

Attention-Deficit/Hyperactivity Disorder

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Some children can't sit still. Others are highly distractible, forgetful, or inattentive. Some appear distracted by every little thing and don't seem to learn from their mistakes. Many of these children disregard rules, even when they are punished repeatedly. There are also those who tend to act without thinking, resulting in many accidents and reprimands. This collection of problematic features is called Attention-Deficit/Hyperactivity Disorder (AD/HD).

AD/HD is one of the most common reasons children are referred to mental health professionals. It may be one of the most prevalent problems of childhood. The consensus of professional opinion is that approximately 3 to 5 percent of children have AD/HD. This translates to as many as two million school-age children. Every classroom in the country averages one AD/HD child.

Some studies suggest the prevalence of ADHD is greater in boys than girls. However, because many girls have the inattentive form of ADHD, they have gone undiagnosed and may be underrepresented in the incidence figures. When all forms of ADHD are included, the occurrence may be quite even between genders.

AD/HD makes family life very disruptive and stressful. No matter how hard parents of AD/HD children try to do the right thing, their children persist in daydreaming, missing homework assignments, and neglecting chores.

Types of AD/HD

There appears to be several types of AD/HD. Some children are primarily impulsive and hyperactive, while others are inattentive and distractible. Then, there is a third group who seem to have both impulsive and inattentive characteristics.

Children with **hyperactivity** exhibit aggressive conduct problems, bizarre behavior, and appear impulsive. The hyperactive child is more noisy, disruptive, messy, irresponsible and immature. The "whirling dervish" or "Dennis the Menace" labels will apply. These children have a higher risk for serious aggressive or oppositional behavior and antisocial or acting out behavior.

In contrast, those attention deficit children who are predominantly **inattentive** tend to be anxious, shy, socially withdrawn, moderately unpopular, poor in sports and have low school performance. The primarily inattentive student often is seen staring into space and reports daydreaming, is often forgetful in daily activities, appears to be low in energy, and is sluggish and drowsy. This child seems to have difficulty becoming sufficiently aroused and vigilant at a level that fosters adequate attention to academic tasks.

This student may be described as a "space cadet" or "couch potato" and often seems lost in thought, apathetic and lethargic. He or she is less aggressive, impulsive and overactive both at home and school, and has fewer problems in peer relationships? This category probably makes up the largest number of AD/HD children, yet may be the most underdiagnosed.

Some children can have a **combination** of both inattention and hyperactive-impulsive features. This child will have most of the behavioral manifestations of inattention such as failure to give close attention to details, careless mistakes, and being easily distracted by extraneous stimuli. In addition, the child will have trouble with hyperactive-impulsive features such as fidgeting with hands or feet,

unable to remain seated, often on the go, interrupts others, and has difficulty awaiting his or her turn.

All children will sometimes be inattentive, impulsive or have high energy levels. However, with attention deficit children these symptoms are part of the daily routine rather than the exception. Also, these behaviors tend to occur at school, church, grandma's house and the grocery store, as well as at home. The general rule is that these children are consistently inconsistent.

Causes of AD/HD

AD/HD continues to be one of the most thoroughly researched conditions of childhood. Yet the exact causes are still not known. Neurochemical abnormalities which might underlie this disorder are difficult to identify. The major evidence points to diminished activity in certain brain regions and heredity as the most likely cause of most forms of attention disorder. In other words, many AD/HD children seem to arrive in the world with temperaments that leave them difficult to manage. Part of the basis for this predisposition may be inherited.

The cause of AD/HD is understood to be dysregulation of certain neurotransmitters in the brain which make it harder for a person to sort out or regulate certain internal and external stimuli. These deficits in brain neurochemistry make it harder to concentrate and focus. Several neurotransmitters, including dopamine and norepinephrine, probably affect the production, use and regulation of other neurotransmitters, as well as the functioning of some brain structures. These problems with regulation of certain brain functions seem to be centralized in the frontal lobes which makes it more difficult for an AD/HD person to control input from other parts of the brain. The frontal region of the brain, which is just behind the forehead, is said to control the "executive functions" of our behavior. The executive function is responsible for memory, organization, inhibiting behavior, sustaining attention, initiating self-control, and planning for the future. Without enough dopamine and related neurotransmitters, the frontal lobes are understimulated and unable to perform their complex functions effectively.

