Interventions with ADD/ADHD

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Core principle

- All behavior is an attempt to get needs met!
- The therapist/parent/caseworker/foster parent etc. job is to figure out what needs are they trying to meet and teach them how to do it.

ADD/ADHD

- Everyone with ADD is not hyperactive
- 3 % to 5% of the general population has ADD or ADHD
- That works out to about 15 Million people

Age of DX

Age of Diagnosis

18 Months to 5 years	20%
5-11 years of age	60 %
11 to Adult	20%

Primary Characteristics

Short attention span and distractibility

- Impulsivity
- Free flight of ideas
- Poor organizational skills
- Insatiability
- Hyperactivity (Be careful of this one)

Secondary Characteristics

- Social immaturity
- Performance inconsistency
- Inflexibility
- Mood swings
- Poor short term memory
- Fine and gross motor skills are poor

HIDDEN ASPECTS OF ADHD

- 1. Sleep problems
- 2. High risk for:

  Dropping out of school

  Drug use

  Criminal activity

  Poor interpersonal relationships

  Job difficulties

  Short temper

  Traffic tickets

  Strange habits as adult
- 3.Poor self esteem
- 4.Low frustration threshold

  5. Need for encouragement and supports

Counter-Aggression

- Adults who work with persons with ADD can often become counter aggressive:
- Counter-Aggression is when the professional reacts to the person in crisis with the same emotion and tone.

Professionalism

- Professionalism is doing the right thing (Established procedure, protocol or rule) even though it is hard to do

Historical perspective

- Attention Deficit Hyperactivity Disorder, formerly called hyperkinesis or minimal brain dysfunction, is one of the most common mental disorders among children. It affects 3 to 5 percent of all children, perhaps as many as 2 million American children. Boys are two to three times more likely to be affected than girls. ADHD often continues into adolescence and adulthood, and can cause a lifetime of frustration and emotional pain.

The Three Types of ADD/ADHD

- 314.01
- Attention-Deficit/Hyperactivity Disorder, Combined Type
- 314.01
- Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
- 314.00
- Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type

Diagnostic criteria for Attention-Deficit/ Hyperactivity Disorder

- (This is from: American Psychological Association. (2001). *Publication Manual*
- *of the American Psychological Association* (5th ed.). Washington, DC: Author.)
- * Italics are Dave Zidar's intervention. All other material is the APA

- Either (1) or (2)
- six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

- Inattention
  - often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
  - *Check list and routines*
  - *Partializing tasks (break it into small pieces.*
  - often has difficulty sustaining attention in tasks or play activities
  - *Anticipatory guidance and time limits*
  - often does not seem to listen when spoken to directly
  - *Get eye contact*
  - *Have child repeat prompt*
  - *Sight and touch control*
  - *R/O Hearing loss*
  - often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
  - *Check lists*
  - *Set up rewards*
  - *Consequences*

- often has difficulty organizing tasks and activities
- *Lists and bags*
- *Help with transition times, watches, routines, timers.*
- often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- *Hard task, rewarding task, hard task, etc.*
- *Show function*
- *Short breaks*
- *Rewards for attention*

- often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools)
- *Bags, checklists, scheduled (hard task, fun task, hard task) so they always have something to look forward to.*
- *Teach and model structure*
- *Places for everything, like a fire truck*

- is often easily distracted by extraneous stimuli
- *Study carols*
- *No open classrooms*
- *Limit BD classroom time*
- *Shades*
- *Limit or encourage music*
- is often forgetful in daily activities
- *Big list, little list*
- *Note book (one to tell them what to do)*

- *NOTE: What we want to tell them:*
  - *Contrary to what they are being told, they are not stupid, retarded or crazy. They learn different and have more energy. As such, they can do more than their peers. Reframe this as a gift.*
  - *It will take time to learn to slow down.*
  - *Get supports from the child, we are in this together is what we need to communicate.*
  - *Anything worth while is hard.*

- six (or more) of the following symptoms of hyperactivity-impassivity have persisted for at least 6 months to a year that is maladaptive and inconsistent with **developmental level**:

- Hyperactivity
  - often fidgets with hands or feet or squirms in seat
  - *Given them something in their hand*
  - *Taking notes*
  - *Church: Sit them in the back, bathroom breaks and read bible.*

  - often leaves seat in classroom or in other situations in which remaining seated is expected
  - *Set up bathroom breaks, signal relief*

