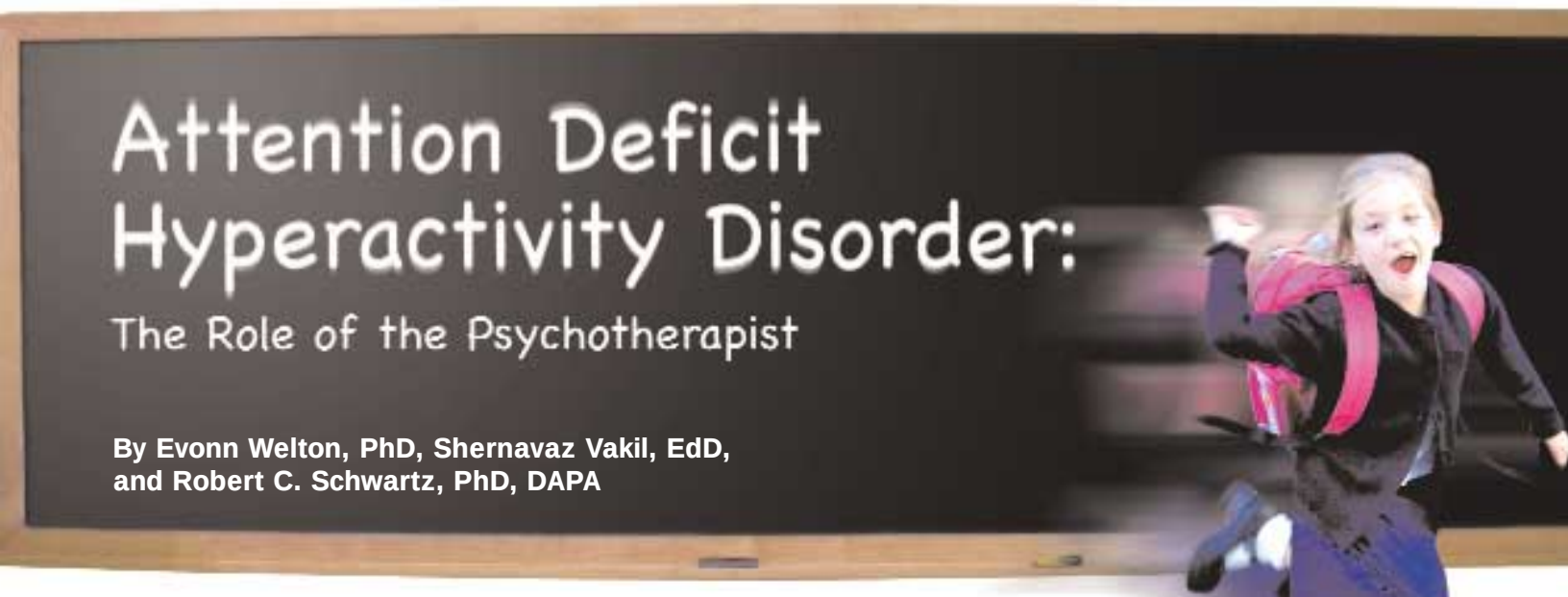
Key words: attention deficit hyperactivity disorder, ADHD, assessment, interventions, psychotherapy

Attention Deficit Hyperactivity Disorder:

The Role of the Psychotherapist



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Abstract

The purpose of this article is to provide psychotherapists with information about effective intervention strategies for children with attention deficit hyperactivity disorder (ADHD). This article provides psychotherapists with information that will facilitate accurate assessment strategies, general interventions, and methods for determining their effectiveness. Collaboration across all disciplines and with parents is emphasized.

Attention deficit hyperactivity disorder (ADHD) is a disorder that leads to a great deal of concern among parents, educators, and psychotherapists. Recent international prevalence studies reveal that 3% to 6% of children manifest ADHD (Tannock, 1998). This indicates that there is a high probability that in the future psychotherapists will be collaborating with families and educators in a search for effective intervention strategies. In order to provide comprehensive intervention services, psychotherapists must be aware of accurate diagnoses, comorbid conditions, and effective treatment strategies.

