ADHD, ADD & ODD

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A Viewer Guide

In this program, Jacqueline Ellis hosts a class on Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), and Oppositional Defiant Disorder (ODD). Jacqueline’s guest expert for the course is Dr. James Kagan, a psychiatrist and pediatrician with many years of experience with these childhood behavior disorders.

Jacqueline, Dr. Kagan, and members of a caregiver support group explore issues on parenting children with these disorders. After a brief introduction on the disorders, the course follows the stories of four children being cared for by parents in the group. The children have one or more of these disorders. Parents provide background information about their children and describe their children’s symptoms to Dr. Kagan, who then offers insights and practical steps about parenting children with ODD and ADHD. Along the way, other parents in the group share their own experiences and the lessons they’ve learned. Dr. Kagan wraps up the course by providing suggestions for parents to use while parenting children with ADHD, ADD, and ODD. The course includes four supplemental handouts.

This companion guide provides an overview of the course on ADHD, ADD, and ODD.

At the end of this course, you will be able to:

1. List three types of Attention Deficit Hyperactivity Disorder (ADHD).
2. Identify behaviors commonly seen in children with ADHD/ADD.
3. Identify behaviors associated with Oppositional Defiant Disorder (ODD).
4. Explain what may contribute to ADHD or ODD in foster and adoptive children and youth.
5. Identify strategies for working with children and youth who have ADHD and/or ODD.
6. Understand the importance of working with the child’s school and physician.
Introduction to ADHD

Jacqueline opens the class by welcoming the members of the caregiver support group, who then introduce themselves. First is Lindsey, the single mom of a teenage foster son. She wants to learn more about her son’s condition. Next are Jesus and Felicia, who are raising their 7-year-old niece, Alicia. Jerry and Kay are the adoptive parents of three children – two girls and a boy, Jason, who is the reason for their coming to the group. Marlene, who participated in the Safe Parenting group, has brought her husband, Thomas, to this one. They are providing care for their 12-year-old grandson, Gregory, who was diagnosed with ADHD when he was 5. Dante and Rose have come to the meeting to learn more about the behavior of their 16-year-old foster daughter, Pearl. They’ve been struggling with her, and it isn’t getting any better. Finally, Cindy has a teenage birth son who is rebellious, and she thinks he might have ADHD. After these introductions, Jacqueline introduces and welcomes Dr. Kagan to the group.

Jacqueline begins the discussion by asking Dr. Kagan if ADHD and ODD always exist together. He replies they don’t, but they often do coincide.

Jacqueline then asks Dr. Kagan how he would describe ADHD. He says ADHD is the most common childhood brain functioning disorder. It is an inherited deficiency of certain chemicals in the part of the brain that deals with focus, attention, and organization of thoughts. Without enough of these essential chemicals, that part of the brain cannot work properly. Some children with ADHD are primarily quietly inattentive, some are quite physically hyperactive as a result of their inability to stay on track, and others are primarily impulsive because of their inability to make well thought-out decisions. Hence we have the three types of ADHD: Inattentive, Hyperactive, and Impulsive. In real life there is a lot of overlap.

Here Jacqueline mentions that experienced foster parents know these difficulties can have a negative impact on how the child does at home, school, and in the community. Lindsey, who is new to foster parenting but has raised two birth children, asks Dr. Kagan, “Don’t all children have these problems, like not focusing their attention or getting pretty energetic and active?” Dr. Kagan agrees they do, and goes on to say that’s why it’s sometimes difficult to distinguish between such concentration problems as normal forgetfulness and being highly distractible. It’s really a matter of degrees.

When Lindsey asks how you know, then, whether it’s ADHD or not, Dr. Kagan says with ADHD, problems with attention, hyperactivity, and impulse control are more extreme and persist for at least 6 months. They interfere with the child’s ability to function in a healthy way for his or her age. Dr. Kagan then provides greater detail about each of the three main symptoms of ADHD.

In the Inattentive category, an ADHD child:
- does not pay attention to details and is prone to careless mistakes
- cannot seem to listen when you’re speaking to him
- does not follow through on what he’s asked to do and does not finish chores, tasks, or school-work. Loses things
- is forgetful
Jacqueline says those symptoms could describe her when she’s tired. Dr. Kagan agrees, but says that with ADHD, the symptoms are present in most settings, most of the time. That’s an important diagnostic point.

