



# NEWSLETTER

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Editor's Word & Point of View : Welcome everybody to another issue of the ADHD Newsletter. Another calendar year has started and already two months have gone by. By the time you receive this issue Carnival would have just passed and Easter would be around. We mention also that the group has started the first Parenting Skills Course aimed at Parents of Children and Adolescents who have ADHD.

Whilst all this is going on, and our attention is geared on doing our best for children, adolescents and adults who have ADHD, we have to keep up our efforts focussed and constant in our endeavour to create the necessary awareness and to disseminate information about ADHD. Students with ADHD have their rights. They are entitled to a level playing ground on which to express their competencies and their knowledge. Students with ADHD have a right to be included, to be encouraged to attain their maximum, to be accepted as they are and for schooling to adapt to their specific needs and condition.

We are all conscious that the above is the ideal and many a time far from reality. Our role is to inform and disseminate the information. It is our role to encourage children and adolescents with ADHD to do their best. It is our aim to be a source of information for all and to provide such information. With this in mind let us gear ourselves further and speak out. The Group is aiming at this and we need all hands on deck to achieve this to the fullest extent.

**What's in this issue** : You will find the third from the series of four articles regarding Sensory Integration and ADHD, this time focussing on The Proprioceptive System – The Sense of Body Position. Some information regarding research into medication (see also two attached documents being sent for information to all members). Finally the regular Library Book Feature.

As always we look forward to be of service to all & to receive your feedback and contributions.

## Coming Meetings of the ADHD Family Support Group

2009	March	13th	- ADHD Child & Parent Relationships
	April	17th	- Practical Tips for ADHD (Education/School/Home)
	May	8th	- Annual General Meeting
	June		Latest Issues – Information from ADDISS Conference
	July / August		Meetings are not normally held however contact can be made through the usual channels.

# THE PROPRIOCEPTIVE SYSTEM

## THE SENSE OF BODY POSITION

GIANNELLA ATTARD SROT



### **Location:**

It is from the muscles, joints and ligaments that the individual receives proprioceptive input.

### **Function:**

This system helps the individual be aware of the whereabouts of his body parts, and also their doing without the necessity of vision. I can move one part automatically without having to think about the movement necessary to do the action. Thus this allows for movement without the need to observe what one is doing.

### **Application:**

A child with poor modulation of proprioceptive information, that is a child who has difficulties with the input from his muscles, joints and ligaments will seek such sensory input by for example fidgety and physically active movements. This is when we say that they are like motor, constantly on the move, cannot sit down and have to squirm in the chair constantly.

These children will be considered as clumsy, falling frequently, having stiff and uncoordinated movements and often crashing into the environment as if not there.

Due to such difficulty, a child may have difficulties with holding a pencil because the sensory input being provided is lower than it should be thus the child will hold the pencil very hard often breaking the points.

### **Possible remedies:**

Heavy work activities (i.e., proprioceptive input) are used for children with sensory processing difficulties to help increase attention, decrease defensiveness and modulate arousal.

*Proprioceptive input is the performance of tasks that involves heavy resistance and input to the muscles and joints, and is essential in helping our bodies assimilate and process both movement (vestibular) and touch (tactile) information.*

### **Heavy work activities include:**

- **WHOLE BODY** actions involving pushing, pulling, lifting, playing, and moving

### **Carrying objects, such as...**

- ✓ groceries
- ✓ stacking or moving chairs/books
- ✓ watering cans
- ✓ laundry basket
- ✓ raise/lower flag at school
- ✓ tug of war rope
- ✓ mop/sweep floor with a mop, broom and dustpan for kids
- ✓ wrestling
- ✓ raking leaves, dirt
- ✓ pushing/pulling self or others on a jumbo scooter board
- ✓ Thera-Band
- ✓ "push of war" between partners (with ball, have to cross over line)
- ✓ riding bicycles / scooters
- ✓ kids roller blades
- ✓ horse riding
- ✓ jumping into bean bags

