ADHD news

ADD Information Services (ADDISS) Registered Charity No 1070827

SPRING 2002

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Future directions in ADHD: understanding ADHD in girls and women

Patricia O. Quinn, M.D. and Kathleen G. Nadeau, Ph.D.

Many new projects are afoot to promote better understanding of the needs of girls and women with AD/HD. This month, two exciting companion volumes to Understanding Girls with AD/HD have been released: a clinical guide, Gender Issues and AD/HD: Research, Diagnosis, & Treatment, edited by Patricia Quinn and Kathleen Nadeau, and a practical guide, Understanding Women with AD/HD, edited by Kathleen Nadeau and Patricia Quinn. We have also established the National Centre for Gender Issues and AD/HD, a non-profit organisation dedicated to increasing knowledge and public awareness of the unique issues faced by girls and women with AD/HD. The Centre can be reached at www.ncgiadd.org

Women's medicine is an exciting field that has rapidly gained recognition by highlighting the ways in which women are impacted differently by a variety of health concerns. But even in this dynamic, gender-focused field, the issue of AD/HD in girls and women has received only minimal attention. Although Dr. Joseph Biederman and others have proclaimed this lack of recognition of AD/HD in females a significant public health concern, their message has not been heard by the larger community of health care providers. Research on AD/HD in females is sorely lacking. AD/HD is the most highly researched childhood disorder, but of the several thousand published studies on AD/HD fewer than 50 have focused on females.

The assumption that AD/HD was a disorder of childhood has largely been swept aside as recognition of AD/HD in adults has grown in the past decade. It is now time to challenge another central assumption – that AD/HD is a disorder that primarily affects males. Recent studies of adults have found nearly equal numbers of males and females. These findings imply that either many girls with AD/HD have gone unnoticed, or that AD/HD in females has a different course. Some research suggests that AD/HD in females may become much stronger in puberty and beyond.

Early Interest in Gender Issues

The first clear sign that gender issues in AD/HD were being considered was the "Conference on Sex Differences in AD/HD," held at NIMH in 1994. The conference closed with a long list of proposed research directions were recommended including: exploration of how AD/HD is manifested and experienced in girls and women, research to assess whether the expression of the disorder, its course, and its prognosis differ for females, research on issues unique to females, such as the impact of hormonal fluctuations, and the challenges of motherhood for women with AD/HD. Sadly, in the intervening seven years, very little research in these areas has taken place.

Now, nearly eight years after the NIMH conference on sex differences, we propose another list of critical areas for research. Since many women have been diagnosed in the intervening years, and since clinical interest in gender issues has grown, perhaps now there will be adequate impetus to encourage the initiation of long-needed research.

i) Issues Related to Gender Appropriate Diagnostic Criteria

Perhaps the most critical need is for more gender-appropriate diagnostic criteria and diagnostic tools. Without more gender appropriate diagnostic criteria, females included in studies will be those who most closely resemble males with AD/HD, rather than being representative of their gender as a whole. Barkley has proposed a fresh look at adult patterns, suggesting that AD/HD in adults is different than, not "less-than" AD/HD in children. We propose a similar reassessment of female patterns, proposing that AD/HD in females may be different than, not less than AD/HD patterns in males.

1. Differences in age of onset

There is growing evidence that symptoms of AD/HD in girls, particularly girls with predominantly inattentive type AD/HD, aren't always evident until puberty. Continuing to require evidence of AD/HD before age seven, or in the early elementary school years means that many girls and women with AD/HD will not receive a diagnosis.

2. Differences in the life course of AD/HD

The course of the disorder for women, throughout their lifespan, has yet to be studied, but clinical evidence suggests that the strong interaction between estrogen levels and AD/HD symptomatology in women would lead to gender specific patterns throughout adult life stages.