  - often runs about or climbs excessively in situations in which it is inappropriate (in adolescent or adults, may be limited to subjective feelings of restlessness)
  - *Set up a time to be mild that is healthy. This will help with these transition times.*
  - *Set up work that requires big muscle use*
  - *Vocational direction: Set them toward what they like*
  - *Realize that in most cases they will not get tired*

- often has difficulty playing or engaging in leisure activities quietly
- *Set up quiet time and build the time up as they go.*
- *Basement*
- is often on the go. or often act as if driven by a motor
- *Plan an activity or become an activity*
- *Large social setting: Make sure the child knows he's going to leave.*
- *Set up an alliterative activity*
- often talks excessively
- *Start with waiting a turn activity. Do it in the home they are ready in school.*
- *Start being the voice in their head.*
- *Private conversations*
- *Help with flight of ideas*

- Impulsivity
  - often blurts out answers before questions have been completed
  - *hand raising*
  - *At home practices*
  - *Reward control*
  - often has difficulty waiting for their turn
  - *Think then do*
  - often interrupts or intrudes on others (e.g., butts into conversation or games)
  - Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
  - Some impairment from the symptoms is present in two or more settings (e.g., at school or work and at home).
  - There must be clear evidence of clinically significant impairment in social academic or occupational functioning.
  - The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Code based on type:

- 314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type:
- If both Criteria A1 and A2 are met for the past 6 months

- 314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly
- Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months

- 314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly
- Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 month

- Coding note: For individuals (especially adolescents and adult) who currently have symptoms that no longer meet full criteria, in Partial Remission should be specified.

ADD assessment best practices

- Conner's scale
- Behavioral observation in both school and home
- Second Opinions
- Family and other care giver reports
- Ohio Scales, CAFAS, ETC.
- How is it impacting his/her life in all domains

Let's do some more Interventions

Remember, there is not a pill for every problem.

The Directive cycle

1. Get Eye Contact
2. Say the students name
3. Give the directive in small pieces (typically no more than three steps
4. Follow up and praise or give feedback

Ideas for Attention Deficit Children

- 1.Pause and create suspense by looking around before asking questions.
- 2.Randomly pick reciters so the children cannot time their attention.
- 3.Signal that someone is going to have to answer a question about what is being said.
- 4.Use the child's name in a question or in the material being covered.
- 5.Ask a simple question (not even related to the topic at hand) to a child whose attention is beginning to wander.
- 6.Develop a private running joke between you and the child that can be invoked to re-involve you with the child.
- 7.Stand close to an inattentive child and touch him or her on the shoulder as you are teaching.
- 8.Walk around the classroom as the lesson is progressing and tap the place in the child's book that is currently being read or discussed.
- 9.Decrease the length of assignments or lessons.
- 10.Alternate physical and mental activities.

More ideas

- 11.Increase the novelty of lessons by using films, tapes, flash cards, or small group work or by having a child call on others.
- 12.incorporate the children's interests into a lesson plan.
- 13.Structure in some guided daydreaming time.
- 14.Give simple, concrete instructions, once.
- 15.Investigate the use of simple mechanical devices that indicate attention versus inattention
- 16.Teach children self monitoring strategies.
- 17.Use a soft voice to give direction.
- Employ peers or older students or volunteer parents as tutors.

Differentiating ADD and PTSD

They can coexist

Pathologies that can be mistaken for ADD/ADHD

- Hearing loss/ Vision
- Head injury
- Some allergies
- Chronic illness that is undiagnosed
- R/O biology
- Bipolar: Mood disorders
- Thought disorders
- Trauma

Perry's Trauma Model

Sense of time	Extended Future	Days/Hours	Hours/Minutes	Minutes/Seconds	Loss of sense of time
Primary /secondary Brain Areas	Neocortex Subcortex	Subcortex Limbic	Limbic/Midbrain	Midbrain/Brainstem	Brainstem/Autonomic
Cognition	Abstract	Concrete	Emotional	Reactive	Reflexive
Mental State	Calm	Arousal	Alarm	Fear	Terror

Post Traumatic Stress Disorder
Risk factors

- **Pre-incident (Trauma) Risk Factors:**
- Co-morbidity with other pathology
- Low self esteem
- Previous Trauma
- Low or poor mother-child bonding
- Poor or strained family relationships
- Lack of consistent adult role models
- Developmental or Cognitive limitations