In the Hyperactivity category, the ADHD child:
- fidgets and squirms a lot
- runs or climbs in the extreme
- cannot play quietly
- talks or moves around excessively

As for the Impulsive category, the ADHD child:
- cannot wait his turn
- makes snap decisions based upon his immediate needs without taking the consequences into consideration

When Jacqueline wonders how widespread ADHD is among children, Dr. Kagan says that, by some estimates, ADHD affects 3% - 10% of all children. He goes on to say that studies have shown the incidence is even higher among the population of foster and adopted children. He then cautions that, although ADHD is relatively common, it’s very important that children not just be labeled with ADHD, without a very clear determination of what’s going on with them.

Jacqueline picks up on the word “labeled,” and Dr. Kagan continues. Yes, every child who is thought to be ADHD deserves a comprehensive diagnostic evaluation of his or her problem. This is a medical/psychiatric condition requiring medical and/or psychological expertise to diagnose. Nothing less.

At this point, the group moves on to the topic of ODD.
Introduction to ODD

Dr. Kagan describes Oppositional Defiant Disorder as a pattern of defiance, negativism, and hostility that has lasted for at least six months. Jacqueline asks, “So these kids just don’t follow directions?” Dr. Kagan emphasizes it's more than that. Children with this disorder can be quite vindictive and may focus on getting even with others. This is a disorder that can tax the patience and skills of almost any parent or teacher.

ODD children or teens show several or all of the following:

- frequent loss of temper
- touchy, irritable, or easily aggravated by others
- frequent debates and arguments with adults
- resentful and spiteful
- defy or refuse to comply with adults
- habitually blame others
- annoy others on purpose

Cindy immediately thinks she sees her teenage son in this description of ODD children and teens. But Dr. Kagan cautions that these behaviors have to last for at least six months; they have to be more serious than usual; and there have to be four or more of them. Also, these problems must impair the child’s success in his social functioning at home, at school, or at a job.

When Cindy describes her son’s behavior as disobeying her, going out through his window a couple of times, as well as begging and begging to go out until she’s tired, Dr. Kagan feels this could be within the normal range of adolescent behavior. When he wonders whether it impairs her son’s social life or school functioning, Cindy doesn’t really think so.

Lindsey speaks up and says her teen is in a whole different league. He’s got an authority problem. He has told his teachers, his counselor, and even the principal to “f” off. He lost his job because he couldn’t listen to the manager and finally told him to shove it. And that’s how he is at home. He never is wrong, never loses an argument. He’s always right and will not take responsibility for being wrong. He stomps off every time Lindsey says anything. This has been going on for as long as she can remember, and she’s frustrated.

Dr. Kagan states this is more likely ODD, not only because it has been going on for over six months, but because it is affecting the child’s success in his social functioning at home, at school, and at work.
Here Jacqueline asks Dr. Kagan how ODD and ADHD are related. His answer is that they're related in at least two ways. First, about half the children with ADHD also develop ODD. Second, the frustrations of having ADHD often lead kids to conclude that it is just easier to refuse to do what is requested than to feel the awful sense of failure they get when they are unable to comply.

Jacqueline says she now has a clearer understanding of these disorders. When she asks the group how many of them have (or have had) a child in their home with ADHD or ODD, most of them raise their hands.

**Jason’s Story**

In this scenario, Jerry and Kay describe the difficulties they’re having with their son Jason, who is hyperactive. He has lived with them for two years, as have his two older sisters. The birth mom, who had a drinking problem, had neglected the three children. Dr. Kagan asks whether she used alcohol a lot during her pregnancy. Jerry says they’re not sure, but they do know she had a serious drinking problem.

According to Kay, Jason is “on-the-go” constantly, at home and at school. His sisters, though, are mellow. Jerry adds they all get tired of Jason’s non-stop “Energizer Bunny” life-style. Dr. Kagan sympathizes, commenting that he knows how difficult this can be. But before he can say whether Jason has ADHD, he needs to know more. First, he needs to try to find the cause of Jason’s hyperactivity, because the right treatment depends on it. He suggests they try to uncover the cause or causes of Jason’s hyperactivity by exploring his symptoms. Jerry and Kay are eager to do this.

