PARENTS' MODULE I: WHAT IS AD/HD?

OBJECTIVE:

At the end of the module, the parents of children with AD/HD are expected to:

- demonstrate an understanding of the core symptoms of AD/HD and its psychological effects on the children and their parents.
- Identify the different causes of AD/HD
- describe the psychological reactions of a child to his AD/HD symptoms
- discuss the psychological reactions of parents to their child with AD/HD

CONTENT OF LECTURE

A. Basic Features of AD/HD
- Symptoms of hyperactivity, inattention and impulsivity
- Persistent and pervasive
- More severe than expected in children of that age and level of development

B. Common Causes of AD/HD (Etiological Factors of AD/HD)
- Biological factors (genetics, brain disorders, infection)
- Psychosocial factors (family conflict and violence, community violence)
- Lifestyle factors (diet, effect of media)
- Unknown

C. How Common is AD/HD? (Epidemiology of AD/HD)
- 10-20% incidence worldwide
- 4th most common childhood psychiatric disorder from 2006-2009 (PGH Child Psychiatry census); comprises 8.81 % of total cases

D. Differentiating a Normal Child from a Child with AD/HD (Normal Child Development vs Child Psychopathology)

NORMAL CHILD	CHILD WITH AD/HD
Increased motor development and exploratory behavior from age 1 ½ years to 2 ½ years old	Extreme motor activity to the point of being "out of control"; extremely energetic/always "on the go"

NORMAL CHILD	CHILD WITH AD/HD
Able to do more complex tasks with the use of fingers, able to engage in cooperative play, knows about good and bad at 2 ½ to 6 years old	May not have well-developed fine motor abilities due to tendency to do things haphazardly (seemingly always in a hurry in doing tasks); frequently gets into a fight during play; may know good versus bad but has difficulty preventing self from committing "bad" deeds
Good concentration, developing friends, able to control self at 6 to 12 years old	May not do well in school due to poor concentration; may have very few friends or may be disliked by classmates because of poor control of temper
Increased intellectual abilities, has a deeper sense of right and wrong, more responsible, able to divert impulses into meaningful activities such as sports at age 12 years old and above	May be intelligent but may be childish; may engage in risky behavior such as substance abuse or drunk driving due to difficulty controlling impulses

E. How Do I know if My Child Has AD/HD? (DSM Criteria for AD/HD)

- DSM Criteria for AD/HD
- Commonly used scales in diagnosing AD/HD: SNAP-IV, Conner's Parent Teacher Rating Scale, Vanderbilt

F. Psychological Reactions of A Child to his AD/HD

- Low self-esteem and depression
- Trauma (anxiety and fear) due to repeated failure
- Withdrawal from others
- School avoidance
- Regressed/childlike behavior
- Bullying and aggression
- Clowning or self-ridicule

G. Psychological Reactions of Parents to their child with AD/HD

- Denial
- Anger
- Blaming
- Sadness
- Mourning over loss of ideal child
- Helplessness

STRATEGIES:

Lecture
Small-group discussion

FEEDBACK

What appeared to be very informative to the parents was the discussion of the specific symptoms of AD/HD and how they are similar to or different from other psychiatric disorders such as oppositional-defiant disorder, conduct disorder, anxiety, and depression.

Expect the parents to also be very interested in knowing how to differentiate between normal and abnormal behavior in their child with AD/HD.

A few of the parents were enlightened after discovering that AD/HD is in part a biological disorder. For some parents it would be a relief to know that AD/HD has very strong genetic foundations that are outside of their control. The facilitator should watch out for parents who are looking for scapegoats to explain their child's symptoms or those who appear to be blaming themselves as these parents may be suffering from caregiver burnout and may benefit from psychiatric services as well.

The different psychosocial factors that may aggravate AD/HD are important to discuss in order to educate the parents that though they are not to blame for their children's illness, they have a big role in either modulating or aggravating its symptoms.

