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I Just Learned My Child Has ADHD — Now What? PART 2

Cindy Lopez:
Welcome. My name is Cindy Lopez, the host of this CHC podcast, Voices of Compassion. We hope you find a little courage, feel connected and experience compassion every time you listen. If you're a parent of a child with ADHD, you'll be glad to know that Dr. Glen Elliott, ADHD expert, says there is light at the end of the tunnel. Persistent loving, unconditional support and adjusting to your child's needs can lead to really positive outcomes for your child. Today's all new episode features a continuing conversation with Dr. Glen Elliott. He's not only an expert on the subject, but he's also a parent of a now adult son with ADHD. So he speaks with experience on all fronts. Here is sage advice about how to support your child with ADHD, plus effective interventions and strategies you can use. Welcome Dr. Elliott.

Dr. Glen Elliott:
One of the fascinating things about ADHD is it turns out there are a lot of different interventions that actually are quite effective. What they have in common is that they don't cure ADHD, but they significantly reduce the symptoms. And it's a little like having high blood pressure or asthma or other things. I wish we had a cure and someday we may, but the goal is not to cure ADHD, it is to reduce its negative impact on the child's development and other areas and there's really a popery of different types of interventions that we can think about, and that may change again over time as the problems change. So what we're looking for is not a universal one intervention fixes everything, but given where the problems are now, what do we need to do? And probably the most important thing to keep in mind is if things stop working it's time to reassess what's going on because the likelihood is something has changed in the child's environment or the expectations or response to treatment and there may need to be a change in the intervention.

The other thing is that all of the interventions we currently have that includes behavioral interventions as well as medications have the shortcoming of working while you use them and not working as soon as you stop using or not instantly necessarily, but within days to weeks. So anything you enter into, you have to feel comfortable expecting that you're going to have to do this for years, not days or months, this is not like treating an ear infection, for example. And particularly with behavioral programs, and I'm a fan of

behavioral programs, both at school and at home, just keep it simple. Ask yourself, am I going to be able to do this for the next year or two? Uh, and if the answer is no then you need to sort of rethink about what you're doing.

My two boys are two and a half years apart. So they were like nine and seven, something like that. We actually went over to a friend's and they had a chore list and they got points and all of that, and I should know better, but I created at their request, this just draconian chore list, which died of its own weight because it was just way too complex. Uh, you know, if they did X number of things, Y number of times, then they got points and the points led to other benefits. You want to keep things really, really simple. Re-evaluating on a regular basis, not necessarily weekly, but you know, monthly or even quarterly, how are things going? Where could things be better? What don't we need anymore? …makes good sense, but also be prepared. There's this real tendency, particularly well actually with any interventions, when things are going well to say, "gosh, things are going so well, let's stop." And that almost never is a good idea because with ADHD kids what tends to happen is then they go back into their old behaviors and then parents and the child both feel very frustrated.

The other thing is really incorporating the child into all of this, even with medications, but there has to be some level of buy-in. One of the things is to not say, "this is for your ADHD." This is so you can do X, Y or Z that you couldn't do before, so that you can listen to the teacher better, so that you can play with your friends more easily. Something that's very concrete for the child that he or she's got to be motivated to do. There's a book I probably over-hype, but I really really like by a fellow named Ross Greene called, *Raising Human Beings*, it is literally the only book I've ever read that I wished I had available when I was starting out as a new parent. The main focus of that is, things work best when the child is included in decision-making processes, and things work least well when it's a top-down adult decision about this is the problem, here's the solution and we're going to apply the solution.