3. Gender differences in AD/HD Behaviours

Gender differences in behaviour associated with AD/HD are most readily observable, and have become well established. Many studies report that girls are less hyperactive and demonstrate fewer impulsive behaviours. Behaviour patterns associated with girls with AD/HD might more appropriately include: shyness and social isolation or, conversely, hyper-talkativeness, slow

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Future directions in ADHD...(cont from page 1)

production of classroom work, emotional hyper-reactivity, poor handwriting, test anxiety (related to need for approval), or unusual messiness or forgetfulness.

ii) Gender sensitive approaches to treating girls and women with AD/HD

Not only do we need to do a better job in diagnosis, but we also need to custom tailor our treatment approaches to meet the differing needs of girls and women. What follows is a partial list of gender differences with important implications for all aspects of treatment – with medication, in psychotherapy, and in the classroom.

1. Different motivating factors for girls with AD/HD

Recent research suggests that children with inattentive type AD/HD are strongly motivated to seek approval, in contrast to children with more hyperactive/impulsive patterns. Such findings are very important in designing treatment programs or classroom interventions for girls, the majority of whom fall into this inattentive subtype.

2. Social rejection

Some research suggests that peer problems are more troublesome for girls, but treatment programs to address their problems in social relationships have been slow to develop. There is growing evidence that experiences of social rejection are among the most damaging aspects of AD/HD for girls. Support groups, social skills training, strategic seat assignment, and increased teacher awareness could be very helpful for these girls.

3. Trauma and anxiety in the classroom for girls with AD/HD

Recent research has documented that for many girls with AD/HD the classroom experience is anxiety provoking, even traumatising. Teachers need to make the classroom feel more safe and supportive for girls with AD/HD, whose needs are now typically ignored while teachers struggle to maintain behaviour control of boys with AD/HD.

4. The impact of female hormones on AD/HD in girls and women

The interrelationship of female hormones and AD/HD symptoms in females suggests that different treatment regimens should be considered that may involve the use of hormone replacement, as well as psychostimulants. Studies of the effects of the interactions of estrogen and AD/HD symptomatology in females are needed.

5. The challenges of motherhood for women with AD/HD

Another area of research specific to women is the challenge of being a mother with AD/HD. The little research that exists suggests that these women with AD/HD are more likely to put their children at risk in a variety of ways. Most parenting books and parenting programs for children with AD/HD don't take the likelihood of a mother's AD/HD into account. Research in this area is badly needed, for the sake of both mothers with AD/HD and their children.

6. Greater risk for cigarette smoking

The relationship between AD/HD and substance abuse is also a critical issue for females. Biederman and his colleagues (1999) reported that girls with AD/HD are at even higher risk than boys with AD/HD to become substance abusers. Girls with AD/HD are also more likely to take up cigarette smoking and at a younger age, compared to boys with AD/HD. Research is needed on the relationship between AD/HD and substance abuse, exploring whether patterns of abuse vary according to gender.

7. Obesity and problem eating patterns

Obesity, although clearly recognised as a significant public health problem in the U.S., has not been considered in connection to AD/HD in women. One initial study suggests that AD/HD may be a factor among women who are most unsuccessful in achieving weight loss using traditional methods. Research is badly needed to explore whether women with AD/HD and patterns of compulsive overeating need different treatment approaches that address their obesity and AD/HD in tandem.

Hope for the future

AD/HD is a very treatable disorder, but first the diagnosis must be made. Many women with AD/HD remain undiagnosed because the many of the current diagnostic criteria are not appropriate for girls and women. It is of the utmost importance that this stumbling block be removed. Beyond the diagnosis, treatment approaches focused on the unique concerns of women must be developed. Only when these two critical issues have been addressed will women with AD/HD gain the possibility of leading full and satisfying lives.

Mothers of children with AD/HD have long been a major force behind the development of accommodations and supports for their children with AD/HD. It is time that women bring this same energy and effort to increase recognition of AD/HD in females, demanding that health care providers and educational institutions turn their attention to girls and women with AD/HD, helping them to feel and function at their best.

(This article is an adaptation of the closing chapter of Understanding Women with AD/HD, edited by Kathleen Nadeau and Patricia Quinn and first appeared in ADDvance Magazine, February/March, 2002.)

Support Group News

The Sussex ADHD Support Group

Patrons: Dr Geoff Kewley
Dianne Zaccheo
Dr. Philip Marriott
Reg. Charity No. 1072241

The Group was formed in 1993 with official membership commencing in 1995. What started as a small group of concerned mothers meeting round someone's kitchen table has grown to a membership of well over 100 families and interested professionals.