The topic on "Common Psychological Reactions of Parents to their Child with AD/HD" elicited a positive response from the parents. Expect some to be teary-eyed as reactions such as denial of the child's illness, anger and frustration towards their child with AD/HD, and parental sense of helplessness and hopefulness are brought up. While most mothers will openly talk about such feelings, most fathers and a few mothers will be reluctant to speak and may appear to be satisfied in being a passive listener.

This first parent session will already be a rewarding experience for several of the parents who find that their new-found knowledge has made them more hopeful about their situation.

RECOMMENDATIONS

At the end of the module, the parents of children with AD/HD are expected to:

1. Each parenting session should be at least 2 hours to allow for sharing of experiences among the parents.
2. Distribution of pamphlets/brochures about the module.

PARENT MODULE 2 : WHAT ARE THE TREATMENT OPTIONS FOR AD/HD?

OBJECTIVES:

To understand the different treatment options available in treating children with AD/HD using a Multi-Disciplinary Approach

Competency for the Parents

At the end of the lecture, the parents are expected to :

1. Identify the different treatments/modalities available for children with AD/HD
2. Differentiate the importance of psychosocial treatments and psychopharmacological treatment in the multi-disciplinary approach in treating children with AD/HD

Outline of Lecture (45 minutes)

I. ADHD: A Review on the Basic Core symptoms
   - A. Common problems of children with AD/HD

II. Goals of Treatment

III. Current Modes of Treatment
   - A. Psychosocial Approach
     - a) Why do therapy?
     - b) Group Therapy for Children
     - c) Individual Child Therapy
     - d) Parent Counseling
     - e) Family therapy
     - f) Modifying Behaviors at home
       1. Token System
       2. Time out
   - B. Others needs: Occupational Therapy
   - C. Pharmacological Intervention
     - a) Mode of action

b) Expected side effects
c) Safety guidelines
d) Researches on Medication use

D. Role of the Community and Schools

IV. Role of Parents in the Treatment of AD/HD

V. Conclusion

VI. Open Forum

FEEDBACK

- The lecture started with a short warm up exercise by way of self introduction. To add some twist on the usual introduction, the parents were asked to introduce themselves by naming their favourite actor/ actress and what they have in common.
- A short quiz was given to gauge their level of understanding on the different treatment modalities available for AD/HD.
- Most of the parents in the group were misled to thinking that medications intended for AD/HD are harmful, they do more harm than good. Most of the misconceptions came from neighbours and friends who had a bad experience with medication. Some were afraid to try because of the stigma that will be attached to their child once started on medications. Majority were just afraid of the notion that their young child will be on medication and were hesitant due to its side effects
- At the end of the lecture, most of the parents were convinced that medications may indeed help but are still anxious to try it on their own children due to the side effects

RECOMMENDATIONS

- A separate session should be allotted to give parents an opportunity to express their fears, doubts, hesitations about giving medications
- The said session would aim to focus on their emotions, feelings, thoughts about AD/HD, a separate and short term group therapy for parents is recommended.

PARENT MODULE 3: What are the Consequences of AD/HD?

OBJECTIVE:

To learn about the consequences of AD/HD

Specific Objectives:

After the session the parents should be able to :

- Identify the possible effects of AD/HD as the child reaches adolescence and adulthood.
- Discuss the risks related to AD/HD as the child grows up.
- Identify other problems that may arise from having AD/HD

OUTLINE OF THE LECTURE

A. Consequences of AD/HD (risk factors)
B. Discussion of Adult AD/HD (presentation of studies on the development of adult AD/HD)
C. Other problems that may lead from having AD/HD

LECTURE

Whether in a child or an adult, AD/HD can have serious consequences. Some studies show that children with AD/HD have more emergency room visits than their non-AD/HD peers. Adolescents with AD/HD are more likely to engage in risky behavior, leading to substance abuse, sexually transmitted diseases, and teen pregnancy.