- **ORAL** actions such as chewing, sucking, and blowing

### **Chewy foods such as...**

- ✓ dried fruit
- ✓ gummi bears/worms etc.
- ✓ liquorice
- ✓ beef jerky
- ✓ bagels
- ✓ cheese
- ✓ gum
- ✓ raisins
- ✓ soft pretzels
- ✓ popcorn



### **Resistive sucking using items such as...**

- ✓ through thin straws
- ✓ sports bottle with long straw
- ✓ lollipops
- ✓ drink milkshake with a straw
- ✓ hard candies
- ✓ peanut butter

### **Blowing activities, such as...**



- ✓ wind instruments
  - ✓ bubbles
  - ✓ balloons
  - ✓ whistles
  - ✓ "snake"/blower party favours
  - ✓ make splatter paintings (use thin paint on paper... blow air through a straw and watch the paint move! can also use chocolate pudding thinned with milk on freezer paper)
  - ✓ kazoos, whizzers, **and other noise makers**
- **USE OF HANDS** for squeezing, pinching, or "fidgeting"

- ✓ squeeze toys
- ✓ playdough
- ✓ plasticine
- ✓ balloon filled with flour
- ✓ brush the family dog
- ✓ use of rolling pin
- ✓ Cooking activities, such as stirring, pressing, kneading.



### **Study compared Concerta and Strattera**

Often questions arise as to whether a stimulant medication or a non-stimulant medication is better for treatment of ADHD. Many have strong opinions about this question, but until recently there was not a controlled study that fairly compared these two types of medication. Newcorn and colleagues reported a 20 site study of 516 children aged 6-16 yrs. with ADHD randomized to treatment with oros methylphenidate (Concerta), atomoxetine (Strattera) or placebo at a reasonable dose for six weeks.

Defining adequate response as at least a 40% reduction in ADHD rating scale score, 45% responded favorably to atomoxetine (ATX) and 56% to oros methylphenidate (MPH) while only 24% of those on placebo had comparable rating scale score reductions. Interestingly, of the 70 children who did not respond to MPH, 43% subsequently responded to ATX. And of the 69 children who did not respond to ATX, 42% later responded to MPH. These findings support the notion that while many individuals respond equally well to either MPH or ATX, some respond significantly better to one than to the other. If a patient does not respond well to one class of medication, a trial of the other class of medication is usually appropriate. Newcorn, J.H., et al. (2008). American J. of Psychiatry. 165: 721-730.

Source – The BrownLetter on ADD

## **A New Treatment for Children with Inattentive ADHD: Encouraging Findings**

The core symptoms of ADHD are inattention and hyperactivity-impulsivity. Although most children with ADHD struggle in both areas, and are diagnosed as having the combined subtype of ADHD, a substantial number show high levels of inattentive symptoms only. These children are frequently described as having ADD, technically, however, the correct term is ADHD, Predominantly Inattentive Type, or ADHD-I.

Some prominent ADHD researchers have suggested that although children with the inattentive and combined subtypes of ADHD both show high rates of attention difficulties, these are really very different disorders. Children with the inattentive type tend to have more severe alertness/orientation problems, including more symptoms of sluggish cognitive tempo and slower processing speed. Socially, they are less aggressive but more highly withdrawn and passive and may have even greater social difficulties.

Given the large number of ADHD treatment studies conducted it is surprising to note how little work has focused exclusively on treatment for children with ADHD-I. The limited evidence that is available for the treatment of ADHD-I is focused primarily on stimulant medication and initial results suggest that medication treatment is about as effective for these children as for children with the combined type of ADHD.

Behavioural interventions for children with ADHD-I, however, have not previously been examined and this is an important gap in the literature. The literature on behaviour therapy for ADHD has focused on evaluating programs that have been for children whose ADHD includes both inattentive and hyperactive-impulsive symptoms. These children have substantially greater problems with aggression and other forms of externalizing behaviour than children with ADHD-I and tend to have different types of social difficulties. Thus, programs that may be effective for them may not adequately target the different types of problems experienced by children whose difficulties are restricted to inattention.

Given the absence of research on behavioural therapy for children with inattentive ADHD, a study published in a recent issue of the *Journal of the American Academy of Child and Adolescent Psychiatry* represents an important addition to the field [Piffner, L., et al. (2007). A randomized, controlled trial of integrated home-school behavioural treatment for ADHD, Predominantly Inattentive Type. *JAACAP*, 46, 1041-1050.]