Children without this genetic predisposition can develop AD/HD through illness or injury, but this rarely happens. At this time, there is very little evidence that AD/HD can arise purely out of social or environmental factors, such as family dysfunction, diet, toxins, or faulty parenting. It is true that parental frustration and negative reactions toward your child can aggravate the problem, but it does not actually cause AD/HD. The ultimate cause of ADHD appears to be an inherited condition affecting the biochemistry of brain function.

A current area of research is being done by Dr. Daniel Amen utilizing Single Photon Emission Computer Tomography imaging (SPECT scans). While MRI and CAT scans are anatomy studies that show the structure of the brain, SPECT imaging shows what happens with the brain when you try to work it. In the 18 minute process, radioactive isotopes are taken up by the brain and the imaging illustrates the metabolic activity and blood flow. With this tool Dr. Amen, and other colleagues around the country, have been able to correlate the functions of different brain parts to certain behavior in patients and see how abnormal brain patterns cause specific mental and emotional problems. These correlations relate roughly to five major areas of the brain: the Limbic System, Basal Ganglia, Prefrontal Cortex, the Cingulate System, and the Temporal Lobes.

Dr. Amen has identified six different types of Attention Deficit based on these brain imaging results. The types are:

1. Classic ADD—hyperactive, restless, distractible, and impulsive.
2. Inattentive ADD—space cadets, daydreamers, couch potatoes.
3. Overfocused ADD—trouble shifting attention, stuck, obsessive and argumentative
4. Temporal Lobe ADD—aggressive, memory problems, headaches and dark thoughts.
5. Limbic ADD—depression, negativity and a negative internal filter.

6. Ring of Fire ADD—angry, overly sensitive, moody and oppositional.

While these ADD types are not yet part of the official diagnostic protocol, it is very interesting research with a lot of promise for both diagnosis and treatment.

Diagnosis of AD/HD

It's quite difficult and somewhat humbling, to contemplate the fact your child may have AD/HD. Denial is understandable and you certainly should not rush out and obtain an evaluation without careful consideration. Take the time to read several articles or books on AD/HD. Talk to other parents who have already been through the process. Prayerfully evaluate what you have learned about attention disorder and compare the information to the consistent behavior of your child. If the descriptions seem to match up, an evaluation may be appropriate. Here are some conditions or characteristics that might suggest an evaluation is necessary:

- If many of the symptoms of inattention, distractibility or hyperactivity/impulsivity described earlier have persisted for at least six months;
- If the AD/HD type descriptions are very prominent in the day-to-day life of your child;
- If other parents or relatives have suggested to you that there might be something out of the ordinary going on with you son or daughter;
- If a teacher or caretaker has told you of frequent problems with inattention, distractibility, forgetfulness, noncompliance, daydreaming, impulsivity, problems with peers, underachievement, or incomplete assignments;
- If, as a parent, especially the mother, you have had a nagging concern for some time, that there might be some type of problem based on the high maintenance requirements of your child;
- There are too many days when you find yourself getting continually frustrated and angry, with your child, even to the point of not liking him or her very much.
- You see the self-esteem of your child get lower and lower because of problems with self-control, social or school failure, or inability to sustain an interest in activities which occupy most children.

These conditions or events are telling you something. This list of features is not exclusive to attention disorders. However, these enduring characteristics are indicative of some kind of problematic situation. It would certainly be wise to seek professional help in determining the causes and pointing you in the direction of treatment and help.

There is no simple test that determines a child has AD/HD. Diagnosis is a complicated process that requires the skill of a psychologist, psychiatrist, pediatrician, pediatric neurologist or other mental health professional that specializes in special needs of children. A proper diagnosis orients the child, parents, and caregivers to the exact nature of the child's difficulties by providing information about strengths and weakness. It also should clarify the specific problems with attention, overarousal, and impulsivity. A diagnosis should also reveal a student's learning style and academic capabilities with direction and recommendations for parents and teachers.

