathematics. These individuals must be able to pursue advanced courses whenever possible. When a child has learning difficulties, the pursuit of a strength can go far to alleviate anxiety and prevent the onset of low self-esteem due to

academic underachievement. In other words, your strengths can keep you afloat when you are struggling to overcome the effects of your weaknesses. Strengths also have implications for choosing careers, avocations, and even courses in secondary school.

Because of their critical importance and enormous potential for redeeming a child, strength delineation and management should be part of every educational plan for every student. Nothing is more tragic and wasteful than a strength that goes unrecognised and unutilised throughout childhood, especially if that child is having trouble succeeding in school.

A child's affinities are also vital. An affinity is an area of knowledge toward which a student feels a strong attachment. An affinity should be distinguished from a recreational interest (such as football or horseback riding). Examples might include prehistoric animals, politics, medieval history, space, or computers. It is important for every child to develop at least one area of intellectual passion and nearly obsessive interest. Ideally, such intense commitments should last for years (at least they shouldn't change weekly).

Affinities should evolve into domains of expertise. Every kid should be an expert at something. Depth in an area of knowledge can yield remarkable benefits. For example, it has been shown that the best way to learn how to read well is to read about something you know a lot about. Similarly, writing skills can grow if a student keeps writing within his domain of affinity and expertise.

Parents can help uncover and nurture a child's affinities. They can arrange for trips, magazine subscriptions, and home-based projects that focus on a child's affinity. They can share a child's interest and allow her to discuss it in the car and at the breakfast table. Most of all, they can display open pride in their child's expertise in the chosen area.

Schools should also encourage the acquisition and growth of affinities. All children should have delineated topics they can pursue in depth over time. Such pursuits can lead to term papers and projects. A child should experience the satisfaction of knowing that he quite possibly knows more about his topic than any member of the school's faculty! Such mastery does wonders for academic self-esteem while allowing children to experience the feeling and the intense satisfaction that comes with being a true scholar, a person who possesses knowledge in depth.

So it is that both strengths and affinities are crucial characteristics of an individual child. However, in so many cases they do not come forth and grow automatically. Instead, the adult

world needs to conspire with children to help them find and exploit their assets. Then teachers, parents, peers, and the students themselves can celebrate and enjoy the remarkable diversity of all kinds of minds.

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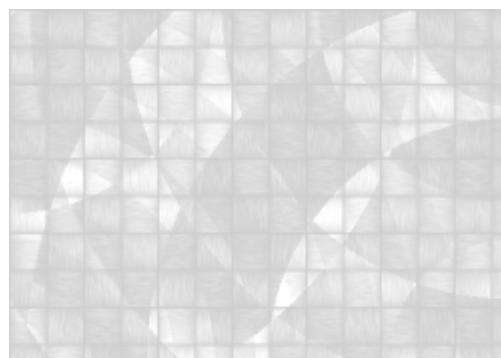
**When the door of happiness closes,  
another opens;  
but often times we look so long at the  
closed door that we don't see the one,  
which has been opened for us.**

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## **\*\*10 STEPS TO HIGHER GRADES FOR YOUR ADD CHILD\*\***

by Katherine West September 18, 2000

\* \* \* This graphic was done by my thirteen-year-old who usually claims that she can't draw. She recently discovered that computer graphics are fun, giving her a release for her artistic expression. I have been encouraging her to try new things. This is one of them. Since this looks like a puzzle that has been solved, I thought it might compliment this article. In many ways ADD/ADHD is a puzzle - one that can have multiple solutions.



Setting up an IEP (individualized education plan) for your child is done in cooperation with their school and teachers, unless you are a parent who home schools. To do this, your child must have some sort of learning disability. Let's face it, we would not need to do this unless there was a reason. Keep in mind that many of these ideas can be used at home even if your child does not have ADD. If your child is having trouble in school, the first step is getting a diagnosis from a trained

professional. Many times, the teacher is the first one to notice these problems.

You cannot simply depend on teachers who tell you that your child may be ADD, though. Too many times a parent takes the child to their family doctor, explaining what the teacher said. He or she prescribes medication. No, you must have a battery of psychological tests and even physical tests done. There are many medical problems that can mimic the symptoms of ADD or ADHD.

Lead poisoning is just one thing that can make a normal child act like an ADD child. Hyperthyroidism is another disorder that can be responsible for the misdiagnosis of ADHD in a child. Many psychological problems can be misconstrued as ADD behaviour too. If your family physician doesn't suggest a specialist, you should! Always get a second opinion from a psychologist and even a third opinion from a neurologist. Only after the tests are confirmed should you even consider drug therapy or classroom interventions.

If your child is diagnosed with ADD or ADHD, research the disorder. Do searches about it on the Internet. Go to seminars on ADD/ADHD. Read everything that you can get your hands on about this disorder. It is also a good idea to get your child into some type of therapy that teaches him or her how to deal with their impulsive behaviour. You will learn so much from interacting with the child's counsellor. Ask questions and ideas of them. Remember that knowledge is power. It is much harder for school administrators to bully an educated parent. You expect your children to do their homework, right? Well, do yours!

### 10 Steps to Creating an IEP (Individualized Educational Plan)

1. Ask the doctors, educators, and psychologists many questions about ADD, and have them explain practical classroom strategies. These should be customized to your child's needs.
2. Meet with your child's teacher and also the principal. Share your fears and views with them. Ask for an IEP. The parent is usually present when completing this plan.
3. It is also a good idea to request that the school psychologist and the director of special needs or special education also be present at this meeting or subsequent meetings with the school.
4. At the meeting, focus on your child's strengths, while exploring his or her weaknesses.
  - a. If your child is verbal, ask about verbal testing.
  - b. If your child has problems with sloppy handwriting, ask if your child can type out writing assignments on the computer.
5. Give the teachers and administrators ideas. Tell them what successes that your child has had with

learning. Tell them what your child enjoys and what works for him or her.