Assessment Procedures

The first step in effective intervention is obtaining an accurate diagnosis. The actual diagnosis is determined by the psychotherapist; however, individuals who are closely involved in the child's life are integral in the determination of that diagnosis. While specific intervention strategies are linked to the needs of the individual child rather than his or her diagnosis, the diagnosis can provide a starting point for understanding the child's difficulties. Accurate and comprehensive assessment is critical for obtaining an accurate diagnosis.

Referrals for assessment generally result from parents' observations of elevated levels of activity and/or teachers' reports of decreased concentration, increased distractibility, difficulty remaining seated, and difficulty conforming to classroom expectations. Parent-initiated referrals often occur in early childhood and are usually in response to an excessively active and often difficult-to-control toddler (Campbell, 1990). While obtaining a valid diagnosis is difficult in young children, evidence exists showing that children later diagnosed with ADHD have a history of difficulties beginning in the infancy and/or toddler stages of development (Teeter, 1998). These problems may be first identified in the home setting, but may also be identified through day care or preschool teacher reports. At this point, the psychotherapist must consider several factors.

Using the parents and others familiar with the child as collateral sources of information, it must be determined if the problem is chronic or acute. Examining patterns of behavior across settings and individuals is also important. Observations and checklists may assist with determining whether the child's difficulty with activity levels or impulsivity is actually beyond the range that one would expect of a typical toddler or preschooler. It is possible that the parent may be unfamil-

iar with the often difficult, yet typical, behavior that young children demonstrate. It is also possible that the parents are experiencing personal stress, which may result in inconsistent parenting, daily routines, or disciplinary procedures. Therefore, the child may be reacting to stress within the home, abuse, or excessive hours in a day care setting.

Although an accurate diagnosis can be made solely through the careful collection of information about specific behaviors, psychometric evaluation and psychological testing can aid in identifying whether the problem is actually ADHD or some other developmental disability. It may also reveal whether an additional comorbid diagnosis exists. For example, research has shown that several distinct mental disorders often co-occur with ADHD. Many clients manifest substance-related disorders (Wilens, Spencer, & Biederman, 2000) and/or mood disorders (Spencer, Wilens, Biederman, Wozniak, & Harding-Crawford, 2000) concurrent with ADHD. Brown (2000) provides an updated account of these comorbid conditions.

A child with a cognitive or language disability may present as inattentive or noncompliant when the child is actually behaving within the range expected for his or her ability. Autism spectrum disorders may also present as overactive and inattentive behaviors in addition to the characteristic social (e.g., limited eye contact, inappropriate play) and language characteristics (limited or unusual expressive language such as echolalia, the often pathological repetition of what others say) found in this disability (Pliska, Carlson, & Swanson, 1999). Lastly, childhood depression may be manifested as irritability and difficulty with attention (Welton & Vakil, in press). According to the DSM-IV-TR (American Psychiatric Association, 2000), ADHD must be differentiated from age-appropriate behaviors in highly active children (e.g., being noisy in school). ADHD should also be differentiated from rigid resistance to, or purposeful non-compliance with, work or school tasks found in children with oppositional defiant disorder (ODD). Finally, symptoms of ADHD must be distinguished from repetitive motor behaviors found in stereotypic movement disorder (SMD) (p. 91). Psychotherapists should note that although ADHD is most often identified during childhood (American Psychiatric Association, 2000), symptoms may perpetuate into adolescence or even adulthood.

Referral of the school-age child from the educational setting likewise warrants careful investigation regarding alternative etiological factors and possible comorbid conditions. Problems that may appear as attention difficulties may be as simple as difficulty with visual or hearing acuity. A child who cannot hear the teacher due to a hearing impairment may appear inattentive. Mild mental retardation or learning disabilities may also result in secondary attention problems due to difficulty with curriculum materials. It is also possible that ADHD coexists with mental retardation or learning disabilities (Pliszka, Carlson, & Swanson, 1999). Medical rule-outs, such as absence of seizures or metabolic problems, should also be considered. This is especially true if the referral includes a concern regarding "daydreaming," as seizures are easily mistaken for staring dreamily off into space. Tourette's syndrome or problems with substance abuse may also result in difficulty with concentration.