A thorough diagnosis should also determine the presence of other problems, such as learning disabilities, conduct disorder, history of abuse, poor socialization skills, or disruptive family relationships. Understanding of all these factors allows you and your professional team to design and implement a more effective intervention program.

AD/HD is a complex disorder which works its way into all levels of a child's life. Therefore, the most helpful professional is one who will gather information from multiple sources and arrive at a diagnostic decision based on a reasonable integration of the data. For a problem this chronic and

multifaceted, you need someone who is willing to deal with the diversity of issues that arise at home, in school, and within the community.

As the primary advocate for your child, you must take the initiative to secure the best help available. Ask questions, become informed, and read everything you can get your hands on. This allows you to challenge and ask about those things that don't make sense to you. Your goal here is to be an active collaborator in the process. When you call or meet with a professional, ask if he or she has had specific experience in the diagnosis and treatment of AD/HD. What kind of professional workshops has s/he attended? How many children has s/he evaluated? How involved does the professional become in the monitoring of treatment? If you or your child has a problem, how available is the doctor to respond?

You need to feel comfortable and confident with the practitioner. If s/he won't answer your questions or gives unclear answers, look elsewhere. When you are uncomfortable with a practitioner's personality or professional approach, confront the issue or find someone else. This is too important an issue to tolerate incompetence or unprofessional conduct.

At the same time, let me remind you there are no immediate cures or quick answers to the problem of AD/HD. If you go looking for a doctor to immediately eliminate all stress and strain from your life, you will always be disappointed. Likewise, if a professional promises you quick fixes, charges unusual fees, and offers unorthodox methods, you should be extremely cautious.

Your local school district can be a resource for obtaining a diagnosis and prescription for classroom help. Contact your neighborhood school and ask the principal or school counselor about conducting an assessment for your child. You may also be able to obtain diagnostic help through a Christian counseling center in your area, other mental health agencies, university clinics, or home school associations.

Another resource is Children & Adults with Attention Deficit Disorders (CH.A.D.D.). Through family support and advocacy, public and professional education, and encouragement of scientific and educational research, CH.A.D.D. works to ensure that those with attention deficits reach their inherent potential. Local chapters of CH.A.D.D. can help you locate resources in your area for both diagnosis and multi-modal treatment. If you need help in locating a local chapter of CH.A.D.D., contact the national office in Plantation, Florida at (800) 233-4050. They can be found on the internet at www.chadd.org.

Coexisting Disorders

As many as 70 percent of children with AD/HD have at least one other major disorder. Any disorder can coexist with AD/HD, but certain disorders seem to occur more commonly with AD/HD. The most common disorders to occur with AD/HD are disruptive behavior disorders such as oppositional defiant disorder or conduct disorder; mood disorders; anxiety disorders; tics and tourette's syndrome; and learning disabilities.

Because of the strong possibility of these coexisting disorders complicating the diagnosis, it again reinforces the need for a thorough and competent diagnosis by a professional experienced in the evaluation of special needs of children and adolescence.

Treatment of AD/HD

If you find out your child has AD/HD, don't be in too big a rush to run out and make all sorts of changes. Take some time to process your own feelings and reactions first. Let God know how you feel and talk to some trusted friends or family members about the situation. There is "a time to

weep and a time to laugh, a time to mourn and a time to dance" (Ecclesiastes 3:4). And yes, there is every reason to have hope. However, before you can start helping your child, you need a little time to come to peace with your own questions and reactions. Once you have done that, here are some suggestions for helping your child.

There is no cure or quick fix for attention disorders. In spite of claims to the contrary, special diets, electronic gadgets, or singular environmental alterations have not been proven to be helpful with significant numbers of AD/HD children. The good news, however, is we do know a great deal about how to intervene with AD/HD children. There are numerous strategies and procedures that can improve your child's behavior, self-esteem and overall quality of life.