6. Tell your child's teachers just how bright he or she is. Instruct them to expect excellence from your child.

7. After the meeting check with your child on the specific interventions. Ask him or her if the teacher is doing these things.

8. Many times, schools just talk. Too many times they do not follow through with the IEP. A parent must follow up with the school several times throughout the year. Be persistent. Be stubborn. Be a pain even. This is your child's education!

9. Schedule conferences with your child's teacher even if the teacher does not request the meeting.

10. Create open communication between you and the school. Sometimes this can be difficult due to the persistence that we must display, but it can be done.

I hope that this article not only gave you the information that you need to help your child's education be a success, but that it has also inspired you to change a few things. Remember to get the facts and demand a change! Good luck.

**Dream what you want to dream;  
go where you want to go;  
be what you want to be,  
because you have only one life  
and one chance to do all the things  
you want to do.**

### **\*\*ADHD AND LOST INCOME\*\***

By Dr. Sam Goldstein

This past month, Dr. Joseph Biederman and his research group at Harvard announced the results of a 2003 survey of 500 adults with ADHD relative to a variety of lifestyle issues. The study reported that lost income for adults with ADHD averages 77 billion dollars a year and pointed to job loss, lower income, higher divorce rates and more driving accidents as contributing factors. ADHD would appear to be one of the costliest medical conditions that have been researched. By comparison it is reported that the direct and indirect costs of drug abuse in adulthood are estimated to be about 58 billion a year, depression 44 billion a year and alcohol abuse 86 billion a year. The figures from the ADHD survey were based on the lower incomes reported by adults with ADHD compared to the general population. A 3% to 5% incidence rate was utilized for adult ADHD.

The researchers reported that high school graduates with ADHD had household incomes approximately \$10,800 lower than those without the condition. For college graduates, incomes were about \$4,300 lower. As has been reported in other research studies, adults with ADHD were less likely to have finished high school, attend or finish college and less likely to be employed in jobs consistent with their educational background.

### **Stimulants for Healthy Children**

A Food and Drug Administration Ethics Panel has decided that the advancement of science outweighs the risks of giving a stimulant to healthy children as young as nine years of age. The eleven member paediatrics ethics subcommittee panel reviewed a proposal by respected researcher Judith L. Rapoport, M.D. to give a single 10 mgs. dose of dextroamphetamine to 78 children and then use Magnetic Resonance Imaging to reveal brain patterns as the children completed specific academic tasks. The goal of this study is to determine whether the brains of children with ADHD respond to stimulant medications in fundamentally different ways from normal children. Such research might lead to more efficient and effective diagnostic protocols and treatments.

In the proposed study, half the children ages 9 to 18 years would have a diagnosis of ADHD. The other half would be unaffected or healthy children. It was suggested to the panel that the dose of dextroamphetamine proposed was roughly equivalent to 50 to 75 mgs of caffeine, about five cups of average coffee. Dr. Rapoport reported that household surveys have demonstrated that many healthy school children are exposed to such doses of caffeine by drinking soda daily. Despite the subcommittee's recommendation, there were a number of concerns raised, including the inability to predict that a particular child may have a significant adverse reaction to the dose of stimulant and that the researchers were offering families \$570 to participate in this study in exchange for about eleven hours of the child and family's time. Concern was raised that families at lower incomes might be lured to participate in the study, exposing their children to unnecessary risk. This panel's recommendation was used by the FDA Paediatric Advisory Committee to grant approval two weeks ago to Dr. Rapoport to begin her study. The FDA also suggested that families receive not more than \$110 for participating in the study plus reimbursement for expenses such as meals.

### **Green for ADHD**

In the past few years I have pleasantly spent a number of hours per week on golf courses. I enjoy the time spent outdoors. Now a number of researchers are questioning whether outdoor

activities, specifically exposure to green space, may prove therapeutic for children with ADHD. In the September issue of the American Journal of Public Health, researchers Drs. Frances Kuo and Andrea Faber Taylor examined the impact of relatively green or natural settings on ADHD symptoms across diverse sub-populations of children. Parents nationwide rated the after-effects of forty-nine common after school and weekend activities on children's symptom severity. After-effects were compared for activities conducted in green outdoor settings versus those conducted in both built outdoor and indoor settings. As a basis for their study, the researchers cited three previous studies suggesting that disruptive behaviour in general could be reduced in inner city children with exposure to green space. In particular for children with ADHD in these studies, parents suggested that their children's symptoms were better than usual after activities in relatively green settings. Further, they reported the improvements generalized for a period of time afterwards. The present study was uniquely completed using a website and incentives for parent participation including a list of recommendations for coping with ADHD based on the study's findings and the chance to win a gift certificate. The final study was based on 452 completed surveys from parents throughout the country. The findings appeared consistent regardless of the child's age, gender, income, community size, region of the country, case severity and comorbid conditions. Surprisingly the benefits of green space exposure were also found even for the group of children within the sample who, according to parents, had not been formally diagnosed as suffering from ADHD.