Our aims are; to provide support to families, raise awareness in the community and encourage an informed framework of professional assessment and management.

We try to do this by a helpline which has a voice mail with information how to get information and a contact number to speak to someone. We have done it this way so the contact can be changed as the calls can be very intense and time consuming. The different areas have co-ordinators who hold regular meetings and offer telephone advice as well to their local members.

There is also a separate phone contact, in Hastings, specifically for teenagers and adults which is becoming more and more

Little Devils A.D.H.D Family Support Group Norwich

We started off as a small group in a doctor's surgery in September 2000 and we were called A.D.H.D and associated disorders support group Norwich. We used to meet every Friday morning between 9.30-11.30. We were in a little room at the back of the West Earlham doctor's surgery which was a bit cramp with all the children in there, but we coped with it.

Joanne Allen who is the chairperson of the group who herself has got 2 children with ADHD started the group in September to help other parents and children with this disorder as there were a lot of children in the Norwich area with ADHD and other associated disorders and there was no support for them.

I started going to the group as a parent of 2 children with ADHD, my name is Alison McCartney, Joanne asked me if I would like to help in the group and now I am the treasurer of the support group and I really enjoy it and like helping other parents. Janice Whitworth who is the secretary of the group takes the minutes every week. She has also got a child with this disorder.

We moved from the doctor's surgery to Cadge Road community centre north Earlham Norwich and we named ourselves Little Devils ADHD family support group and we meet every Wednesday now between 10am-1.30pm .We provide a free crèche for the younger children so the parents can relax and chat to other parents have a coffee and talk about their problems they have had and hope to get some tips from other parent to help them with their children. We have other organisation come to the support group to talk to other parents as well. In the summer the centre closes for 2 weeks and in those weeks we take them out on a trip somewhere. Last August we took them to Chessington Park. We also took them to Pleasurewood Hill in the first year we were running the group and early last year on the 6th May we took them to Suffolk wildlife park, which the children and the parent really enjoyed.

We received a grant from the children fund of £7,000 which has helped the group go further and has helped the children and the parents that come to the group. We are hoping to get a website up and going soon and we should have our charitable number soon too. We also received a grant of £1,000 from New Deal in Norwich to help us set up a library in the group so parents can borrow books and videos to read and see and this is going well thanks to the grant we received. Donna Dyke who is an adult that comes to the group has got ADD herself and does the library every week and really enjoys doing it and likes to get involved in the group .

We have applied for 2 laptop computers from the acorn trust for the group to help them in the skills of computers and if any of the parents want to take it further in computers they can do so.

We do fundraising throughout the year like raffles. We also do fetes and cooking at Cadge Road Community Centre North Earlham, Norwich on a Friday morning at the advice drop in centre .

We provide help and support to parents and children with ADHD and other disorders and information is available. If anybody needs any information on these disorders please contact:

Joanne on 01603 503970 or Alison on 01603 748898.

needed, as where in the past it were the children and their parents/carers who needed the support, now more and more adults are in need and provision is poor.

The co-ordinators also have a bookbox with books and videos and other titles can be requested as different areas have some basic information the same but differ in other book/tape selection.

The newsletter which is published quarterly provides members with up to date articles, directions on where to find out more in the internet etc. book reviews and a calendar of events.

These events can be national but we also organise local speakers. In the past year we have had Lisa Blakemore Brown, Noel Swanson and Robert Doyle, to name some. Dr Geoff Kewley who is one of our patrons also does regular lectures.

Factsheets with information and advice on the different aspects of ADHD are available and sent as a package to every new member.

Representation at Special Educational Needs Forums and various other committees gives the opportunity to raise awareness and exchange of information.

At present our membership is still very constant but it is very hard to recruit new committee members as I gather is a problem for many groups, but we hope that this will be resolved as it is still a very worthy cause to work for.

The committee has decided that when the opportunity arises it will affiliate with ADDISS, thereby still keeping the independence but gaining support on a wider scale. Representation at initial meetings has already taken place. Looking at what is happening at national level this appears by far the better option.