Dr. Glen Elliott:
Let's go back to the basics for a minute. Could you briefly talk about ADHD and the types of ADHD? It really is important because it helps to think about what type of treatments are going to be most useful. So there are three subtypes of ADHD, the most common one, what people usually think about when the term ADHD comes up is the so-called combined type. What that means is that children have problems with impulsivity. They have trouble with what's called motor-hyperactivity. They're just fidgety. They can't sit still. They're sort of constantly on the move, and they have trouble with sustained attention and poor focus, which are slightly different. So there are some kids who are easily distracted. If there's somebody next to them who's rustling papers or

doing something, they get pulled away to that task. I have a five-year-old grandson who does not have ADHD as far as I can tell, but I've experienced what I now think of as TV hypnosis. In the middle of a conversation as soon as the TV comes on, he's completely gone. I mean literally stops in the middle of a sentence, is focused on the TV, no matter what's on the TV.

One of the things that parents have to learn early on is nothing gets in if the child's not listening. So a lot of times, whatever the diagnosis, you need to make sure that you have the child's attention. And so early on, before kindergarten, if this problem is going to manifest, it's usually what's called hyperactive-impulsive subtype, and these are the kids that get in bad trouble in preschool because they don't get along well with other kids. They don't follow rules very well. They won't sit in circle time. They're running around when they're not supposed to, and it can be devastating for parents because as any parent with a young child knows it's not that there are an infinite supply of nursery schools and preschools. And literally these kids often get ejected from the school because they've bitten some other child or they've done something else. Fortunately, that's relatively rare, but that requires sort of immediate action, and we can talk about some of the options there.

The more common diagnoses occur once kids get into elementary school. So first, second, third grade is a very common time for the so-called combined-type ADHD to be diagnosed. And I want to emphasize that's not because it's when the problems appear. It's when other kids who don't have ADHD, the behaviors that these kids exhibit just disappear. The average seven year old knows not to get out of the seat without permission, doesn't just wander over and sharpen pencils just because it seemed like a good idea at the time. So if you look at like questionnaires that you used with diagnosis, what happens is that the ADHD child is staying sort of more or less stable with symptoms and the non-ADHD children, those behaviors kind of disappear. So usually at that point, it's the school that's saying this is really interfering, but the child has more sort of options to be impulsive and hyperactive, and that sometimes they run across streets. They're not paying attention. They're engaged in behaviors that are dangerous to themselves or to other people.

And then as kids sort of move into fifth, sixth and seventh grade and then into adolescence often that's when the issues of planning, organization, attention to detail begin to get really problematic. And interestingly enough, and we don't exactly understand the mechanism, usually the hyperactivity, and to some extent, the impulsivity grow less. So it just makes the inattentive problem that much more obvious and also of course the expectations change. So, we have to look at each of those. The final type is just the inattentive-type and those kids often don't even get diagnosed until

late because as a society, we don't really have a lot of expectations about sustained attention in five and six and seven year olds. But by the time you hit fourth and fifth grade, that's when you begin to have projects that require sustained ability to do things in an organized fashion, and these kids really began to crumple at that point.

Cindy Lopez:
So it's important for parents to understand the type of ADHD their child is dealing with because the intervention is going to be more specific to that type.

Dr. Glen Elliott:
Yes, absolutely.

Cindy Lopez:
I wonder who should they be seeing as they think about interventions? Is it their pediatrician? Is it other specialists?

Dr. Glen Elliott:
I wish I had an easy answer. About a third of kids have just combined type ADHD, period. And mostly are having trouble with academic kinds of situations, school setting, because that setting is just so difficult for those kinds of kids. And a lot of times pediatricians both feel comfortable and are perfectly competent at dealing with that. So, that may be a great place to start, usually it's easily covered by insurance. It's less complicated, the kid feels less singled out because they're used to seeing their pediatrician. If that's all it takes, great. You may also need to do some work with the school, and we'll talk about that in a minute, but in terms of what the pediatrician's likely to offer is medication. Pediatricians generally have a pretty limited number of medicines that they're used to using. If those work great. If they don't work, that's when it's time to go to somebody who's got sort of more extensive training. The other two medical specialties are so-called behavioral and developmental pediatricians, and they do extra training specifically around children who have behavioral issues or developmental delay and that kind of thing. And most of them are more sophisticated in terms of their ability to know what medicines might be useful for treating ADHD and also other kinds of approaches, and then the third group are child psychiatrists and child psychologist, and both of them potentially may be useful and appropriate, particularly with kids who either don't tolerate the initial interventions very well or who just seem to need more than what they've been getting.