It is premature to hypothesize as to the exact meaning of this research. From my perspective there are numerous methodological flaws, including relying only on parent report absent efforts to actually quantify and observe children's behaviour. Nonetheless, as human beings it would not be unexpected for our behaviour and emotions as well as attitudes and perhaps even beliefs to be modified by specific types of environmental exposure. Based upon this study, I would not suggest that parents and professionals prescribe "green time" for children with ADHD. However, I also don't believe that double blind controlled research is necessary to encourage all children, and adults for that matter, to participate in outdoor activities, even golf.

### **Behavioural Therapy vs. Medication in the Treatment of ADHD?**

In last month's article, I reviewed a series of studies suggesting that in children with ADHD who are positive stimulant responders, psychosocial interventions did not add significant improvement to behaviour or academic

functioning. In that article I briefly mentioned a number of studies presented at professional meetings by Bill Pelham and his colleagues. Dr. Pelham suggests that consistent and appropriately administered doses of behavioural therapy are as effective as medication for symptom reduction in ADHD. In an interview with a Buffalo Newspaper, Dr. Pelham took the offensive, suggesting that "doctors and professionals in the ADHD field over-emphasize the role that medication should play in the treatment of children." He also noted that because of this, "Unfortunately the end result is that many parents of ADHD children are not made aware that there is a well-established, evidenced based alternative to medication-behaviour therapy." His basic message - there is an effective alternative to medication for treating ADHD. Dr. Pelham has published a series of articles beginning in 1997 summarizing research from his summer treatment program for ADHD. Two of the most recent studies published in the Journal of Behaviour Therapy, according to Dr. Pelham, continue to report the benefits of a comprehensive psychosocial treatment program. Dr. Pelham reported that children who receive behavioural therapy in advance of drug treatment required much lower doses than children who were put on drugs without first undergoing behavioural therapy. Further, only about a third of behavioural treated children subsequently were taking medications two years later.

Dr. Pelham suggests that unlike drug therapy, behavioural therapy may produce long-term benefits for children with ADHD such as teaching coping and behavioural skills that can generalize and be taken into adulthood. Medicine then is seen as symptom relieving while behavioural intervention is proposed to change long-term outcome. It should be noted, however, that Dr. Pelham's research as with studies involving stimulant medication, may demonstrate symptom relief but have yet to longitudinally demonstrate long-term, significant positive changes in children with ADHD. Dr. Pelham commented in this article that "more parents would opt out of using medication as the first line or sole treatment if they were provided with this information and if physicians did not opt for medication first." Dr. Pelham concluded, "every mental health professional in the country can do behavioural parent training and parents and paediatricians need to push for it in their community if it doesn't appear to be available."

I urge professional readers to review Dr. Pelham's studies. As I noted last month, the psychosocial intervention proposed is extensive and costly. As far as I am aware, neither managed care, community mental health nor the schools are willing to foot the expense for this type of service.

Most parents cannot afford to pay out of pocket. Most professionals cannot afford to stay in business and not participate in managed care. Participants in Dr. Pelham's programs were not charged, as far as I am aware, because his research was funded. Thus, while these interventions may be effective, we have yet to determine how to translate this cost effectively into clinical practice. This is not a reason to abandon these treatments. I believe it is one of the reasons that medication is often first offered and accepted by parents. However, as I have pointed out repeatedly, stimulant medication as well as behaviour management may lead to effective short-term symptom relief but neither has been demonstrated to lead to long-term life changes for those with ADHD.

I don't have a solution for the managed care and community funding problem for these types of programs. As I noted in my article last month, the debate about medicine versus psychosocial treatment versus combination of the two is likely to continue to heat up in the coming year. As a clinician I have found it extremely difficult to consistently implement the kind of behavioural therapy suggested by Dr. Pelham with the majority of families with whom I work. The road blocks are not just time and funding, but often the family's ability to follow through. I am most concerned that Dr. Pelham's opinion that "behaviour modification is the fabric of good parenting" may lead to parent bashing if parents of children with ADHD are unable to consistently follow through with the level of behavioural management required.

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**The happiest of people don't necessarily have the best of everything; they just make the most of everything that comes along their way.**

## **\*\*THE ROLE OF PSYCHOTHERAPY IN THE TREATMENT OF AD/HD\*\***

Sam Goldstein, Ph.D.

Within the healthcare professions, there has been a movement towards the use of evidenced based or scientifically validated treatments. This movement is reflected in mental health care as

well. However, the first wave of empirically supported treatment research has, I believe, focused rather narrowly on efforts at relieving the specific symptoms used to define diagnosed conditions. While this is certainly a valid means of assessing treatment effectiveness, there are other benefits to be derived from treatment, particularly for individuals with chronic neurologic or medical conditions. For example, we would not argue that someone with a terminal medical condition could not be helped to cope with their final days simply because the "counselling" did not cure the condition. In this month's article, I will provide a brief overview of the history of counselling for ADHD and offer a rationale for considering individual, cognitively based counselling for children with ADHD based on an increasing body of research focusing on empirically supported therapy relationships.

In our 1998 second edition textbook, *Managing Attention Deficit Hyperactivity Disorder in Children*, Dr. Michael Goldstein and I wrote that the intuitive appeal of helping children with ADHD through a counselling approach develop internal strategies to allow them to act as their own change agent and thus reduce impairment, adversity and perhaps symptoms of ADHD had led to a seductive quest for researchers and clinicians over forty year period. In the very same textbook, Dr. Lauren Braswell succinctly summarized the available research literature pointing out that a variety of cognitively based therapies on both individual group bases over a six to twelve month period had not demonstrated effectiveness in improving the behaviour and functioning of children with ADHD. Dr. Braswell suggested that medication and behaviour management approaches should be viewed as first order treatments for ADHD but that "cognitive behavioural methods can serve as useful adjuncts in tailoring treatment plans to meet the needs for a particular child, family and school staff."