Dr. Kagan begins by asking whether Jason has difficulty falling or staying asleep. Does he sleep restlessly or awaken early? Kay responds that he can’t seem to go to sleep very easily. He keeps getting up and bouncing around his room, asking for water. He never wants to go to bed. It might be hours before he finally collapses. Dr. Kagan lets her know that these are symptoms of ADHD, but they are also symptoms of depression.

Next, Dr. Kagan inquires about Jason’s eating behaviors. Jerry says he eats pretty well. However, he just can’t sit still in his chair, so they let him stand up when he eats. According to Dr. Kagan, many ADHD children are too busy to sit still to eat.

Dr. Kagan’s next question for Jerry and Kay is whether Jason can be comforted when he’s upset. Does he relax in their arms, or does he stiffen up? Kay responds that Jason has never been able to sit still long enough to be held and rocked, even when he gets hurt.
Now Dr. Kagan wonders whether Jason gets violent or destructive on purpose. He says children with ADHD often break things, but it’s usually accidental. Jerry replies that Jason’s toys do have a short life span. He’s pretty rough on them, and those that don’t get broken seem to get lost.

Dr. Kagan mentions that hyperactivity is often associated with Fetal Alcohol Syndrome, and he asks whether Jason’s physician has seen any physical findings of this disorder. Kay says their doctor has never had Jason checked for this.

Finally, Dr. Kagan asks Jerry and Kay whether there’s a history of ADHD in Jason’s biological family. Jerry replies that there probably is. They know Jason’s mom is really impulsive, although his sisters seem ok…well, mellow. Dr. Kagan says the current thinking is that ADHD is almost always hereditary, so other family members often have the disorder as well.

Here Jacqueline asks Jerry and Kay a question. Didn’t they say, in some previous meeting, that Jason’s mom had poor pre-natal care and that Jason was a low birth-weight baby? Kay responds yes, and that after Jason was born, his mother was quite depressed and left the baby and the older daughters with different strangers. There were reports of neglect, and the pediatrician diagnosed failure-to-thrive. The children were in three different foster homes before Jerry and Kay’s.

Dr. Kagan describes that as good background information. Often foster children are especially vulnerable to ADHD. Lindsey seems a little surprised and asks, “so neglect can play a big role in ADHD?” Dr. Kagan says, “Absolutely. Neglect, for example, produces a lot of chaos around the infant or young child. The lack of structure can impact how the nervous system develops and how the child organizes his world.”

Insights & Steps

At this point, Jacqueline asks Dr. Kagan to pull all this information together. He sums up that, as he sees it, Jason should be assessed for ADHD, probably the combined type with all three main symptoms: problems with paying attention, hyperactivity, and impulse control.

Some factors that may account for Jason’s ADHD symptoms are include:

- Jason’s mother’s history of depression
- a lack of predictable, loving care and attention in the first 18 months of life
- possible Fetal Alcohol Syndrome
- failure to thrive
- possible inadequate nutrition that interfered with normal brain development
Jerry comments that all of this helps him understand the possible causes of Jason’s behavior, but he still wants to know where they go from here.

Here are Dr. Kagan’s suggestions and directions for parents with children like Jason, who have the combined type of ADHD:

- Pinpoint the problem by tracking the behavior in question and discovering when, where, and how often it occurs.
- Accentuate the positive. Decide what positive behaviors you want your child to learn. Reinforce those behaviors that you want to increase. Use only quick negative consequences as needed, and use them sparingly.
- Break tasks down into manageable parts that the child can reasonably finish.
- Use simple visual and verbal reminders. Go over what behavior is expected of her ahead of time, and rehearse it.
- Don’t blame or pity the child for having ADHD.
- Don’t take things personally, and keep your sense of humor.
- Learn from what you’ve tried. If one approach doesn’t work, consider another.
- Work closely with your family doctor or psychiatrist if your child is placed on medication. Doctors can be most helpful when they know the specifics of how the child is behaving and responding to medication.