Brigit Solomon, chair.

Report on the Adult ADHD Conference

9th November, London - Judith Guest

On November 9th I joined a friendly group from the Hastings ADHD Support Group and travelled up to Kensington Town Hall in London for the ADHD in Adult Life Conference. All these Mums have children with ADHD and were looking to the future and wanting to know what will happen and what services are available for Adults with this disorder.

After a brief introduction from Andrea Bilbow of ADDISS, Professor Eric Taylor of the Institute of Psychiatry at King's College London gave us a deep and learned discourse on ADHD. He also told us about an ongoing research project that he heads in East London. This 20 year Project began by identifying and interviewing a large number of children with ADHD, Oppositional Defiant Disorder and also a control group at the age of seven. These have just been re-interviewed at the age of seventeen and will be followed up again when they are adult. But it already shows that those with the combined disorders are at higher risk of developing problems. It is the largest and longest ongoing study into ADHD in the UK and I found it exciting that at last someone was doing something. Prof Taylor stated that interventions and treatments in children are now getting good results but in adults there is still high rates of underachievement, crime, accidents including car crashes, stress, medication becoming non effective and substance abuse.

Dr Nikos Myttas from Finchley Memorial Hospital followed with a discussion about problems in diagnosis. He asks four core questions before making an Adult diagnosis of ADHD. These are:

1. Was there a childhood onset?
2. Is impairment substantial and persistent?
3. Is there an alternative explanation?
4. Are there co-morbid conditions?

He stated that of the 3 to 5% of children with ADHD 50 to 80% will continue to have problems into adulthood which is the equivalent of a 2 to 3% prevalence in the population. Adult ADHD affects all IQ ranges and socio-economic groups. Co-morbid Disorders can be: Unipolar Affective Disorder, Bipolar Affective Disorder, Psychoactive Substance Use Disorder, Alcohol Abuse, Anti Social Personality Disorder and Borderline Personality Disorder to name but a few. The route a child can take begins with untreated ADHD which becomes an Anxiety Disorder, which in turn develops into Conduct Disorder then a Mood Disorder and a Substance Abuse Disorder. Adults diagnosed retrospectively have the demographic, psychosocial, psychiatric and cognitive features of children with ADHD. They will also respond to the same medications as used to treat children such as Tricyclics and Stimulants. He says that worries about treating children with stimulant medication will predispose them to try Cocaine later in life are unfounded. Many adults with ADHD will smoke Marijuana instead of Cocaine because it helps to calm them.

Sixteen percent of depressed adults have a history of ADHD and 25% of ADHD adults will suffer from Depression, Anxiety and Mood Disorders. A very interesting and factual account of the problems facing ADHD adults but no solutions!

Zara Harris an Occupational Therapist was next at the podium. She covered a range of strategies which are said to have worked for ADHD adults; such as Time Management i.e. Use a diary, plan to arrive early, resist impulses! All of what she said was excellent theory and may very well work with some ADHD adults but not the ones I know unless delivered in an intensive, closely followed programme on a one to one basis. Who pays, who copes? She described some of the Social Problems adults with ADHD suffer from and they included; Difficulties in making/keeping friends, Marital Problems, Impulsive comments, Quick to anger, Verbally abusive, Poor follow through, Self centred and immature, No empathy and Poor listening skills. Coping Strategies offered were; Medication, Education of self and others, Psychotherapy/Group Therapy, Counselling, Coaching, Self Help Groups, Websites, Internet Groups, Vocational Guidance. The majority of these will have a cost implication and in my opinion if the adult has the above mentioned Social Problems they would in the main be unable to afford the therapies they need! A heartrending tale from the parent of an ADHD son followed.

After lunch, where we had the opportunity to network and buy books and videos (mostly American still), Dianne Zaccheo who is a Family Therapist and Medical Social Worker with the Coaching Centre introduced the Current Trends in Behavioural Treatments. Much of what Dianne stated was for me just repetitious of what previous speakers had said as in; there is ongoing research, ADHD has a devastating effect of the sufferer and their family, recent studies indicate a need for more research and discussions on ADHD development, and the Clinicians role in treatment.