Since the publication of our 1998 text, there has been insufficient published research to significantly modify those opinions. Although the preponderance of the data still argues strongly that cognitive interventions, particularly in the form of individual counselling, do not directly impact ADHD symptoms, there has been an increasing volume of literature suggesting that counselling, particularly cognitive counselling can be effective in dealing with self-esteem and related problems that develop in children and adults as the result of living with ADHD, by building motivation through changing perception and attitudes. In fact, a chart review study by the Harvard group treating adults with ADHD found reason to suggest that cognitive behavioural therapy may not only be effective in facilitating improved mental health but also in enhancing self-control and reducing severity of

ADHD symptoms. In 1998 we suggested that on even a basic level, increasing parents' and teachers' ability to understand, anticipate and see the world through the eyes of children with ADHD, could not help but lead to a more motivated adult participant and ultimately a more effective change agent. Further, the recent work of among others, Drs. Bill Pelham and Myrna Shure, give reason to believe that if sufficient time for training and generalization is planned, children with ADHD can and do demonstrate improvements in behaviour and reduction in severity of ADHD symptoms.

A recent, special issue of the clinical journal, *Psychotherapy*, guest edited by psychologist, John Norcross, presented an increasing body of research indicating that the "person" of the psychotherapist was significantly tied to the outcome of psychotherapy. In fact, a number of researchers have concluded that there are large positive therapist effects beyond the type of therapy being offered and that these effects may in fact exceed the benefits derived from a specific kind of therapy. Recently the American Psychological Association Division of Psychotherapy presidential task force sought to identify and disseminate information on empirically supported therapy relationships. They reviewed a large body of research and drew a number of interesting conclusions that support a place for psychotherapy in the treatment of ADHD across all ages.

- A strong alliance created by the therapist through good communication, empathy, openness and efforts to avoid angry or hostile interactions with clients independent of condition or treatment type led to improved functioning.
- A strong causal link between therapist empathy and positive outcome was demonstrated, suggesting that empathy served a positive relationship function and can be powerfully impacting in client's lives
- Warm acceptance unconditionally, particularly when therapists ensure that their positive feelings are communicated to clients made a positive difference.
- The therapist's capacity to communicate and be congruent in what is said and done led to positive outcome.
- Providing feedback, problem solving and emotional support led to positive outcome.
- For individuals similar to those with ADHD who manifested impairment in two or

more areas of life (family, social, occupational, school, etc.) greater benefit was derived from lengthier, more intensive treatment supplemented by psychoactive medication.

So what does this have to do with ADHD? ADHD is a neurobiological disorder that is clearly not the result of bad parenting or other environmental adversities. Engage your common sense. Each of us has had an experience of feeling inadequate at one time or another. Each of us has had an experience of repeated failure despite effort. Think of how you coped and responded then think of dealing with those kinds of experiences on a routine, often daily basis in multiple settings. How would this affect your mindset and mental health?

The problems of children with ADHD result not only from an interaction of their neurology and the environment but also as the result of the coping strategies they develop, which as my colleague Dr. Robert Brooks points out, arise from their effort to cope with these adversities. The majority of children with ADHD experience repeated failure. This places them at greater risk to develop an external locus of control, feelings of helplessness and an inability to understand why they experience so much difficulty meeting the expectations of their world. For these reasons, I believe that all children with ADHD at the time of diagnosis should be placed in short term counselling to assist them in developing an understanding of the manner in which they are coping with their environment and the reasons for their difficulties. Counselling can afford the opportunity to reduce feelings of helplessness, foster optimism, increase motivation and improve coping skills. Counselling can help children and adults with ADHD address issues about themselves and family members. Most importantly, forming a counselling alliance with a therapist capable of developing an empirically supported therapy relationship provides another layer of protection facilitating resilience and allowing an agreed upon means for dealing with problems whether current or future. Thus, in the case of ADHD, while therapy may not take place on a regularly scheduled basis, a therapist is likely to see a child or adult for that matter, repeatedly over many years.

In the absence of significant comorbid problems, the majority of children with ADHD do not exhibit difficulties requiring intensive psychotherapy. However, given the significant comorbidity of depression and anxiety with ADHD a significant minority will require directed treatment for these conditions. In these circumstances, treatment modifications must be made, taking into account the impact executive functioning deficits will have upon a child, or for that matter adult, in their ability

to benefit from empirically proven treatments for depression or anxiety.

For adults with ADHD, therapists can not only provide emotional support but assist in helping these individuals develop time management, organizational skills, problem solving ability and anger management. As Dr. Robert Brooks pointed out in his chapter in my co-edited text with Ann Teeter Ellison, *A Clinician's Guide to Adult ADHD* (2002), a therapist can help individuals with ADHD recognize that they have control over their lives, that success is not based on chance, that failure is not an indication of inadequacy and that they may have much to offer the world. As Dr. Brooks points out, each of these issues when addressed in psychotherapy can and will improve the daily lives of adults with ADHD. Finally, as Dr. Kathleen Nadeau points out in the very same text, since ADHD is primarily a neurobiological condition that affects behaviour and emotions, psychotherapy must employ a cognitive rehabilitation model helping individuals gain skills, develop compensatory abilities and restructure their lives.