Alicia’s Story

Felicia opens this scenario by sharing her concerns about the 7-year-old niece she and Jesus are raising. Alicia is finishing the second grade now, but Felicia and Jesus have been thinking about holding her back because of her bad grades. Lindsey mentions she has met Alicia, and it seems clear to her that Alicia is a very smart little girl. She can’t understand why they would be thinking of holding her back. Felicia says it’s because Alicia just doesn’t seem to like school. Her teacher thinks she’s distracted and lazy. Her teacher also thinks Alicia is really unhappy.

Dr. Kagan wonders whether Alicia is like that at home, too. Jesus replies that sometimes she’s very growly and grumpy. She doesn’t do anything. It seems like everything weighs her down. Felicia interrupts Jesus to defend Alicia, saying she tries, but it’s a real struggle for her. It’s not that she’s a bad kid.
Next Dr. Kagan wonders whether Alicia might have some learning disabilities. He asks whether Alicia had any delays in learning to speak, or whether she now has any identified learning disabilities. According to Jesus, Alicia didn’t talk much when they first got her. When she was three, she would grunt and point at things she wanted. Felicia adds she doesn’t think anyone had really helped Alicia with her speaking. And the school has never done any testing. Jesus goes on to say he thinks Alicia understands a lot more than she shows. She’s pretty quiet, but he’s seen her play with her toys and make up little stories out loud.

The next question Dr. Kagan asks Jesus and Felicia is whether Alicia shows any symptoms of depression, such as poor appetite, trouble sleeping, or low self-esteem. In reply, Felicia says Alicia does not eat much, and she's definitely more down during the week than on the weekends. Her concentration has always been a problem. Felicia doesn’t think Alicia is a very happy kid. Jesus reports that Alicia has told him she can't sleep. And sometimes he hears her playing in her room when she should be sleeping.

Insights & Steps

Having heard this information about Alicia, Dr. Kagan says it seems she may well have the attention deficit disorder called ADD, that is, ADHD without the hyperactivity. But there are other concerns here. Alicia may have learning disabilities that affect her brain’s ability to function, for example with arithmetic or spelling. This is a pretty common occurrence with ADD kids.

Jacqueline noticed Dr. Kagan touched on depression with his questions, and she wonders if that is part of ADD. Dr. Kagan answers, “yes and no,” and then he explains. ADHD by itself is not the same thing as depression. But ADHD can occur at the same time as depression. Alicia may have ADHD and may also be depressed, which can be either a medical illness or an emotional problem created by her poor functioning. There are a couple of other possibilities, too. She could have hypothyroidism, a medical condition that causes sluggishness and depressed mood. Urinary tract infections could also produce these symptoms. That's why she should have a physical examination.

By now Lindsey is feeling a little overwhelmed and wonders whether it's possible to understand all of this. Dr. Kagan acknowledges the difficulty, and he goes on to say it's important to get really clear on which ADD symptoms Alicia has. For example, does she have trouble getting and staying organized? Can she make a plan and stick to it?
Jacqueline expresses concern that so many foster, kin, and adopted children come from early environments that were very traumatic and chaotic for them. She thinks that must have an impact on how these kids think, concentrate, and learn. Dr. Kagan definitely agrees, and he cites several special matters to keep in mind with these children. Child abuse, neglect, and sexual exploitation may contribute to the ADHD/ODD problems in different ways. For example, a younger child who is hyperactive may become the family scapegoat and the target of abuse because of his hyperactivity, causing more behavior problems. Jacqueline mentions it sounds like a vicious circle. When these children are abused, they build feelings of anger that further feed their hyperactive, impulsive behavior. Dr. Kagan says “yes, sad but true.”

Children with ADHD can also be quite prone to accidents and injuries, especially in a neglectful home, and so they are especially vulnerable to physical harm. Here Jesus wonders how neglect might have worked in Alicia’s case. Dr. Kagan’s response is that early neglect can also affect how the growing brain develops. The brain develops according to the stimulation it gets from the outside world. Without a healthy, organized world to promote normal brain development, children’s thinking can be delayed and disjointed.