Participants were 69 2nd-5th grade children (23 females) all of whom were diagnosed with ADHD-I. The sample had a good representation of minorities and included families from a wide range of socioeconomic backgrounds. Only 2 children were taking medication at the beginning of the study and none began medication during the 12-week program.

Participants were randomly assigned to the newly developed intervention called the CLAS Program (Child Life and Attention Skills) or to a "treatment as usual" control group. (Unfortunately, details on what treatment as usual consisted of are not provided.) Unlike existing behavioural treatments for ADHD, The CLAS Program was designed to target the most prominent difficulties for children with ADHD-I and included the three inter-related components described below.

**- Teacher Consultation** - Each child's teacher was given an overview of behavioural interventions and classroom-based accommodations for ADHD-I, followed by 4-5 1/2 hour meetings of teacher, parent, child, and therapist over 12 weeks. In addition, a daily report card system in which teachers rated key target behaviours for each child, e.g., completion of assigned work, accuracy of completed work, appropriate social behaviour) was implemented so that parents were kept informed of their child's progress in these key areas. This enabled parents to reward children on a daily basis for attaining important classroom goals.

Environmental and academic accommodations such as preferential seating, reduction in assigned work, help with organization) were provided as needed to each child.

**- Parent Training** - A 12-week parent-training program that included 6-8 families began with an overview of ADHD-I followed by a set of strategies for managing ADHD-I and associated impairments. Strategies covered included the use of positive attention, rewards, establishing effective routines, planning activities, giving directions and commands, and using prudent negative consequences.

In contrast to parent training programs developed for children with the combined type of ADHD, where acting out behaviour problems are more common, there was less focus on disciplinary strategies and greater focus on improving homework routines, independence, and organizational and time-management skills to improve academic performance. Parents were also taught ways to promote and reinforce their child's use of social skills that were covered in the children's groups (see below).

**- Child Skills Training** - The Child Skills Training Groups met concurrently with the parent training groups. Child groups were divided into modules focused on skills for independence, e.g., academic, study and organizational skills) and skills for social competence, e.g., being a good sport, combating "spaciness", being assertive, dealing with teasing, and initiating friendships.

Each module provided children with knowledge about the specific skills being addressed as well as providing ample opportunity for rehearsal and practice. Children were helped to become more "alert" by group-reinforced attention checks during which the children were prompted to repeat the last comment made or the last activity that had occurred. Role-plays of common problem situations for children with ADHD-I were included in each module. Each week children brought in a record of rewards they had earned at home and school to exchange for rewards in the group setting. This was done both to motivate the children and to promote the generalization of desired behaviours across settings.

**- Measures** - A wide variety of measures were collected before, immediately following, and approximately 4-6 months after treatment ended to evaluate the impact of the CLAS program. The primary outcome measure was the average ratings made by parents and teachers for the 9 inattentive symptoms of ADHD. Parents and teachers also completed ratings of behaviour indicative of "sluggish cognitive tempo", e.g., daydreaming, lost in a fog, sluggish/drowsy, which were also averaged.

In addition to these primary outcomes, parents and teachers rated each child's social skills, organizational skills, and overall degree of improvement. As with the primary outcome measures, parent and teacher ratings for these secondary measures were averaged.

**- Results** - Compared to the treatment as usual group, children in CLAS showed a significant decline in DSM-IV inattentive symptoms. Both groups started with an average of approximately 6.3 symptoms (out of 9) before treatment. Immediately following treatment this had dropped to 3.0 symptoms for the CLAS group and to 5.1 symptoms for the control group. Symptoms levels at follow up were 3.2 and 4.4 respectively. Following treatment, 55% of the treated group had scores in the normal range compared to only 27% of the control group. Similar results were found for ratings of sluggish cognitive tempo.

In addition to these positive results for the primary outcome measures, children in the CLAS group were also rated as showing greater improvement in social skills, organizational skills, and on overall impressions of improvement.