Cognitively based psychotherapy will not cure ADHD. I believe and suggest there is sufficient scientific evidence to strongly offer the opinion that psychotherapy can and does help individuals with ADHD - human beings suffering with a chronically impairing condition - cope and feel better, ultimately improving the quality of their lives. Though insurance companies increasingly refuse to compensate psychologists for their psychotherapy work with individuals suffering from ADHD, I strongly urge my professional readers to continue advocating for the important role of including psychotherapy in the treatment of ADHD across the life span  
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- Living on Earth is expensive, but it does include a free trip around the sun every year.
- *Birthdays are good for you; the more you have, the longer you live.*
- Happiness comes through doors you didn't even know you left open.
- *Ever notice that the people who are late are often much jollier than the people who have to wait for them?*
- How long a minute is depends on what side of the bathroom door you're on.
- *Most of us go to our grave with our music still inside of us.*
- If Wal-Mart is lowering prices every day, how come nothing is free yet?
- *You may be the only person in the world; but you may also be the world to one person.*



## **\*\* A Comparison of Multimodal and Stimulant Medication Treatment \*\***

(Note: The newsletter from where I obtained this review receives support from pharmaceutical companies who manufacture stimulant medication to treat ADHD. Although the author does not believe this has influenced the objectivity of the study reviewed below, he wants people to be aware of this relationship).

I am reviewing a recently published treatment study in which two types of treatment were compared – medication treatment alone and medication treatment plus behavioural and academic interventions. The question addressed in this study is whether the addition of academic and behavioural interventions to carefully monitored medication treatment results provides greater benefit to children’s academic functioning than medication treatment alone. As you will see, results from this study are a bit surprising, and, in some ways, are inconsistent with results from other similar research. Although the findings reported may be disappointing to many, this was a carefully conducted project and the results are important to the field.

Although stimulant medication treatment is a helpful intervention for the majority of children with ADHD, this treatment also has important limitations. In particular, even when treatment is carefully implemented, many children remain impaired in their behavioural and academic functioning and continue to require additional supports. Academic difficulties – which are especially prominent among children with ADHD – often continue, and although medication treatment is associated with short-term gains in academic performance, the ability of such treatment to produce long-term achievement gains is not yet documented. As a result, it is generally asserted that academic interventions are important for children with ADHD, regardless of whether they have a co-occurring learning disability.

The academic struggles of children with ADHD are likely to result from multiple factors including inattention, poor organizational and study skills, poor working memory, and perhaps other types of cognitive difficulties. It thus stands to reason that providing children with specific training/instruction in organizational and study skills, as well as a carefully constructed and individualized educational plan should yield superior academic outcomes than if children are treated with

medication alone. Documenting the benefits of combining a comprehensive academic intervention with medication treatment was one important focus of a study published recently in the *Journal of the American Academy of Child and Adolescent Psychiatry* (Hechtman, et al., Academic achievement and emotional status of children with ADHD treated with long-term methylphenidate and psychosocial treatment, *JAACAP*, 43, 812-819).

Participants were 103 7-9 boys and girls with ADHD who showed a positive response to medication treatment during an initial 5-week trial of stimulant medication. The sample was restricted to participants who benefited from medication because the key research question was whether a comprehensive multimodal approach is superior to medication alone for children who respond positively to medication. In addition, because the study treatments were to include 2 full years of medication treatment, it would have been inappropriate to include children who were not positive medication responders.

Children were randomly assigned to one of three conditions: medication treatment only, medication treatment plus multimodal psychosocial treatment, and medication treatment plus “attention control” psychosocial treatment. The medication treatment provided to all children was immediate release methylphenidate (the study began before the long acting medications more commonly used today were available). Careful titration was done to identify the optimal dose for each participant and ongoing monitoring was conducted so that adjustments could be made as required in order to optimise the ongoing benefits provided by this treatment.

### **Multimodal                  Psychosocial                  Treatment**

Children in the multimodal plus methylphenidate group received an extensive array of services that targeted key domains of psychosocial functioning. These interventions included academic intervention (described below), individual psychotherapy, and social skills training. Therapy sessions were provided on a weekly basis during year 1 and on a monthly basis during year 2. The treatment focused on educating children about ADHD and its treatment; children’s attitudes towards taking medication, enhancing self-esteem through positive feedback, and developing effective social skills and social problem solving skills. In addition, children’s parents received training in behaviour management and educational information about ADHD. Finally, teachers completed daily report cards so that children could be rewarded at home for meeting behavioural and academic expectations at school.

The academic intervention was also extensive. It included 16 weekly 1 hour sessions in which 4-5 children worked with a master's degree level special education teacher on organizational skills, study skills, organization of written work, and following instructions. To maximize the training's relevance, materials included children's schoolwork. Following the 16-week organizational study skills program, special education teachers implemented worked with children on a weekly basis for 8 months to implement an individualized academic plan. The emphasis was on helping children with their current academic work while continuing to provide practice and instruction in organizational and study skills. Remedial tutoring in reading, writing, and math was provided as needed.

Clearly, this was a comprehensive approach for helping children with ADHD. In fact, it would be quite difficult to obtain this coordinated array of services in many communities.

### **Attention Control Psychosocial Treatment**

Children assigned to this group worked with college-level non-specialists on a variety of non-academic projects. General assistance with homework was provided, but specific academic difficulties were not addressed, nor were children provided with specific strategies to overcome them. This condition was included so the researchers could determine whether simply providing additional individual and small group time with an empathetic adult, rather than the comprehensive multimodal intervention described above, would convey benefits above and beyond those provided by medication.

### **Measures**

Although a wide variety of outcomes were evaluated in this study, the results summarized below are limited to academic outcomes. All participants were administered a standardized test of academic achievement – i.e., the Stanford Achievement Test – to assess their proficiency in math, reading, comprehension and spelling. This assessment was conducted before treatment began (i.e., baseline), and then again 12 and 24 months later. This enabled the researchers to measure change in achievement over time, and to learn whether children receiving the multimodal psychosocial treatment made greater academic progress than children in the other groups.