Then Dr Robert Lloyd Doyle Director of the ADHD Clinic at Massachusetts General Hospital began his talk. He explained how Ritalin works and then went on to discuss various types of medication available to help with adult ADHD. These included Aricept as used in treating Alzheimer's Disease, Adderall, Concerta, Metadate, Pemoline, Dexedrine, Biphetamine, Methamphetamine, Tricyclic Antidepressants, Desimipramine, Buproprion or Zyban, Monoamine Oxidase Inhibitors, Venlafaxine, Modafinil, a patch form of Ritalin and a Tomoxetine Study. Dr Doyle very obviously knows his stuff well and described all these medications in great detail! The surprise one for me was Zyban which is the newly licensed anti smoking drug which has the side effect of treating ADHD symptoms

in adults. I liked Robert Doyle's information enough to attend his lecture in Eastbourne the following day when he stated that the hardest symptom of all to treat in adult ADHD was the inability to organise oneself. He does believe that Co-Morbid Disorders should be treated first before attempting to treat ADHD symptoms except with substance abuse when treating the ADHD will often reduce the substance abuse. I also asked him about the now fairly common UK habit of giving dual diagnoses of ADHD and Asperger's Syndrome. He says that in the USA Psychiatrists are asked to specify one Disorder as the main one and then add that symptoms of the second disorder are also present.

My overall impression of the day was that many well-connected people have now awoken to the fact that ADHD persists into adulthood and some efforts are now being made to address the problems faced by some of these adults. My opinion is that a high percentage of ADHD adults will end up in the penal system and that is where more research and therapeutic intervention should be targeted. Currently prisons are not allowed to dispense Ritalin to ADHD prisoners, ADHD adults who find it difficult to co-operate with Probation or Community Service Orders because of their lack of management ability end up in prison instead. There are currently no statistics about how many people in prison have or could potentially have an adult ADHD diagnosis. My belief is that it could be as high as 25%. Surely this is the best place to use therapeutic interventions, retraining techniques, life skills coaching along with appropriate medication and then offer sensible support with reintegration into society? For me this Conference left me with more questions than answers. Judith Guest ADHD Adult & Adolescent Support Network Hastings.

Treatment Update

Until February this year the only stimulant medications available for the treatment of ADHD were short acting preparations.

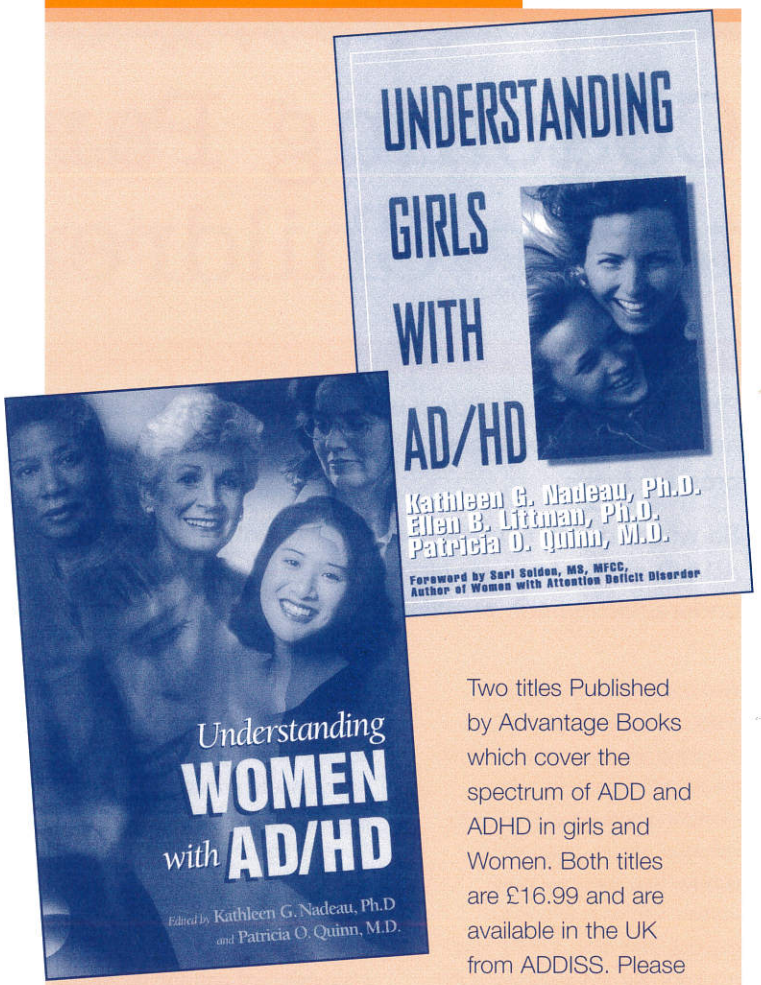
Concerta® XL , an extended release formulation of methylphenidate which lasts approximately 12 hours was given its license in February this year. Concerta® XL is available in 18mg and 36 mg tablets. There are plans afoot to introduce a 54mg tablet and a 27mg tablet at some later stage. Concerta® XL is distributed in Europe through Janssen-Cilag Ltd. More details about Concerta® XL can be found on www.concerta.net.