The types of intervention fall into five categories:

1. general education about AD/HD by the parents and the enhancement of parenting skills,
2. teaching the child self-control, attention, decision making and social skills,
3. medical intervention,
4. educational accommodations, and
5. spiritual assistance.

Education and Parenting Skills

The process begins by increasing your understanding about the nature and symptoms of AD/HD. Books, tapes, seminars, support groups, and professional educators and mental health professionals are sources of information to help you broaden your awareness of how AD/HD impacts your child's behavior.

AD/HD children need clear structure, definite descriptions of what they are being asked to do, specific consequences for their behavior, and consistent enforcement of these principles. The child needs an organized environment where the demands of a specific situation are identified ahead of time. Lots of rewards and praise for successful and appropriate behavior is a necessity. As the parents and other caretakers refine their ability to carry out these ideas, the child will be enabled to behave more appropriately and achieve more success.

Many resources are available to help you identify and implement this positive structure for your child. Consult them for details about strategies such as positive direction, ending interactions successfully, behavior management, response-cost, negative reinforcement, cognitive self-monitoring, overcorrection, time-out, grounding, and logical or natural consequences.

Appropriate incentives, offering both rewards and punishments, are necessary. Time-out, and grounding can be very useful, but be careful to adapt each tactic to the needs and age of your child. If you run into problems, consult with a psychologist or other professional.

Parenting Suggestions

- Be sensitive to your child. Most children will be confused, discouraged, or upset when they learn their AD/HD diagnosis. They might think there is something terribly wrong with their bodies or brains. Or they may want to use their diagnosis as an excuse, saying, "I can't help myself. I have AD/HD." Just like you, they will need time to adjust to the diagnosis and its implications. Your child needs a lot of special understanding and encouragement at this time. Although most children feel relieved, because now they know why they have struggled so much, they need hope for their future.

- Explain AD/HD simply. One of your most difficult tasks is to explain AD/HD to your child. Without an explanation he will conclude he is either a "bad" child or that he is dumb or inferior. He needs to know that you realize he has a difficult time sitting still, stifling interruptions, and keeping his mind on a job and he needs to know his academic problems are not his fault. Tell him you understand he is doing the best he can, but that he has a problem which makes it hard for him to concentrate and get his work done.
- Your explanation needs to be simple and phrased in word pictures your child can understand. Tell him that every person is unique and that we all have specific strengths and weaknesses. Some people have certain parts of their brain arranged in such a way that they can't see very well. These people wear glasses to allow them to view their world more clearly. Other kids have teeth that need straightening. They wear braces and retainers to correct their teeth so they can eat correctly, play the horn, or whistle.
- It's important to let your child know he is not the only one in the world with this problem. There are probably lots of kids in his school who also have attention deficit. If someone else in his extended family has the same problem, share this fact also. There are many parents, teachers, and very successful people who have attention problems. Above all, convey your total love and acceptance for your child just the way he is.
- Focus on what your child can do, not on what s/he can't do. Your child may have difficulty concentrating while reading to himself, but does much better when listening to someone read aloud. Rather than force silent reading, which leads to frustration, let your child learn new information by reading to him, listening to a book on tape, or watching a videotape.
- Remember the big picture. Schoolwork is important, but a child's love for God and emotional and social adjustment is more important. Be thankful for all the things that are going well in other parts of your child's life.
- Teach and model that mistakes don't equal failure. An AD/HD child may tend to see his or her mistakes as huge failures. You can model, through good-humored acceptance of your own mistakes, that errors can be useful and can lead to new solutions. Mistakes and problems are not the end of the world. When your child sees you taking this approach to your mistakes and the mistakes of others, s/he can learn to view his or her mistakes in the same light.
- Communicate the concept that this is a family effort. Yes, your child has to take responsibility for doing her chores, completing homework, and putting out her best effort. However, your child is not in this alone. Everyone will work together to make school as successful as possible.
- Pray together and work on projects as a family. Emphasize family traditions, stories, and legacies to help keep the problem of attention deficit in perspective. In the larger scheme of things, family, faith, and loving relationships are truly what is important.
- Do not compare your child with any of his brothers and sisters or classmates. Accept your AD/HD child as s/he is. Be the best cheerleader your child will ever see!
- Keep to a regular routine. Children with AD/HD need a predictable schedule. Try to keep daily events such as bedtime, meals, and homework on a definite schedule. Be firm about limits and consistent about enforcing them. Use that time to expose and encourage your child to follow other pursuits. Limit the amount of TV.
- Take care of yourself. Most AD/HD children are high-maintenance kids. The constant advocacy, attention to details, remediation efforts and patience needed for a child with attention disorders can wear down the best parent. There will be days when you are at your wit's end and