Following are Dr. Kagan’s suggestions for parents of children like Alicia who have ADHD with co-morbid conditions.

- Have the child assessed for ADHD and for depression. If she has both, the approach to medicating can be quite different.
- In addition, the child needs to be thoroughly evaluated for a possible learning disability.
- Keep expectations for achievement at school realistic.
- Support the child’s efforts to keep up at school but do not overdo it with nightly study hall or endless tutoring sessions.
- Work with the child on controlling pouting and exploding. Teach her to calm herself down, to locate a quiet place to simmer down, to figure out what she wants and needs, and to identify what she wants and how to negotiate for it.
- Set up realistic and well-timed rewards and consequences.
- Recognize and constantly reinforce positive activities that build self-esteem and mutual enjoyment.
Gregory’s Story

As this scenario begins, Thomas tells Dr. Kagan that his 12-year-old grandson, who lives with him and his wife Marlene, was diagnosed with ADHD at the age of 5. Dr. Kagan asks how the diagnosis was made, explaining he has a protocol which he likes to follow and would recommend. Thomas responds that the family doctor sent Gregory to a pediatrician, who tried all sorts of medications. When Dr. Kagan asks if they know what medications were given, Marlene says yes, the doctor tried Ritalin, Concerta, and Cylert. Gregory’s mom and dad said that the Ritalin and Concerta worked for a while, but they thought Gregory was actually worse on the Cylert. Marlene doesn’t think any of the meds have really worked.

Thomas recalls that, at the time Gregory was first diagnosed, his kindergarten teacher described him as “an accident waiting to happen.” Marlene thinks this was a good description. She says he could walk in the house and in five seconds be in five places at the same time, knocking over lamps, dropping books, falling, all while eating a Pop Tart.

Dr. Kagan says Gregory sounds like a real handful, and he wonders what sorts of learning problems Gregory has in school. According to Thomas, Gregory struggles with everything – reading, writing, spelling, and math.

Insights & Steps

Marlene is anxious to know whether Gregory will ever outgrow his ADHD. Dr. Kagan replies that, on the question of kids outgrowing ADHD, the answer is split. Whatever genetic abnormalities are responsible for the ADHD are “locked in” and won’t ever change. But the brain will grow and mature. The child's ability to understand and problem solve, for example, will improve over time, as will the person's willpower and ability to plan and think things through. Actually, most adults with ADHD do quite well without the help of medications.

Marlene then returns to the topic of school, which she describes as a big issue for Gregory, and she wonders what they can do. Dr. Kagan recommends they talk to his school about setting up an Individual Education Plan (IEP) for him, which involves getting him evaluated for learning problems.
Jacqueline asks Dr. Kagan if there has been any progress with medication. He responds that, in general, medications for ADHD include stimulants, some anti-depressants, and a new drug called Strattera. Jacqueline then asks him for some information about Ritalin and Dexedrine, which he describes as the two stimulants that have been used for decades to treat ADHD. Even though some people have serious concerns about safety, the FDA, child psychiatrists, and pediatricians consider these two medications safe and effective. They are usually the first-line medications for treating ADHD.

Jacqueline wonders whether there have been improvements in Ritalin and Dexedrine; Dr. Kagan says yes. They both now come in long-acting 12-hour versions. The ones with Ritalin are Concerta, Ritalin-LA, and Metadate-CD. The one containing Dexedrine is Adderall XR.

In terms of antidepressants, Wellbutrin is helpful sometimes. Also, tricyclic antidepressants like imipramine and desipramine can be useful. A new one, Strattera, was introduced in January of 2003. Its main advantage is that one dose lasts for 24 hours.

There is no magic pill yet – but at least there are some options to help. Even with a medication the doctor has tried previously, sometimes it may mean trying higher doses or combining it with other medications to get it right. The doctor makes the medication calls, but needs the parents' help to understand what is going on.

Jacqueline mentions that, as with any drugs, we know there can be problems with these. Dr. Kagan agrees and adds this note of caution: tricyclics can be useful, but they should not be given to children under 13 years of age because of certain side effects. Strattera or Wellbutrin may be more appropriate for younger children.