Celltech Pharmaceuticals Ltd also have an extended release tablet waiting for a license in the UK.

Celltech launched Metadate CD™ in the USA earlier this year but it has yet to gain a license here. Metadate CD™ is a modified release form of methylphenidate with a length of action that eliminates the mid-day dose. If it gains license approval here it is likely to be known as Equasym XL™ and be an addition to the instant release 5mg, 10mg and 20mg Equasym™ tablets already established.

Eli Lilly and Company are still running trials both in Europe and in the USA for a nonstimulant product to treat ADHD. The new drug works by increasing levels of norepinephrine. This brain chemical is believed to regulate pathways in paying attention and controlling impulses. The product, Atomoxetine is awaiting FDA approval in the USA but it will be some time before it is available in the UK.

Book Review



Two titles Published by Advantage Books which cover the spectrum of ADD and ADHD in girls and Women. Both titles are £16.99 and are available in the UK from ADDISS. Please ask for the ADDISS Catalogue.
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Coaching Parents to Help their Children with AD/HD

By Dianne Zaccheo MSW

Parents who have children with AD/HD seem to derive very little joy from traditional helping service agencies, especially when AD/HD is not recognised as the main problem focus.

So where do parents turn when they are desperately trying to get some help for their AD/HD child who is struggling with the devastating effects of chronic academic underachievement, social rejection, low self-esteem, and family disharmony?

Well not surprisingly the very practical methods used in coaching are now being used for the AD/HD population with increasing popularity. An AD/HD individual can be coached to achieve their personal best, parents can be coached to manage their difficult child, and teachers can use coaching in the classroom with challenging pupils to achieve much better results.

Having acted more like a coach than a therapist myself for many years, I would add that the good news is: progress can be seen in a very short span of time, which in AD/HD is absolutely essential. A good coach will help you to identify areas of personal growth and change, develop a step-by-step action plan to achieve those goals, and motivate you along the way towards your success.

What follows is an example of how I am using coaching as a therapeutic intervention with a mother who is struggling to address her 16-year-old son's oppositional behaviours, current suspension and impending failure at school.

Mrs B was a very well read parent who had already taken her son to many professionals with little or no improvement in his behaviour. Josh had recently begun to lie about everything: homework, his whereabouts, and money. He seemed to be on a fast track towards becoming very oppositional with teachers, other pupils, his parents, and his little sister. Mrs B said Josh was chronically agitated and aggressive and that the medication, which was once working well, had become less effective these days.

Mrs B said Josh had agreed to speak with me and I agreed to travel to their home. Josh was sitting at the kitchen table when arrived; he had just eaten his breakfast at 2 pm in the afternoon. When I sat down Josh politely cleared a space for me and told me he wasn't in school today because he wasn't feeling well. Mrs B looked at Josh and said, "don't be ridiculous I've already told Dianne you were suspended".