But those were the three or four groups that parents should think about, and I listed them in that order because pediatricians are far more common and easily accessible. The other three really depend on the area you're at. The fourth area of school depends

on the school district, and you can comment on this more than I. This is not a new experience for school districts, so they often have programs that are so-called 504, which I'm probably not going to spend much time on, which is actually part of the Americans with Disabilities Act of all things, but allows for so-called accommodations for kids, like extended test time and those kinds of things, which schools can help arrange. They're sort of used to this, but it really needs to be targeted for the child. So one of the weird things I've seen for example, is there are children with ADHD who get extended time for test taking, which is completely useless for them because they're always the first ones done. The problem is not needing more time, it's that they don't bother checking their work. And they've done the front page, but they didn't bother to turn over the page to see that there's a back page. So they get half of it done, and so they need a different kind of accommodation than somebody who genuinely just takes longer to get the task done.

Cindy Lopez:
Yeah, I've definitely seen that in the classroom. Also thinking about young children, I wonder would it be part of an intervention program for them to also see perhaps an occupational therapist or a speech and language pathologist, or would that come as a result of seeing some of the other specialists who might recommend that?

Dr. Glen Elliott:
Well, I think OT, occupational therapists, they often can be very helpful. Many of these children do actually have problems with fine and gross motor kind of behaviors and also particularly the more energetic ones, finding ways to help them expend that energy in more acceptable and productive ways can be really useful. And OTs can be exceedingly helpful with that. Uh, there are so-called fidgets that can be remarkably helpful to allow the child to sort of be doing something while focusing on what's supposed to be happening.

Speech and language I would say really would depend if the child seems to be at level or above level in terms of language. I don't know that I'd recommend that, but again, we know about a quarter of kids with ADHD do have speech and language problems, and about a quarter of kids with speech and language problems have problems with ADHD. So it goes both ways, and it's a bad combination because speech and language difficulties require sort of more concentrated interventions and that's really tough if you can't pay attention. One of the most fascinating experiences I had many years ago is I worked with the deaf center at UCSF and that combination, which is fortunately rare of ADHD plus deafness, turns out to be an extraordinarily difficult problem because deaf kids only learn if they're watching whoever's doing the teaching, and ADHD does not

contribute to watching whoever's doing the teaching. So there it can make an enormous difference if we can get them to the point where they're actually able to stay focused.

Mike:
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Cindy Lopez:
As we think about interventions for ADHD, at least in my head, maybe in yours, two different buckets, so to speak. So the behavioral and medication, and I don't think they're exclusive of each other either. So maybe, talk a little bit about that.

Dr. Glen Elliott:
Right. So again, this depends on the age. One of the expectations which has now been thoroughly debunked is that it's possible to teach kids with ADHD who are seven, eight and nine year olds to self-monitor. And you start with a program that rewards them for decreasing their impulsivity and hyperactivity, and somehow they internalize that. It's a lovely fantasy. It doesn't work. What does work, it's been shown very, very well is that consistent parental interventions and educational interventions, sometimes very, very simple ones can make a huge difference, but they've gotta be simple because you need to sustain them.