In addition to this standardized achievement measure, parents rated children's homework behaviours using the Homework Problem Checklist. This scale was used to assess problems that parents observed their child to have

with accurately completing homework assignments.

### **Results**

The authors predicted that children who received academic intervention as part of multimodal treatment would obtain higher achievement ratings at both 12 and 24 months compared to children in the other 2 groups.

Quite surprisingly, there was no evidence to support this prediction. As expected, children in all 3 groups showed achievement gains over time. These gains reflect the learning that occurs during the course of each school year. Contrary to expectations, however, the achievement gains made by children receiving the academic intervention were no greater than gains made by children who received medication alone, or medication plus the non-specific adult attention. In fact, there was essentially no indication that the extensive multimodal intervention was associated with better long-term academic performance at either the 12 or 24-month assessment.

Similar results were obtained for parents' report of homework difficulties. As with the achievement results, children in all 3 groups were reported to experience fewer homework problems over time. However, the reduction in homework problems was essentially equivalent for children in the 3 groups.

### **Summary and Implications**

The authors of this study expected that the academic intervention provided to children as part of multimodal treatment would enhance the effect of medication treatment and lead to superior academic outcomes. Contrary to these expectations, however, no such incremental benefits were found. The authors' state, "Because remediation and psychotherapy were part of a comprehensive psychosocial intervention, the lack of efficacy on academic... functions reflects the failure of a broad-based, intensive effort to supplement the impact of long-term stimulant treatment." Although not discussed in this particular review, similar negative findings were also obtained for emotional functioning, peer relations, and behavioural functioning.

The clinical implication they draw from these results is that children with ADHD who respond positively to medication treatment and who are not comorbid for learning or conduct disorders will not routinely benefit from comprehensive multimodal interventions. Thus, whether these additional interventions should be routinely provided is called into question. This is a controversial implication, as it appears to contradict a

commonly held view that medication treatment alone is generally inadequate for children with ADHD, and that a comprehensive multimodal approach is routinely preferable. I have even seen these results interpreted as indicating that there is generally no value in providing ADHD treatments beyond medication alone.

There are a several important reasons, however, why such an interpretation is problematic.

First, some children with ADHD do not benefit from medication or experience adverse effects that prevent them from taking it. In this study, participants were restricted to positive medication responders and the results thus have no implications for children who are not.

Second, the medication treatment provided in this study is likely to have been more carefully conducted than in routine community care. As a result, the benefits participants received may have been greater than is typical for children treated in community settings. If this is the case, than community-treated children may frequently have greater need for additional supports.

Third, as the authors note, their findings do not apply to children with ADHD who also have specific learning disabilities, which is approximately 15-20% of the ADHD population.

Fourth, as the authors also note, their findings are limited to 7 to 9 year old children, and their results cannot be generalized to preschoolers or adolescents. It is possible that a different pattern of results would be found for these age groups. In particular, given the increased organizational and study skill demands that children experience upon entering middle school, the academic intervention implemented in this study may have provided more discernible benefits to older students. This would be an important question to pursue in subsequent research.

Fifth, the overall absence of group difference reported may have obscured differences that occurred in particular subgroups. For example, among children with ADHD, as among all children, there is enormous variability in academic performance. It would have been instructive to examine the impact of the multimodal treatment on those children who demonstrated the greatest academic difficulty at the beginning of treatment. Perhaps for those with the greatest need, the academic intervention provided benefits above and beyond medication, even though such benefits were not evident among children who had with fewer academic struggles to begin with. Unfortunately, because there were less than 35 children in each treatment group, examining outcomes for particular subgroups would be difficult.

Sixth, it should be noted that in the MTA Study, which is the largest treatment study of ADHD ever conducted, and which also compared outcomes for children receiving medication treatment alone vs. children receiving medication treatment plus intensive behaviour therapy, modest benefits were observed for children receiving combined treatment. The superiority of combined treatment was not evident in any individual outcome, but became evident when different outcomes were combined into a more global measure of overall functioning. In this study, the authors examined each outcome individually. Perhaps combining outcomes across different domains to produce a composite functioning index would have shown the benefits of the multimodal approach.

Two final points are important to emphasize. First, because there was not a no-treatment control group, or a non-ADHD comparison group, it is difficult to determine how much participants benefited from the treatments provided. The fact the 3 groups did equally well does not mean that treatment was effective in normalizing their academic functioning. In fact, given what has been learned from other studies, it is likely that many children continued to experience important academic difficulties despite treatment. Thus, these results cannot be interpreted as indicating that for children who respond positively to medication, there is no need to continue to work towards developing effective academic interventions.

Finally, because multimodal interventions were given to children who were already known to be positive medication responders, one cannot conclude that the additional interventions provided were not effective, as we do not know what their impact would have been on non-medicated children. For example, it is possible that if children received the multimodal treatment in the absence of medication, they may have done as well as children treated with meds. This is not a fault of the study, as it was not designed to answer this question. However, it is easy to misinterpret the results of this study as indicating that the psychosocial interventions provided were not effective, rather than the more appropriate conclusion, which is they apparently did not provide incremental benefits to children who were positive medication responders.

In conclusion, results from this study indicate that in children who benefit from medication treatment, and who receive carefully monitored medication treatment on an extended basis, even comprehensive multimodal intervention may not be superior to medication alone in regards to long-term academic achievement. Thus, for these children, additional supports may not be needed on a routine basis. However, for children who

continue to struggle despite medication treatment, or who fail to respond positively to medication, interventions such as those provided here may be critically important and necessary.