Thomas asks how often they should have Greg's medication reviewed. Dr. Kagan says, in general, when children are being started on a new medication, he would usually check them monthly. Once they are stable on an effective dose, he sees them every 6-12 months.

Marlene returns to the topic of school, and wonders what more they should do about that. Dr. Kagan emphasizes that, with children like Gregory, parents should remember their child has a right to an adequate education. Thomas says he understands that, but wonders what it really means. Dr. Kagan says that's a great question and goes on to explain if the child has been diagnosed with ADHD, the parents can make a written request for the special education department in their school district to evaluate him. The school district is required to evaluate the child for specific learning disabilities and to do a “functional” assessment of how ADHD affects his school performance.
Rose mentions she did that when her daughter, Pearl, was diagnosed with ADHD. She requested an evaluation from the school. The evaluation found that Pearl needed a distraction-free workplace, and the teacher provided that. Dante says he and Rose worked with the school. Now Pearl wears headphones with static to block noise, so she can concentrate.

Dr. Kagan adds that the teacher should consider using other accommodations, such as computers. The teacher should focus on teaching Pearl skills she is capable of learning and being successful using.

Lindsey contributes that, with her birth son who had a concentration problem, his teacher uses clear, short-and-sweet rules and guidelines with short-term, immediate rewards and consequences. This seems to help her son.

Dr. Kagan says everything helps. Even the teacher making a daily printed schedule for the child to follow is important.

Pearl’s Story

Dante begins this scenario by saying he’d like to talk more about his foster daughter Pearl, who was diagnosed as ADHD when she was in third grade. He and Rose worked with the school and had to watch her constantly. Now she is 16 and seriously rebellious.

When Jacqueline asks what she’s doing, Rose answers that Pearl is just a handful. And it’s gotten worse as she’s gotten older. She argues with them about everything. Dante agrees and continues that, because of her ADHD, he felt he had to be super-strict with her, much more so than with his other children. But Pearl still keeps skittering out of control, so he clamps down even more tightly. It is exhausting. At present, he sees her as less hyperactive, but the trade-off is that now she has a defiant streak. Rose agrees, and says this is exhausting for them.

Dr. Kagan begins his response by commending Dante and Rose for working together as parents facing a problem. Pearl’s symptoms sound to him like Oppositional Defiant Disorder, which has, in a sense, grown out of her ADHD. Jacqueline wonders whether that’s common. He replies it is, and it’s discouraging for parents and children. He goes on to say that many children with ADHD and learning disabilities eventually become so discouraged when failing to please parents and teachers, and when failing to meet their own goals and expectations, they do a total about-face. They refuse to try at all. They’d rather accept the punishment than
to continue trying to please and then failing. But Pearl's extreme rebellion goes well beyond the usual teen behavior.

Dr. Kagan asks whether Pearl is currently taking any medications for ADHD. Rose responds that she has a prescription for Strattera, and they set up a weekly pill bin and she checks to see if Pearl has taken it. Dr. Kagan says that's good. The most common reason medications seem to stop working is that they are not being taken. Many children with ADD simply forget to take their medications, and many with ODD actually refuse. Offering the medication with a glass of water, and nonchalantly watching her swallow it, helps make sure that it gets where it's supposed to. It's best to avoid power struggles over taking medication, but it's not always easy to do that with teenagers. Having a regular routine, however, can help.

Jacqueline asks about Pearl's friends, and comments that they can have a huge influence on an adolescent. Rose says Pearl has some pretty nice friends, and they actually seem a little put off when Pearl gets really argumentative with her. Sometimes Rose thinks Pearl's oppositional streak is mainly with adults.

**Insights & Steps**

Dante wants to know what he and Rose can do. Dr. Kagan says that, if he understands it correctly, Pearl has a dual diagnosis: ADHD and ODD. As she grew up with ADHD, she began to show signs of ODD. Over the years, Dante and Rose used more external control to compensate for her lack of internal control. And Pearl may have seen this as a challenge and tried to overcome it through further opposition and defiance.

Jacqueline asks Dr. Kagan what the next steps for Dante and Rose would be. He replies that he has several points that might help this couple. No matter what the age of the child, treating the ADHD is important to softening the symptoms of ODD. This might take a combination of medication and perhaps involvement in therapy for the child and family. As parents, Dante and Rose might want to take some parenting classes on structured behavior modification.