When his mother left the room, Josh told me that he hated school and he hated having to take medication. He admitted that he often threw the tablets away when his mother wasn't watching. He blamed the medication for having no friends. He said other kids looked at him as if there was something wrong with him, and he just could not bear this public embarrassment any longer. He did admit that the medication had actually helped him to concentrate and finish his work... when he took it.

I asked Josh to tell me about his diagnosis and he said that all he could remember was when he was first diagnosed, he would often hear his parents disagreeing about whether or not he should have to take the tablets, This unresolved question, and the constant teasing from friends and his sister, about being a "nutter" left Josh with the idea that he had to make a choice between being controlled by medication and ridiculed by others, or taking control of the problem himself.

Unfortunately, Josh's Mom and Dad split up shortly after his diagnosis (something Josh may blame himself for) and now he sees very little of his Dad. Mrs B said that Josh's dad seems to think that Josh is just "messing about because he can" Apparently Mr B doesn't really think Josh has AD/HD, and Josh says he never discusses AD/HD with his Dad because "he just gets really angry"

Josh has a tendency to remember and get stuck on certain negative ideas. He suspects that most people want him to disappear, or just go away, and in his own words: "stop being such a bother to everyone."

Interestingly enough, Josh could not tell me what AD/HD actually meant, or why he needed to take medication, so I began my work by explaining AD/HD to him in a very accurate yet simple language that explained the condition and its positive and negative characteristics. After a short while Josh had become a bit restless with a possible few tears in his eyes, when he blurted out a question, "Are you saying that I don't really have anything wrong with my brain?" In many ways, yes, I said. You have a very fast acting brain and you **can** learn how to get the most of it, and keep your performance at it's best.

Josh's mother came back into the room with most of his school records for me to review. I looked at Josh and asked him for his permission to read his school reports. Josh just laughed and said, "it's all a pack of lies anyway. No one in that school cares if I live or die." Mrs B said, "That's not true Josh, some of your teachers like you very much. Mr Dean your PE teacher said you had real talent for swimming and he offered to coach you after school hours." "Most of Josh's teachers are just so upset at how little he seems to care about himself and his work." Mrs B continued "it's a shame really, his grades and his performance have dropped so low, he had actually made some improvements on the tablets at the

start, but his behaviour towards others has not improved which is why he was suspended. He has such a chip on his shoulder"
I looked at Josh and asked him if he wanted my help to try to make a go of things at school again and he said "yes". OK then, I took out a large piece of paper drew a line down the middle and said OK, let's write down what you did in the past that seemed to worked, and then we'll write down on the other side what you did that didn't work. Josh was very brave, or perhaps a bit impulsive, when he blurted out "what didn't work was throwing all those tablets away".

Mrs B was quite visibly upset by learning that Josh had thrown his tablets away but I turned to her and asked her very calmly to repeat mentally the following words for the rest of this exercise: "that was then and this is now" she smiled and continued to brace herself throughout our meeting.

I asked Mrs B and Josh to make a list in their own words of how they saw the problem and I made a list as well.

When the list was completed I asked them to pick 4 items that we could plan some action steps around.

Our short list became:

Josh refuses to listen and follow instructions.
He doesn't swim, has no friends and spends too much time on the computer.
Josh doesn't tell the truth and he blames everyone but himself.
Josh's sister is constantly upset by Josh's poor treatment of her.
Josh does not seem motivated do well in school and he appears insensitive to the consequences of his actions.

Josh said he was tired of always being in trouble and wanted to change.
Josh wanted people to stop checking up on him, getting him into trouble, and not believing a word he says.
Josh wanted to get on with school and get teachers off his back.
Josh wanted to earn some money and possibly get a job.

I wrote: Josh is a very talented young man with great potential, but he just doesn't believe in himself at the moment.

Our action plan started off with putting the following in place:

I asked Mrs B to schedule a meeting at the school which would include Josh, his parents, myself, special education teachers and the school head. Our agenda was to find out how we and the special ed teacher, could support Josh to catch up on missed assignments and maintain 'good enough' behaviour at school. This turned out to be a very positive start, and Josh felt encouraged by the fact that people seemed to listen and care very much about how he feels and truly did want the best for him. When the meeting finished, we all felt that Josh had a real good chance of making this new plan work, and that we could act as a strong team for him.