Finally, all parents rated their overall level of satisfaction with the CLAS program as "very satisfied" and all but one rated their child's attention problems as improved. More than 90% rated the strategies and skills taught as either "useful" or "very useful". The vast majority of children - roughly 80% - reported enjoying the program and that it helped them to do better at home and school.

**- Summary and Implications** - Results from this study support the efficacy of behaviourally based psychosocial treatment for children with ADHD-I. As noted above, the CLAS Program "...led to statistically and clinically significant reductions in attention problems and improvement in organizational and social skills relative to the control group, and these reductions were maintained at follow-up." The magnitude of the effect on inattentive symptoms was similar to what has been reported in studies of stimulant medication treatment for children with ADHD-I.

These are extremely encouraging results and the authors are to be commended for developing and beginning to evaluate a psychosocial intervention specifically geared to children with ADHD-I. There are several important limitations to this study, however, several of which are acknowledged by the authors, which makes it premature to consider this an established treatment.

First, there is limited information provided on the services received by children in the treatment as usual control group. We are told that only 2 of these children began medication during the study, which is a strikingly low rate. How results for the CLAS Program would compare to children who received adequate medication treatment is thus unknown.

Second, because the authors averaged parent and teacher ratings for all outcomes, it is not possible to know whether similar improvements were observed by both parents and teachers, or whether the overall effects were primarily attributed to greater improvements seen by only one of these groups. In particular, because parents committed significant time to the program, it is possible that they were "biased" to see improvement in their child. If both parents and teachers observed similar improvements, this would be quite impressive but the data is not presented in a way that enables this to be determined.

Third, there were no objective measures provided of children's academic performance. Thus, whether the program resulted in tangible gains in children's academic success is unknown.

Despite these important limitations, results from this study are certainly encouraging and suggest that a psychosocial intervention that specifically targets the difficulties experienced by children with ADHD-I can be effective. As the authors note, "future randomized, controlled trials are needed to compare and contrast the CLAS Program and medication treatment and examine their combination in multimodal approaches to identify the most efficacious approach to treating ADHD-I over time."

Parenting Skills Courses 2009 aimed specifically for parents of Children / Adolescents with ADHD. Those interested are encouraged to contact the group on [info@adhdmalta.org](mailto:info@adhdmalta.org).

# LIBRARY CORNER

By - Marlene Chetcuti Ganado



Dear members of the ADHD Support Group,

Once again I shall be introducing to you one of the books in our library. This time I have chosen “MAKING THE CONNECTION” (A Parent's Guide to Medication in AD/HD), by Mohab Hanna, MD. This book deals with the dilemma parents go through once their child has been diagnosed with AD/HD, and as a result the psychiatrist could have suggested medication.

It is understandable that the decision to put one's son or daughter on medication is a tough one. But as you read through the book, you will be provided with all the information you need to make the right decision.

The author addresses many of the questions parents face, and has written a simple to use, yet essential guide for every parent of an AD/HD youngster. Dr Hanna starts off by helping parents to understand what the condition of AD/HD actually is. What causes this condition, how common such condition is, the symptoms, types, and some other common conditions that tend to be seen alongside AD/HD.

He then goes on to explain what may happen if this condition / disorder is not treated. In Section Two of the book, one finds “Twenty -One Medication Rules Every Parent Needs to Know”. As Dr. Richard Sarles, MD (Professor in Psychiatry and Paediatrics) writes : “These 21 rules, together with an excellent reference, the listing of professional organizations and Web sites, are particular helpful to all parents of children with AD/HD.

A particular chapter in the book deals with the different medications currently in use for the treatment of AD/HD. (Stimulants, and non-stimulants). It explains both the benefits, as well as potential adverse effects of these medications. Towards the end of the book a whole chapter is dedicated to common questions frequently asked by parents, and the appropriate answers to these questions.

I have personally read this book more than once, as I often find that I need to refer to it from time to time. Just as the sub-title of the book says; this book is a parent's Guide to Medication in AD/HD. I suggest that anyone who is presently going through the dilemma of whether to give their AD/HD child medication or not, should try and read through this book, and thus be able to see things from a different perspective.

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