you will feel like giving up and trading in the family minivan for a one-way ticket to Australia! Find some time for yourself. Talk with a friend and maintain your sense of humor. Laughter is good for the soul. Your home needs to be safe, supportive, and fun. Do all you can to become that kind of parent and your child can learn to feel great about himself in spite of his attention problem!

Teaching the Child Self-Control and Social Behavior

The next category of intervention is assisting your child to utilize more of what he or she knows about self-control and positive social interactions. Often the only thing most AD/HD children know about being still is what their parents tell them. “Joey, sit still.” “Joey, I’ve told you a dozen times to be quiet. Now do it.” While other children can sit through a meal without incident, an AD/HD child will wiggle, rock, and squirm his way from appetizer to desert.

An AD/HD child must try to learn to take control of his reactions. He can become less active and filter out distractions. You can help your child control his movement, set the idle lower and put a limit on his impulses. This takes specific training. Other children naturally turn their motion on and off. They can consciously focus attention and resist the urge to move around. Your AD/HD youngster must learn how to do this.

Various games and activities such as Statue, Beat the Clock, endurance, calmness, and impulse control training, along with learning how to ignore distractions can be used (See Dr Martin’s book *The Attention Deficit Child*, for more details on these activities).

AD/HD children do not seem to learn this process through “normal” experience and often need specific instruction on how to do it. Parents, as well as extended family, teachers, school bus drivers, and recess monitors are very important in teaching these skills. Research has shown that instruction in self-control does not generalize outside of a specific situation unless the child’s caretakers are very involved in the effort.

The majority of AD/HD children experience social incompetence, immaturity or aggression. While medication has been shown to be effective in reducing aggressive behavior, a component of social skills training is essential for the AD/HD child having problems in these areas. Two of the major goals of social skills training are that the AD/HD child will become more knowledgeable about appropriate and inappropriate social behavior, and that they will learn how to actually implement these social behaviors among their peers and classmates.

There is quite a bit of overlap between social skills or prosocial skill training and the self-control training described earlier. Most programs seem to focus on four major skill areas: (1) social entry, (2) conversational skills, (3) conflict resolution and problem solving, and (4) anger management.

Medical Intervention

Without question, one of the most difficult decisions you will face as a parent of an AD/HD child is whether to use medication. If your child has an infection, you may give them an antibiotic for a few days, and the problem is resolved. In contrast, the drugs given to manage AD/HD must be taken for months and sometimes years. You can’t help but wonder how this long term usage might affect your child.

More children receive medication to manage AD/HD than any other childhood disorder. More research has been conducted on the effects of stimulant medications on the functioning of children with AD/HD than any other treatment modality for any childhood disorder. This extensive research helps us be fairly definitive about the benefits and liabilities of medication. This is one area where

the results are a little easier to identify. This applies to scientific research, not necessarily to most of the sensational media coverage. A great deal of misinformation has been perpetuated by the popular press.