Adolescents and young adults are more likely to drop out of school and less likely to enter and graduate from college, according to some studies. And adults with AD/HD are more likely to suffer from depression and anxiety, be fired from jobs, and get divorced than non-AD/HD adults.

Teens and adults with AD/HD have 2 to 3 times more auto accidents and twice the number of severe accidents resulting in vehicle damage and bodily injury as those without AD/HD. They have coordination deficits, less skill in maneuvering vehicles in traffic, slower reaction time, and inattention.

Do AD/HD children become AD/HD adults?

Klein and Mannuzza found that 37% of the AD/HD subjects continued to have AD/HD into adolescence, compared to only 3% of the controls. It seemed to drop off in adulthood to 7%.

Researchers Dr. Rachel Klein and Dr. Salvatore Mannuzza have conducted one of the most extensive prospective longitudinal studies of children diagnosed with AD/HD. They followed 226 children over 16 years to determine how long AD/HD symptoms persisted, and if the children were at further risk for other problems as they were growing up. At the first follow-up evaluation, the children were average age 8, at the second follow-up they were average age 25. All of the subjects were boys, and none received treatment after the age of 13.

Does AD/HD lead to other problems?

- Academic difficulties

Many studies have shown that AD/HD subjects often experience academic difficulties into adolescence. In one ten-year follow-up study, researchers found that at age 19, AD/HD subjects "completed less formal schooling, achieved lower grades, failed more courses and were more often expelled" than control subjects. Klein and Mannuzza found that AD/HD children were less likely than control subjects to have graduated college or attained a graduate degree. (14% vs. 52%).

- Other mental disorders

AD/HD children may be at greater risk for developing other mental disorders later in life. Klein and Mannuzza found that AD/HD children were more likely to have any psychiatric disorder in adolescence than control subjects. (50% of hyperactive children v. 19% of controls).

Thirty percent of the AD/HD subjects in their study later developed Conduct Disorder, compared to 8 percent of the controls. Those subjects whose AD/HD continued into adolescence were more likely than either the controls or those whose AD/HD remitted by adolescence to develop CD.

AD/HD subjects were no more likely than the control subjects to develop mood or anxiety disorders, however.

- Substance Abuse

Klein and Mannuzza found that in adolescence, the AD/HD subjects were more likely than the controls to develop Substance Use Disorder. (SUD) (17% v. 2%). Interestingly, however, it was only those who subsequently developed Conduct Disorder who showed this increased risk, so it was not the AD/HD itself that predicted the SUD.

It is also interesting to note that the discrepancy between the AD/HD subjects and the controls only existed for substances other than alcohol; they were no more likely than the control subjects to have a problem with drinking.

- Criminal behavior

AD/HD children may be at higher risk for criminal behavior. Klein and Mannuzza found that 39% of their AD/HD subjects had been arrested in adolescence or early adulthood, compared to 20% of the controls. Conviction rates for the former AD/HD children were also higher, 28% v. 11%. However, as with substance abuse, the arrest and conviction rates among the AD/HD subjects were higher only for those who also had developed Conduct Disorder or Anti-Social Personality Disorder later in life.

Four percent of the AD/HD subjects were incarcerated in adulthood, while none of the controls were.

References :
Barkley, R. (1995). Taking Charge of ADHD. New York: Guilford Press. Robin, A. L. (1998). ADHD in Adolescents: Diagnosis and Treatment. New York: Guilford Press.

FEEDBACK

Most parents were eager to learn the possible effects of AD/HD for their child's future. It was also able to answer one of their persistent questions if AD/HD will continue to adolescence and adulthood. Some of them expressed concern, because of the negative consequences of AD/HD. They were assured that with adequate treatment, consequences of AD/HD can be prevented.

RECOMMENDATIONS

1. Regular follow-up consult of participants of AD/HD clinic which also includes psycho-education of parents.
2. Conception of a group therapy for adolescents with AD/HD, including graduates of this program.