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**SOCIALISM:**

You have 2 cows and you give one to your neighbor.

**COMMUNISM:**

You have 2 cows, the Government takes both and gives you some milk.

**FASCISM:**

You have 2 cows, the Government takes both and sells you some milk.

**NAZISM:**

You have 2 cows. The Government takes both and shoots you.

**BUREAUCRATISM:**

You have 2 cows; the Government takes both, shoots one, milks the other and throws the milk away...

**TRADITIONAL**

**CAPITALISM:**

You have two cows. You sell one and buy a bull. Your herd multiplies, and the economy grows. You sell them and retire on the income.

**AMERICAN CORPORATION:**

You have two cows. You sell one, and force the other to produce the milk of four cows. Later, you hire a consultant to analyze why the cow dropped dead.

**A FRENCH CORPORATION:**

You have two cows. You go on strike because you want three cows.

**A JAPANESE CORPORATION:**

You have two cows. You redesign them so they are one-tenth the size of an ordinary cow and produce twenty times the milk. You then create a clever cow cartoon image called Cowkimon and market them World-Wide.

**A GERMAN CORPORATION:**

You have two cows. You re engineer them so they live for 100 years, eat once a month, and milk

themselves.

**A BRITISH CORPORATION:**

You have two cows. Both are mad.

**AN ITALIAN CORPORATION:**

You have two cows, but you don't know where they are. You break for lunch.

**A RUSSIAN CORPORATION:**

You have two cows. You count them and learn you have five cows. You count them again and learn you have 42 cows. You count them again and learn you have 2 cows. You stop counting cows and open another bottle of vodka.

**A CHINESE CORPORATION:**

You have two cows. You have 300 people milking them. You claim full employment, high bovine productivity, and arrest the newsman who reported the numbers.

**AN INDIAN CORPORATION:**

You have two cows. You worship them till they drop dead!

**MALTESE POLITICS:** (You didn't think I wouldn't include Malta, did you?)

You have two cows. The Government says it will practice only "sustainable milking" but then proceeds to milk them both dry; just to spite the Government you grab their excrement & dump it all over streets where the ministers live; the Government applies to the EU for compensation.

(When we worry about getting acceptance and diagnosis etc. for our children in Malta, perhaps we should bear the following article in mind. There is a lot still to be done in other countries too)

## **FOR UNRULY CHILDREN - THE WRONG ANSWER?**

By Elisabeth Rosenthal International Herald Tribune  
Wednesday, October 27, 2004  
MILTON KEYNES, England:

While most parents collect pictures and essays as mementos of their children's school days, Tanya French instead totes around her 9-year-old's behaviour chart, on which teachers document the ways in which her boy has misbehaved.

"Pushing another child," "disruptive and rude,"

"swearing," "calling out," "jumping out of his chair," it reads.

Shane spends long periods of his school day sitting in the corridor as punishment.

Four years ago, French became convinced that Shane was suffering from Attention Deficit Hyperactivity Disorder and sought to get him help. But it was not until last year that he was finally diagnosed, and he has just been started on medications.

In the meantime, teachers and counsellors told French that Shane's problems stemmed from her lack of discipline, or because she is a single parent.

Shane, who reads poorly in part because of all the class time he has missed, is a pariah and has never been invited to a birthday party.

"I am at the end of my tether," French said. "Hardly anyone at the National Health Service knows about it, and neither do the educational authorities. People here just don't want to recognize it. They think ADHD is just an American version of being a naughty boy."

In the United States, 3 percent to 5 percent of school-age children carry the diagnosis of Attention Deficit Disorder or its subgroup, Attention Deficit Hyperactivity Disorder, generally receiving support and treatment for the condition.

In England, well under one percent carry the diagnosis, although recognition is growing. In countries like France and Italy, many if not most doctors do not believe the condition exists.

In Italy, where a recent study found that the lag time from referral to diagnosis was more than three years, medicines to treat ADD were not licensed until this year.

While many leading scientists believe there is excess diagnosis and overmedication in the United States, they concur that the condition has been seriously neglected in Europe - although that trend is changing.

"The rate of the condition is probably the same everywhere, but there is big under-treatment here," said Dr. Eric Taylor of the Institute of Psychiatry at Kings College in London. "Gate-keeping in schools and by doctors filters out 90 percent of these children, and tells them they don't have a disorder."

If treatment rates varied this much for appendectomies or Caesarean sections, it would be a considered a medical scandal. But mental health diagnosis depends not just on science, but also on doctors' paradigms of psychiatry and on society's attitudes toward children.

People shy away from the diagnosis of ADD in Britain "because it feeds into panic about the traditional family breaking down," Taylor said. "In Italy, with its family focus, it is blamed on the upbringing."

French psychiatry is very Freudian, so it is all about psychoanalysis. Many doctors basically don't recognize ADD. There are many very desperate families."

Also, the condition is difficult to treat within public health systems in which access to child psychiatrists is limited by the financial resources available. Diagnosis requires a specialist, and optimal treatment involves both medicine and training-training therapy.

In contrast, in the United States, ADHD provides lucrative business for drug companies and therapists, an incentive for diagnosing the condition.

Studies have shown that the fallout of under-treatment is dire and longstanding. Among teenagers with untreated ADD, 40 percent need special education, 40 percent of girls with the condition end up pregnant, 20 to 25 percent end up arrested and 20 percent have serious problems with drugs, according to Dr. Russell Barkley, a professor of psychiatry at the University of South Carolina Medical School.