In terms of day-to-day living with an ODD teenager, this is tough. Dr. Kagan says his best suggestion is for parents to keep involved with their teenager, even when it seems he or she doesn't want their involvement. It is important to maintain clear guidelines but to be flexible about how to work with the child.
Cindy says she works with her teen to express needs in ways that are respectful of others. She always picks her battles. She actually tracks what issues her kids fight with her about and then decides which ones are worth the fight. She also looks for ways to negotiate with her teen, to see if she can give him at least part of what he's pressing for.

Dr. Kagan says these are all excellent suggestions, and he urges parents to remember to keep things as positive and win-win as possible. Many differences with teens can be resolved by talking them through, by negotiation where possible.

Jacqueline suggests parents learn about tracking behavior. With tracking, you can examine your “hooks” to see how you get involved in fights. And you can learn to reward any effort at cooperation.

Cindy mentions her husband Stephen took an anger management class, in which he was taught to “take space” during a confrontation. So with their teen, when things begin to get heated, her husband says he needs time to think and sets a later time to sit down and discuss the problem.

Dr. Kagan emphasizes that there are a lot of things you can and should do to take care of yourself in such a situation, such as making arrangements for respite and other releases to relax as an individual and as a couple. Another good thing to remember is not to let the problem make you ignore your other children.

He further advises parents to always keep a lookout for depression in ADHD teens. Irritability and anger may be signs of depression.

To stop the negativity problems with schoolwork, Cindy lets a tutor work with her child after school, and that really improved his grades.

Jacqueline concludes this segment of the course commenting on the great suggestions and reminding viewers they can print the handouts. She says time is running out and asks whether there are any other questions for Dr. Kagan.
General Questions and Steps

Lindsey opens this segment by asking: Is medication the only way to cure ADHD?

Dr. Kagan responds that, unfortunately, there is no “cure” for ADHD. ADHD probably involves a defective gene or set of genes working together that do not produce enough of a neurotransmitter called dopamine in certain areas of the brain. This results in inadequate communication between certain nerve cells that handle brain functions like organizing, planning, prioritizing, managing time, resisting distractions and impulses, and completing tasks. The only way to increase the amount of dopamine in the brain is by taking medications like Ritalin and Dexedrine and a few others.

Marlene asks the next question: Are medications used to treat ADHD dangerous and addictive, or do they lead to drug abuse?

Dr. Kagan says all medications have potential side effects and can be dangerous if not taken as prescribed by a physician. But the track records of Ritalin and Dexedrine over the past 50 or so years have been exemplary for safety and efficacy. These two medications do have an addictive potential if taken in larger than prescribed amounts and are therefore classified as “Schedule II” drugs.

The Food and Drug Administration closely controls their manufacture, and a written prescription is required for their use. Several studies have been conducted to see whether they could cause drug abuse in ADHD children later in life. These studies have shown that the rate of drug abuse in children who have taken stimulants for ADHD is actually lower than the rate in children who have not been treated with these medications.

Jacqueline says she’d like to ask Dr. Kagan one last favor — to please give some suggestions on what parents can do if they think their child has ADHD.
Dr. Kagan says he’d be happy to, and that he brought a handout which viewers can print, giving steps parents can follow. To briefly summarize:

- Get an accurate diagnosis.
- It is important to rule out other causes for the child’s behavior.
- Once an ADHD diagnosis is confirmed, a trial of medication is usually recommended.
- Parent skills training may help reinforce the effects of medication.
- There should always be coordination between home and school on school behavior and homework assignments.
- With ODD, it is important for parents, teachers, and others to not get involved in power struggles, and yet set clear expectations.
- Join a support group such as CHADD, which focuses on coping with children who have ADHD.
- Parents of ADHD children must be advocates for their children.
- Parents should also pay close attention to the child’s diet.
- Finally, parents may consider putting their child in therapy and getting involved with family therapy as well.

Jacqueline thanks Dr. Kagan for joining in on the parent support group and for being so supportive. She ends the course by reminding viewers to print the course handouts.