It is possible that in a small number of cases, the parent is referring the child for secondary gain. For example, it is possible that the parent is attempting to gain monetary benefit in the form of social security or disability income, or attempting to gain a prescription for a controlled substance that can be resold for street value. Likewise, teachers may refer children in an effort to obtain a "quick and easy" method of controlling behavior rather than undertaking the more challenging task of committing to behavioral interventions. These possibilities can be ruled out by a careful and thorough assessment investigating all dimensions of the child, as well as obtaining information from multiple sources.

Whether the referral is in early childhood or in a school-aged child, obtaining a comprehensive evaluation is essential for effective intervention. This evaluation will reveal possible alternative or coexisting conditions and prevent the implementation of strategies designed to address nonexistent problems. It will also decrease the probability of adding to the frustration of the child, parents, and teachers.

Treatment Strategies

Providing accurate information. Once an accurate diagnosis has been obtained, a collaborative and interdisciplinary approach to treatment may be provided. Parent training, behavior management techniques that reward positive behavior, and specific educational interventions must be designed to assist children with ADHD so they can better adapt to the home and school environments.

The first step in this model is for psychotherapists to provide a careful and clear explanation of the implications of the disorder to parents and teachers. Parents and educators should understand that ADHD is characterized by behavior that typically includes difficulty following instructions or playing with others, and interrupting conversations or intruding on other people's personal space. These frustrating behaviors are not necessarily the result of the child choosing to be "bad and lazy." Studies indicate that children

with ADHD are vulnerable to failure in school (grade retention, dropping out of school) and have difficulties adjusting socially and emotionally (Smith, 2001). Therefore, parents and teachers should be encouraged to increase empathy for the cognitive processing and behavioral difficulties that children with attention problems encounter. It can be beneficial to carefully explain that the child with ADHD is not simply being noncompliant or oppositional, and truly cannot remember directions or sequences. Increasing empathy can be accomplished by describing the feeling of ADHD as that of drinking seven cups of coffee and then sitting down to complete one's federal income tax forms. Most parents and teachers then recognize the inherent frustration that these children experience on a daily basis. Thus, the psychotherapist can be an excellent source for providing up-to-date and scientifically valid information. In addition, psychotherapy needs to include more than parental/teacher psycho-education if the home or school environment is contributing to an exacerbation of symptoms. Family therapy may be helpful in this regard, as well as consultation meetings with school personnel if appropriate.

Scientifically validated information is especially critical for parents and teachers. The popular media has been saturated with information on ADHD. While some sources have been accurate and informative, others have been misleading. For example, the authors of this article have witnessed media campaigns asserting that ADHD does not exist and is the result of children playing too many video games. The implication of this proposition is that the child can be "cured" if the parent or teacher becomes a strict disciplinarian. The psychotherapist should acknowledge to the parent that, while there may be incidents of over-diagnosis or misdiagnosis, ADHD is a valid classification for a specific population of children. Psychotherapists should be aware that the scientific fact is that ADHD has a neurobiological/neurochemical etiology (Anastopoulos, 1996; Zametkin & Rapoport, 1986).

As with any frustrating and challenging diagnosis, a proliferation of treatments promising cures have been marketed to the general public. Some intervention strategies are not necessarily validated by scientific studies and often come at a high and unreimbursable price. For example, parents can pursue alternative remedies that range from herbs and diets (Kinder, 1999) to karate, biofeedback, or chiropractic services. The psychotherapist must be aware of current research that identifies which strategies are effective. In addition, parents, with the assistance of teachers, should be encouraged to keep careful behavioral data to substantiate any perceived benefits and discontinue strategies if improvements are not forthcoming. Parents or teachers may need assistance with data-recording techniques.