"I don't want to oversell this disorder, but its not benign - not just about a little too much energy, or too much chocolate or caffeine," Barkley said. "Treated early in childhood, these kids do well. But there are irreparable consequences from not taking it seriously."

This is a lesson that has been learned the hard way by some British parents. By the time Monica Harris's son was diagnosed with ADD at age 12 and started on Ritalin, he had been suspended many times, sometimes for months on end. Teachers told Harris, who is black, that he was rebelling against his parents' mixed-race marriage.

On medicine, the boy did better. But his pills were stopped when he turned 16, since it is British national policy to stop treatment at this age for what is considered a childhood

disorder. Within six months he was committing petty crimes and is now serving time in prison.

"By the time my son was in junior school, it was really too late - there was little left to do for him," said Harris from her postage-stamp-sized office in Milton Keynes, where she runs the all-volunteer local support group. "Then they stopped his medicine. That's why my kid is in prison."

A very high percentage of teenagers in British prisons suffer from undiagnosed ADD, said Dr. Quentin Spender, a psychiatrist in Chichester, England. "It's tragic," he said. "If they are not treated they can't succeed at school and they get oppositional. Then their self-esteem goes into their boots. They get labelled as antisocial. They lose school time. They fall in with the wrong crowd. It's a downward spiral."

Most mainstream American doctors believe that children inherit a predisposition to the disorder than probably stems from a biochemical imbalance of brain transmitters. But that line of thinking has only slowly moved across the Atlantic, despite the recent growth of parent groups and efforts to market ADHD drugs to Europeans.

While American psychiatry has been strongly influenced by biochemical factors in mental health and modification-modification theories, French psychiatrists have clung to Freud as their muse and mentor.

"Most primary care clinics are very psychoanalytic and don't see this as a problem of the child that has to do with biology," said Dr. Véronique Gaillac of the Ste-Anne psychiatric hospital in Paris. "Some of these children go through years of psychoanalysis, which to me is not at all effective. Many doctors are passionately, angrily against the idea of ADHD. They think it is an American invention."

That is starting to change, she said, as parents and some doctors try to increase awareness. Still, the disorder is diagnosed only at a handful of university research hospitals in France, and the wait is often long for an appointment. Schools and teachers, who know little about ADHD, are often vehemently opposed to medication and offer "nothing" in the way of therapy or behaviour modification, Gaillac said.

The first line of treatment for ADHD is Ritalin, a medicine that helps children with the disorder focus but lasts for only several hours. Longer-acting forms of the drug, standard care in the

United States, are more expensive and are available in only a handful of European countries.

At the offices of the Milton Keynes ADHD support group, an hour north of London, a stream of women come and go, telling of their battles.

Harris is a tornado of activity, running an expansive Web site and fielding calls and queries: Which psychiatrists can handle a diagnosis in Cambridge? How to cope with a 7-year-old who runs into the street? How to fast-track a referral?

Rachel Begg was horrified to learn that her son Macauley, then 4, was being "cello-taped" to his seat during assemblies at his preschool to make sure that he sat still. For four years she repeatedly sought psychological assessments from nurses and school counsellors, all of which concluded that he was of average intellect but poorly disciplined.

Last year, when the boy was 9, Begg insisted he get referred to a child psychiatrist, who told her it was "obvious" that the boy had ADHD.

Begg is relieved that Macauley is now receiving therapy - he is easier to handle at home. But she is uncertain it will be enough to compensate the bad habits and the bad reputation he has acquired. "If they'd caught this earlier, his social skills would have had a chance to develop, he would have learned lots more, and these bad behaviour patterns wouldn't have developed," she said.

Ironically, the same systems that are slow to treat the children are often all too happy to medicate the parent. The system that was slow to treat Shane French gave his mother antidepressants because she couldn't cope with him.

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Last but not least, here are the Oxford Dictionary's latest definitions of the following words:

**Divorce:** Future tense of marriage.

**Cigarette:** A pinch of tobacco rolled in paper with fire at one end & a fool on the other.

**Lecture:** An art of transferring information from the notes of the Lecturer to the notes of the students without passing through the minds of either.

**Conference:** The confusion of one man multiplied by the number present.

**Compromise:** The art of dividing a cake in such a way that everybody believes he got the biggest piece.

**Tears:** The hydraulic force by which masculine will-power is defeated by feminine water power.

**Dictionary:** A place where success comes before work.

**Conference Room:** A place where everybody talks, nobody listens and everybody disagrees later on.

**Classic:** A book, which people praise, but do not read.

**Smile:** A curve that can set a lot of things straight.

**Office:** A place where you can relax after your strenuous home life.

**Yawn:** The only time some married men ever get t

**Etc.:** A sign to make others believe that you know more than you actually do.

**Committee:** Individuals who can do nothing individually and sit to decide that nothing can be done together.

**Experience:** The name men give to their mistakes.

**Atom Bomb:** An invention to end all inventions.

**Diplomat:** A person who tells you to go to hell in such a way that you actually look forward to the trip.

**Opportunist:** A person who starts taking bath if he accidentally falls into a river.

**Optimist:** A person who while falling from Eiffel tower says in midway "See I am not injured yet."

**Miser:** A person who lives poor so that he can die rich.

**Father:** A banker provided by nature.

**Criminal:** A guy no different from the rest...except that he got caught.

**Boss:** Someone who is early when you are late and late when you are early.

**Politician:** One who shakes your hand before elections and your confidence after.

And last but not least:

**Doctor:** A person who kills your ills by pills, and kills you with his bills!