In general, we can say medication intervention is a significant help to AD/HD children. Recently the National Institute of Mental Health released the Multimodal Treatment Study of Children with Attention Deficit Hyperactivity Disorder (MTA). This study is the longest and most thorough study ever completed comparing treatments for AD/HD. The study found that medication alone, or medication in combination with intensive behavioral therapy, was significantly superior to other types of treatment. Although medication alone was found to be more effective than intensive behavioral treatment, the combination of the two was necessary to produce a variety of improvements, and also led to the use of somewhat lower dosages of medication. Also, for the improvement of social skills and anger management, behavioral treatment was found to be very beneficial and necessary. Medication alone, does not help a child make friends or know how to resolve conflict in appropriate ways.

The primary benefits are the improvement of the core problems of AD/HD—hyperactivity, impulsivity, and inattentiveness. Attention span seems to improve and there is a reduction of disruptive, inappropriate and impulsive behavior. Compliance with authority of figures is increased, and children's peer relations may also improve, primarily through reduction in aggression. In addition, if the dosage is carefully monitored and adjusted, medication has been found to enhance academic performance. Medication does little to rectify any cognitive functioning or learning disabilities. If a child has visual or auditory processing deficits, medication will probably not change this learning problem. What it may do is help the child pay attention better, so that the remedial instructions will have more of a chance to impact the learning disability. If medication is to be considered, it must follow strict controls, appropriate dosages, and careful monitoring.

The most important concept to emerge from the vast amounts of research about AD/HD is that no treatment approach is successful alone. Neither medical, behavioral, psychological nor educational intervention is adequate by itself. We must be conscious of treating the *whole* child or adolescent. Successful intervention makes a difference both on the short and long term. We want to make changes which will help bring about the necessary confidence, competence, organization, discipline, and character in your child. However, we also want changes that will last a lifetime.

"Psychostimulant" compounds are the most widely used medications for the management of AD/HD-related symptoms. It is believed that psychostimulant medications change the levels of transmitter chemicals available to various neurotransmitter systems in the brain. These neurotransmitters are the means by which the different nerve cells communicate among themselves. Between 70-80 percent of children with AD/HD respond positively to these medications. Attention span, impulsivity and on-task behavior improve, especially in structured environments. Some children also demonstrate improvements in frustration tolerance, compliance and even handwriting. Relationships with parents, peers and teachers may also improve. Medication will not make your child act perfect, nor will it make him smarter. However, what it can do is reduce many of your child's attention difficulties so that he can tackle his problems more successfully.

Many parents feel guilty about having their child take medication because they mistakenly think they are tranquilizing him. This is simply not true. The medication helps stimulate the parts of the brain that are needed to concentrate and attend. The decrease in external movement does not mean he has been tranquilized. It means he is able to focus more effectively.

The decision to proceed with medication intervention must be based on the comparison of the risks, benefits, and alternative treatments available. Here are some considerations for you to study in more detail.

Risk of Medication—Short Term Side Effects. The primary side effects noted for stimulant medication is insomnia, anorexia or loss of appetite, weight loss and irritability. Most of these side effects appear at the beginning of treatment. These complaints usually last for about a week and may not be affected by whether the child takes the medication before or after meals.

Appetite suppression is another possible side effect. Your child may be less hungry for a time. This effect may be less noticeable if the drugs are taken with or after meals, as the effects wear off before the next meal. Adjusting the dosage can usually alleviate this symptom over a week or two.

Other mild, but less common side effects, can include sadness, depression, fearfulness, social withdrawal, sleepiness, headaches, nail biting, and stomach upset. These symptoms will usually resolve spontaneously with a decrease in dosage. Some of these symptoms can be considered acceptable side effects in light of clinical improvement. You and the physician will need to make the decision regarding the advantages of decreased distractibility versus side effects such as nail biting. These side effects usually are mild, but they can occur in some children treated with stimulant medication. Alternatively, a trial of a different medication can be initiated.

Long-Term Side Effects. There are no reported cases of addiction or serious drug dependence to date with these medications. Studies have examined the question of whether children on these drugs are more likely to abuse other substances as teenagers, compared to children not taking stimulant medications. The results suggest there is no increase in the likelihood of drug abuse.