Josh and I would create a daily schedule for him to follow. Josh will buy an alarm clock. I will ring Josh at 8 am on Monday, Wednesday, and Friday to Discuss the events planned for that day, and to remind him to take his medication.

Parents would re-institute a weekly allowance with fines allotted for certain behaviours like bothering sister, swearing, and not completing daily tasks.

New rules will be set in place for example: every time Josh really bothers his sister, she will be paid £1.00 out of Josh's allowance-on the spot.

Josh could earn money on weekends working with his dad in the garage.

We would set up a regular training programme for Josh with his PE teacher Mr Dean, who was delighted to offer Josh some coaching in swimming.

Josh and I will meet once a month for a 'blow-out session' where Josh can use this time to express how difficult all of these changes are for him, and how he currently rates his own success.

Mrs B will attend a support group for AD/HD parents and we will talk once a week over the phone.

I will communicate with Josh's doctor and teachers regularly and whenever necessary, and will feed back any problems to the team as needed.

Josh will attend a homework club on Mondays and Thursdays to get his assignments finished and keep himself organised.

Once we will meet as a family team once per month to discuss how everyone is experiencing our progress, and ask for ideas or opinions about further improvements.

All of our work will be written done on our coach forms and stored in a safe folder available for viewing upon request. The family will have their own copy.

So what happened?

In a few months time Josh had less problems at school. His teachers stated they were much happier with his overall performance and his behaviour.
Mr Dean was pleased with Josh's progress and recommended he join the swimming team, which made Josh very happy.
Josh's bullying of his sister came to a complete stop. Josh said his sister was too expensive to tease.

Gradually Josh took on more responsibility for the effect his behaviour had on others. Josh's spent more time with his dad and they both seemed to enjoy working on cars together. Josh's sister felt listened to and much more protected by her parents.
Mrs B was able to spend more quality time with her daughter and they actually had fun together as a family again.

Josh's life was on a tight schedule, but he seemed to thrive on it.
He really seemed to enjoy finishing his work on time, and getting better grades. He also became interested in making new friends and eventually met a very nice young girl from the swimming team who thought that Josh had a great sense of humour.

Josh was certainly on a roll, and we ended our coaching work on a very positive note just as the summer holidays approached.
Mrs B said she might call in September, but then maybe not.

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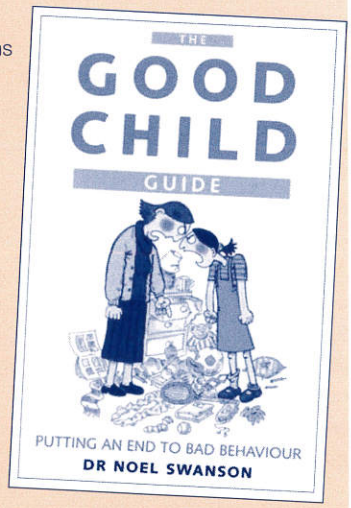
ADHD news

Book Review

The Good Child Guide

by Dr Noel Swanson

The Good Child Guide is a complete parental guide to dealing with children and their various behaviours.



In chapter one Dr Swanson explains why certain behaviours occur.

Chapter two shows parents how to put themselves back in charge using simple and practical strategies.

In chapter three Dr Swanson examines and illustrates how to stop common inappropriate behaviours such as lying and stealing.

Chapter 4 explains how to star good behaviour. The strategies are practical and user friendly ranging from "1-2-3 Magic" to contracts and payments; these are suitable for a variety of age groups.

Specific Problem Behaviours is the title of chapter five, with guidelines on how to analyse and deal with such behaviours as reluctance to do home work, boredom and school refusal.

The final chapter contains advice on how to sum up the way things are and to assess whether programmes have been effective - or whether the same old behaviours have returned to become the norm again. There are also suggestions for rewards, treats and templates to involve the whole family.

Altogether a book that has a refreshingly light touch, is easy to read with lots of practical tips and explanations. Well worth reading.

ISBN 1-85410-704-6 - £7.99 (Available from ADDISS)

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