The incident(s)

What happened

Post- incident (Trauma) Risk Factors:

- Low emotional support
- Weak safety interventions
- Failure to provide debriefing
- Placement moves
- Lack of bio-chemical support
- Lack of consistent adult role models
- Poor or strained family relationships

ADD/ADHD Treatment Models

- Medication: Both Stimulant and non-stimulant medications
- Cognitive -Behavioral therapy
- EMDR (Eye Movement Desensitization and Re-Processing
- Biofeedback
- homeopathic medicines
- Interpersonal therapies
- Activity based interventions: Yoga, Some martial arts, etc,
- Hypnosis and other relaxation methods

Best practice says:

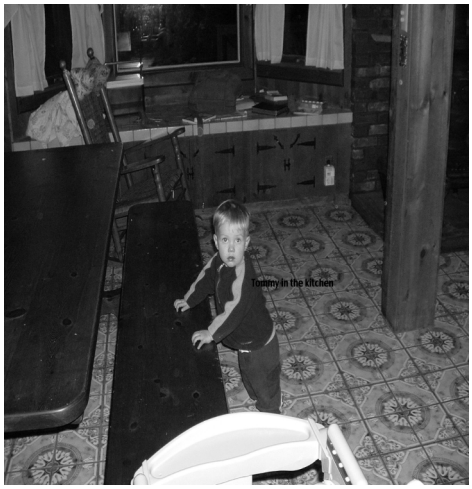
Do a combination of interventions

What to do if you are not seeing change in your child

01. Work with therapist to assess goodness of fit. Sometimes there is a bad match between therapist and client.
02. Are they using the right model? Could they be working over the client's head?
03. What other therapies can be used in conjunction with the current therapist?
04. Look at their disclosure statement, what is their list of competencies; It seems like a petty issue, but it should show detailed areas of compliance.
05. Is it time for a more restrictive placement, or more intensive therapy, i.e., day treatment, alterative school, Community Support Program etc.
06. How consistent is the therapy and the therapist?
07. The local Mental Health Board pays for therapy in residential treatment. This is a good motivator to try new, least restrictive options
08. The agency as the parent, needs to start thinking as a customer, as a consumer of mental health services, are you (Your Client) getting better?
09. With residential, if you do not like the monthly or quarterly report, you can ask for a different format.
10. Develop a collaborative relationship with the mental health board, they know all the providers and their respective skill levels.

Cognitive reframing

- Turning a negative into a positive



Cognitive reframing

Deficit	**Strength**
Impulsive	Decisive
Compulsive	Neat
Worrisome	Thoughtful
Hyper	Active, Spirited, Lively
Sloppy	Creative
Moody	Empathic

Cognitive - Behavior Interventions

Thoughts

+

Feelings

=

Behavior

Behavioral Interventions

- No Interventions
- Planned ignoring
- Sight Control
- Proximity Control
- Touch Control
- Signal Interference
- Support from Routine
- Interest Boosting
- Support from Restructuring
- Direct appeal to Values
- Antiseptic Bouncing (Go back and do it right)
- Social or material Restitution
- Over Correction
- Time out from Positive Reinforcement

Let's try some more interventions

- Let's review the list of intervention, Please feel free to add your own suggestion.
- Here is a brief review

Tommy age 6

- Tommy is the only child of Tammy (19) he was in foster care for a year when he was 3, but mom (with Grandmother) was able to get custody back. Grandmother died suddenly of a heart attack and it sent the family into chaos. Mom moved her boyfriend in and drinking and domestic violence ensued. Tommy was brought into custody late on a Saturday night under JR6. It has been two weeks since placement. Both the school (New) and the foster home report him as distractible, emotionally labial and has a great deal of difficulty with following instructions.

Questions?

- Do we have enough information?
- What would best practice indicate our next steps are?
- Who needs to be on this treatment team?
- What things do we need to rule out?
- What else do we need (and want) to know?
- What other information do you need to share with the clinician?

Stacy 13

- Stacy is a 13 year old foster child who has been in care for 4 years.Stacy is not a very good student. She is quiet and often needs several prompts to attend. At school the other student (and some of the teachers) call her “Spacey Stacy.” Other than those behaviors she does not present with any other known pathology.

Questions

- What is your theory regarding Stacy?
- If it is ADD, what type?
- What other information do you need to share with the clinician?

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