Since AD/HD is a long-term condition, medical treatment may be required for a prolonged period. This also raised the question of whether the child will become tolerant of the medication. The answer appears to be “no.” Over time, the child’s dosages may need to be increased. This probably relates more to their increase in body weight, than to their becoming tolerant of a certain dose. It is possible for a few children to become tolerant of a particular medication. You and your doctor should continue to monitor its effectiveness very closely.

Another possible long-term side effect has been the suppression of height and weight gain. Presently, it is believed that suppression in growth is a relatively transient side effect of the first year or so of treatment and has no significant effect on eventual adult height and weight. Nevertheless, it is wise for the physician to monitor growth in children receiving stimulant medications.

The choice to use medication is an important one. The decisions do not end by just starting your child on a medication. Careful monitoring must be done to evaluate the effects and to determine the proper dosage. Side effects are possible, so careful observations of your child are necessary. Keep in contact with your physician and don’t let significant symptoms go unheeded.

Remember that medication is never the sole treatment program for AD/HD. What you do after the start of medication is where the major benefits accrue. The effects of medication alone are temporary. The effects of instruction and self-control will last a lifetime. Medication can be one aspect of a balanced treatment.

Educational Intervention

It’s no wonder an AD/HD student has problems with school. Nowhere else is your child required to concentrate so long in the face of so many powerful distracters. Successful

performance is dependent on the ability to persist and maintain concentration for long periods of time. All students must learn class routines, conform to teachers' rules and inhibit their impulses to do otherwise. Furthermore, the student must control his body movement, maintain an appropriate level of arousal and delay gratification until report cards are issued.

Our educational system demands more of these skills, and at an earlier age. As a result, the AD/HD child will experience increased frustration and failure. Because of these problems it is often the classroom teacher who raises questions that bring about referrals for an evaluation. While the teacher knows your child has a problem, the confusion may arise over what *kind* of problem it is and what to *do* about it. Unless the teacher believes your child's diagnosis of AD/HD is well-founded and real, it will be hard for you to convince him or her to make all the necessary modifications for your child.

Here are a few guidelines for making educational interventions with your child.

- Staff who accept the legitimacy of ADHD.
- 3. The classroom must be structured and predictable, but not punitive or sterile. The student needs clear rules and consistent scheduling. Assignments should be clearly communicated, both to the child and to the parent. Instruction should be stimulating, clear, and uncomplicated.
- 4. Distractions should be minimized for the student. This may mean seating the student close to the teacher and away from obvious distracters such as windows, active classmates, gerbil cages or pencil sharpeners.
- 5. Immediate and frequent feedback is required. Redirection will often be necessary so that long periods of unproductive activity are minimized.
- 6. The student needs both verbal and tangible positive consequences for attention to task and assignment completion. Other meaningful positive and negative consequences will be needed to assist the student in learning appropriate classroom behavior.
- 7. Directions and instructions to the student must be clear, concrete and concise. Give only a few directions at a time and use as much visual, auditory and hands on demonstration as possible.
- 8. The curriculum needs to be adjusted to allow the student to be successful. This is done by modifying the instruction methods to accommodate the child's difficulty in paying attention and concentrating. Help with organizational skills is necessary. Some flexibility is needed to allow for the student's low frustration tolerance. Assignments may need to be shortened. Computers can be used to compensate for poor handwriting ability. Assignments might be divided into smaller parts to help the student feel successful and to give more frequent opportunity for feedback.
- 9. It is crucial for the entire team of educators, mental health professionals, medical personnel, and parents to maintain continuous communication with each other. Everyone must work together toward the common goal of ensuring the student the best educational experience possible.
- 10. The parent will usually need to maintain an advocate status with the schools. There are many other students to take up the school personnel's time. Don't wait for the six week progress reports. Become very familiar with the teacher and the classroom routine. Be courteous and tactful, but maintain a constant vigil on your child's behalf.

Legal Rights of AD/HD Students

The Federal Government has established several provisions that affect the education of children with Attention-Deficit Disorder. One of these is the Individual's with Disabilities Education Act

(IDEA), and the other is Section 504 of the Rehabilitation Act of 1973. Students with Attention-Deficit/Hyperactivity Disorder, like students with any other disability, do not automatically qualify for special education and related services under IDEA without meeting certain conditions.

