Barnardos

Attention-Deficit/ Hyperactivity Disorder

Translating Evidence to Practice

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Introduction

ADHD is one of the most commonly diagnosed childhood disorders. Approximately 3.5% of Irish children and 5% of children worldwide have been diagnosed with this condition and it affects three times as many boys as girls (Bradley & Hayes, 2007; Flood, 2013; Selikowitz, 2004).

What is ADHD?

ADHD is a recognised clinical disorder whereby high levels of hyperactivity/ impulsivity and/or inattention exist, that result in significant psychological, social, educational or occupational impairment that occurs across multiple domains and settings and persist over time (NICE).

Signs, Symptoms and Impact

The term ADHD describes a spectrum of behaviours with three main subtypes. **Inattention**, which is characterised by an inability to pay attention or focus, easily distracted or forgetful and poor organisational skills. **Hyperactivity and impulsivity** is where the child may present as always on the move, excessively talking and unable to remain in their seat or wait their turn. In the **combined subtype**, a child can demonstrate characteristics of both inattention and hyperactivity and impulsivity sub-types.

Children diagnosed with ADHD can struggle to function in many environments, in particular the classroom. They may experience challenges in concentrating, completing tasks and following instruction, which may cause them to fall behind at times. Limitations in their ability to take turns, focus and positively engage with peers can lead to difficulties in social skills, and cause unstructured play-time to be a particularly challenging experience for the child.

Current Thinking and Research

A significant number of studies were conducted on ADHD prior to the development of an official diagnosis the inclusion of the disorder in the DSM-V. However, ADHD is not necessarily well understood among the public, with many controversies and public misconceptions concerning the disorder (Health Psychology Research, 2015).

Research demonstrates that a large proportion of children with ADHD also have a co-existing psychiatric condition, such as opposition defiant disorder (63%), conduct disorder (46%), anxiety (42%) or depression (29%). It is also not uncommon for children to present with other difficulties such as dyslexia, dyspraxia, OCD and language delays (Selcowitz, 2004).

Practice Tips

When working with children with ADHD:

- Hold sessions in a calm, quiet place with minimal visual or audio distractions
- Consider your session plan, taking into account the benefits of structure and predictability
- Redirect a problem before it occurs and promote problem-solving behaviour
- Give clear, concise instruction to the child and take regular breaks
- Provide the child with opportunities to say how they feel
- Use positive reinforcement liberally and acknowledge small accomplishments
- Take time to identify the child's triggers and develop a reward system for managing them
- Support the child to engage in and understand positive peer interactions

When working with parents of children with ADHD:

- Listen to them with respect for their knowledge and experience of ADHD
- Help them to identify social supports they can draw on at times of stress
- Assist them to understand and source information about their child's diagnosis
- Encourage them to access professional supports, assessments and support groups
- Highlight the importance of seeking advice and support to build positive parent-child contact
- Help them understand how and why to set behavioural rules, boundaries and structures at home that are predictable and consistent
- Support them in learning how to be calm and consistent when responding to, and managing, their child's behaviours

ADHD diagnosis

A diagnosis of ADHD should only be made by a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of the disorder, based on a full psychological assessment and developmental history.

An official diagnosis of ADHD requires evidence of at least six symptoms of inattention or of hyperactivity, as outlined in the DSM-V. These symptoms must last for more than six months and be observed in two or more settings, such as at home and at school (Elder, 2010). The DSM-V states that impairment must be to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities.

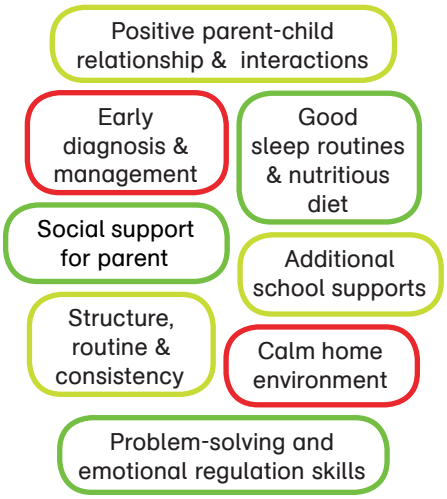
A child displaying what seems to be hyperactivity or inattention does not indicate for certain that the child has ADHD. These behaviours may simply be linked to the child's age and stage of development. Elder (2010) proposes that 1 million children have been misdiagnosed based on behaviours which he would attribute to them being the youngest in their class and therefore more immature than their peers.

Concern may arise if behaviours become age-inappropriate, excessive or disruptive; however, even then, many other problems such as anxiety, depression and learning difficulties can have similar symptoms to ADHD. Further to this, home environments, routine and parental relationships can impact on children's behaviours. Early childhood experience or trauma can also have a demonstrated impact on children, which can result in displayed behaviours similar to that of ADHD.

Due to the complexity of the disorder, it is imperative parents and professionals around the child do not assume or suggest ADHD without a comprehensive assessment being carried out by the appropriate professional. Breggin (2011) argues that a misdiagnosis of ADHD can result in professionals ignoring what else might actually be happening for the child.

If concerned, a parent should seek a referral to an appropriate professional for an assessment via the GP. In some instances, the school can refer to National Education Psychological Service directly.

Protective factors



Treatment

ADHD can affect many aspects of a child's life and therefore often require a number of different, complementary treatments.

Parent training/education programmes should be the first-line treatment for parents or carers of pre-school children (NICE). Guidance and parental support can have positive impacts on parent-child interactions in the home, promoting optimal pathways for the child's development. Responsive and structured environments may reduce the risk of ADHD associated behaviours developing and in cases where they are present, can assist with their effective management.

Individual and group psychological services for children and young people can be effective in working with the child or young person (NICE).

For children with ADHD, maintaining a **balanced, healthy diet and getting adequate sleep and exercise** can be very important. A recent study conducted in the Netherlands and Belgium showed that in 64% of cases, ADHD symptoms improved when children were put on an elimination diet consisting of wholefood (Pelesser et al, 2011).

At times and in most acute cases, treatment may include **medication**. Drug treatment, however, is **not indicated as the first option of treatment** for all young people with ADHD and is not recommended for pre-school children at all (NICE). It should be reserved for those with severe symptoms and impairment or for those with moderate levels of impairment who have not responded sufficiently to parent training/ education programs or group psychological treatment (NICE).

Further Reading

Assisting children with special needs. Flood (2013)
ADHD. Selikowitz (2004)
Diagnostic and statistical manual of mental disorders. APA (2013)
Literature review on the support needs of parents of children with behavioural problems. Bradley & Hayes (2007)
ADHD. Leslie & Packer (2010)
Overview of ADHD in young children. Singh et al (2015)
ADHD is a misdiagnosis. Breggin (New York Times, 2011)
Nearly 1 million children potentially misdiagnosed with ADHD. Elder (2010)
NICE. www.nice.org.uk
HADD Ireland. www.hadd.ie