Educational and counseling strategies. Barkley (2001) notes that individuals with ADHD have significant difficulties with executive and cognitive functions. Specifically, problems with behavioral inhibition, planning, goal-directed behavior, and problem solving have been identified. Flexibility, verbal working memory, and time perception are also problematic. A variety of educational accommodations may be implemented that address these concerns and benefit the child. Organizational and time management strategies, facilitating understanding of task completion, shortening lessons, and the use of computers and media may all be beneficial for the child with ADHD (Wood, 1998). The psychotherapist may be able to suggest these types of strategies during consultations or team meetings.

Individual counseling with the child is often beneficial. However, treatment goals must receive careful consideration. Counseling and behavioral techniques designed to improve task completion and concentration have resulted in limited or inconclusive success. While it may be helpful to reinforce improvements in school performance and teach skills such as organization and task completion, care should be taken to ensure that goals are within a range that the child can accomplish. If the level of goals is not determined properly, the child and parents may become frustrated and discontinue counseling services. If behavioral principles are implemented, positive strategies (rather than punishment-based approaches) for attainable objectives are critical.

A second use of the counseling setting is to improve the child's self-concept and self-efficacy. The child with ADHD has likely received a great deal of negative feedback from parents and teachers, thus negatively impacting self-confidence and self-esteem. Shirk and Harter (1996) report that cognitive therapy can be helpful for improvement of self-esteem in children with ADHD. However, they add that a focus upon self-esteem alone may be insufficient. Rather, the therapist should investigate the reasons for the decreased sense of self-worth and combine interventions that focus on monitoring moods as well as providing activities that will strengthen the area of relative need (such as social and interpersonal skills). It may also involve reevaluating those areas upon which self-worth is based. Shirk and Harter (1996) note that cognitive therapy may be difficult for very young children, as their abstract processing is relatively limited.

Anastopoulos (1996) also stresses the use of cognitive restructuring techniques for the improvement of self-concept in children with ADHD as well as for improvement in family dynamics. Both parents and teachers often have negative beliefs about children with ADHD. The use of cognitive restructuring during family therapy may be very helpful for improvement of family functioning. Teachers can benefit from the application of these techniques by consultants as well.

The topic of medication for children with ADHD has been rife with controversy and is beyond the scope of this article; however, the psychotherapist can be instrumental in assisting families dealing with this issue. Psychostimulants have been shown to be effective in reducing impulsivity and hyperactivity and increasing attention in approximately 75% of

children diagnosed with ADHD (Kaplan & Sadock, 1996). The most common psychotropic medications used to treat ADHD include Dexedrine®, Ritalin®, and Cylert®. Antidepressants such as Norpramin and Tofranil can also be used to treat symptoms of ADHD if stimulants fail (Kaplan & Sadock, 1996). The specific dose, determined by a physician, is often found after a series of clinical trials. Children with ADHD should be monitored at different stages throughout the medical intervention. The psychotherapist can act as a liaison between the family, school, and physician so that information is communicated accurately. The psychotherapist should also communicate that medication has its limitations, and that children with ADHD often still require environmental, psychosocial, and educational interventions in order to increase the probability of long-term success (Allen & Schwartz, 2001).

Conclusion

In conclusion, ADHD is a complex disorder that impacts the entirety of the child's life. Therefore, a comprehensive, collaborative, and interdisciplinary treatment approach must be implemented. The child must have an accurate assessment/diagnosis after which effective treatment strategies can be initiated in order to help these clients become successful at home and in school. The ultimate goal in the treatment of ADHD is not simply symptom reduction, it is the re-establishment of self-esteem and functional abilities. Ideally, all members of the child's environment should function as a team so that data is collected and communication is enhanced. The psychotherapist should have the most up-to-date and scientifically sound information available so as not to recommend an ineffective or even dangerous strategy. All team members should be encouraged to develop a sense of empathy for how the child processes information and for his or her daily frustrations. The individual emotional needs of the child must also be addressed in either individual or family counseling sessions. Teachers should have access to resources that help with classroom organizational skills, teaching strategies, and coping mechanisms, and psychotherapists should serve as consultants in the educational arena. The psychotherapist can provide communication and perhaps act as a liaison with physicians who are unable to attend meetings. This type of wrap-around service will provide the best probability of a successful and happy child.

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