If a child with Attention Disorder is found not to be eligible for services under Part B of the IDEA, the requirements of Section 504 of the Rehabilitation Act of 1973 may be applicable if he or she meets the Section 504 definition of disability. This definition requires or defines a disability as “any person who has a physical or mental impairment which substantially limits a major life activity, such as learning.” Thus, depending upon the severity of their condition, children with Attention Disorder may or may not fit the definition of either or both laws. Not all children with Attention Disorder are covered.

These laws require schools to make modifications or adaptations for students whose ADHD results in significant educational impairment. Children with ADHD must be placed in a regular classroom to the maximum extent appropriate to their educational needs, with the use of supplemental aids and services, if necessary. While children covered under the IDEA must have an individual education plan (IEP), students covered under Section 504 need a less formal, individualized assessment.

Spiritual Intervention

Not long ago a little boy with ADD asked his mother, “Mom, why can’t something be wrong with my arm and not my brain?” Later he added, “My broken arm will get better but you can’t fix my brain.”

You may have had the same kind of questions, along with, “Why my child? Maybe this is God’s punishment for a sins of the past?” or “Why would God allow this to happen?” I certainly don’t have the answers to these “Why?” questions any more than I would claim to understand the mind and long range plans of God.

I do believe ADD children have every potential to have creative and fulfilled lives. There is every reason to be optimistic about their abilities to mature, yield fruit in season and prosper in whatever they do (Psalm 1:3).

Parenting is difficult with any child, and even more challenging for a child with special needs. That is why the spiritual resources of a Christian parent can make all the difference in the world. You don’t have to face this task alone or with only your own strength and understanding. We have God’s promises of direction and power. If part of God’s purpose is to help a parent develop patience and long-suffering, then blessing you with a child with attention deficit is a guaranteed way to meet that goal.

If parenting any child is worth a college education, then raising an ADD child should give you a Ph.D. The task is continuous and the challenge is great. However, our spiritual foundation gives the Christian father and mother a basis to claim a victory even when the progress reports are discouraging.

Prayer. The important injunction to parents is to present our children to God in *prayer*. Prayer is a pretty simple activity. Your prayers do not need to be wordy or complex. A simple expression of adoration for God, followed by statements of confession, need and thankfulness, is sufficient. The model of the Lord’s Prayer is perfect (Matthew 6: 9-13; Luke 11: 2-4).

I know you may have called out to God in times of crises and wondered if He would ever answer. Why does your child have to struggle with problems of inattention, low self-esteem and

conflict with family members? All of us have had the feelings of being abandoned and ignored. Biblical heroes such as Jeremiah and David expressed the same feelings. However, God has made some rather remarkable promises—God will answer our prayers (Mark 11:24); God has never failed to keep His promises (1 Kings 8:56). He does not lie. Remember these promises and claim them as you pray for your AD/HD child.

Being a Christian parent doesn't take the hard work out of raising an AD/HD child. It does give you the spiritual resources to cope with the frustrations. A key ingredient in the process is your ability to learn to trust God for the future of your children. This task of trusting is certainly challenged by the daily drain of coping with a child who doesn't pay attention and seems to overreact to everything in his world.

“Trust in the Lord with all your heart and lean not on your own understanding; in all your ways acknowledge him and he will make your paths straight” (Proverbs 3: 5-6). These verses capture the essence of your need to trust. Your finite understanding can only lead to incomplete efforts to manage yourself and your family. Trusting in God demands an affirmative decision. You must move through the veil of denial which shuts out the light of God. Your path will be illuminated and made straight by choosing to let God be your guide.

Trust happens with experience and grows over time. At this point you may be able to give God responsibility for only part of your life or for only certain aspects of dealing with a special needs child. That's okay. Give Him what you can. As He proves faithful in some things you will be able to hand over more aspects of your life and your ability to parent. May God bless you and your family.

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