It's easy for parents to become very frustrated because they've done all of this effort. The child is doing well. They back off and everything goes away and sometimes it's remarkable how little it takes for whatever they've learned to go away. So just for example, having a substitute teacher in the classroom can be enough to just completely derail the child until the regular teacher comes back, or even it's really sort of hard to imagine, but even moving from one classroom to another classroom sometimes it's like he or she's just erased everything they've learned, but consistency, consistency, consistency I guess is really the model. And there are some excellent books out there about programs that can be very effective. Again, it's gotta be modeled to something the parents feel comfortable with. What we also know is that punishment, tempting as it is, is not effective. It seems like it's effective in the short-term and the long-term it actually creates more problems rather than less, which is not to say that kids don't have consequences, but the main focus needs to be on rewarding them for succeeding rather than punishing them for failure and depending on the severity of the ADHD, the interventions may need to be very, very frequent. There's some nice work again mostly in school where kids start with being rewarded every five minutes for being able to stay on task. The goal is to be able to stretch that out to every half hour or every hour, but

that may take weeks to months to actually be able to do that. And it still needs to be done. It just can be done less frequently.

I failed to mention another group. There's a group called behavioral therapists. They often are not psychologists. They may have a social work degree, but they are trained to help with behavioral interventions, and they can be very, very helpful in designing a program and making sure that it actually works for that particular child.

Cindy Lopez:
Yeah definitely, as you said focusing on the positive where the child is having success versus the punishment. And it sounds so simple, but if you can do that consistently, I've seen it make the biggest difference for students and just whatever you can say to them as a teacher, throughout the day that's going to encourage them.

Cindy Lopez:
Acknowledge that they're doing well.

Dr. Glen Elliott:
Yeah acknowledge that they're doing well, it can be really important. The other thing is to just realize there are certain things over which they don't have any control. So, it's structural issues, like having them towards the front so that the teacher can interact with them more readily rather than putting them in the back where they can get into all sorts of mischief.

Sometimes some kids actually need sort of advanced warning. So having a teacher say, "okay, in five minutes, we're going to be doing this task." Uh, so that the child has a chance to prepare. Often anxiety is another very common trait with kids with ADHD. So suddenly calling on the kid to give an answer with those kids may be disastrous.

So again, letting them know in a couple of minutes I'm going to be asking you this question. I want to make sure you're ready for it. And do you feel comfortable answering it so that they can succeed without necessarily anybody else really knowing about the structure that went into it. The other thing, and this is where parents really learn to know their child, there are children where complimentary behavior actually backfires on you, and you just need to be aware that that's a possibility. There's something about being told they're doing a good job that sets them off and rather than gleaming and going forward, they prove you wrong and that tends to be a steady trait. So those kids may need a different kind of approach. So this is one of these where I actually encourage people to do what we think of as bibliotherapy that is, there are some excellent books out there, we can provide some of those references. CHC has got a very nice list of

references out there, and you can sort of start at that point, but if you get to a point where those things don't work that's the time to bring in a professional, and it's okay if the professional just doesn't seem to jive with your approach as a parent or just doesn't seem to work out with the kid. It's perfectly fine to say this isn't working. Let's find somebody else. If something's not working, don't stick with it.

Cindy Lopez:
Yeah, I was going to say, yeah, they need some time.

Dr. Glen Elliott:
Yeah, you don't want to jump from plan to plan to plan, but if something hasn't worked within a three to four to five week, six week period, the likelihood that it's suddenly gonna work is zero. That's particularly true with medications. The general recommendation both in pediatrics and in child psychiatry, which are the two main organizations that are responsible for treating ADHD is that medications are for many, many children part of the treatment plan, and can be enormously helpful sometimes by itself and often with additional sort of adjunct behavioral therapy and parents worry about that. This is by far the best studied group of kids on medication in our field. And stimulants have been around since 1938, but have been in pretty common use since the early sixties. There have been lots of studies of both short and long-term side effects, and they really do work.

What the studies show is that particularly with combined type ADHD, 65 to 75% of kids will respond well to a stimulant, maybe as high as 85% and there are other medicines that are not stimulants that also can be really useful that may be actually more effective if you've got children where the problem isn't just in school. It's before school waking up and getting ready for school, ready for the day or sort of late afternoon, the limitation of stimulants is they only work x number of hours. And that varies depending on the particular type of stimulant, but they're not designed to be all day solutions. Whereas some of these other non-stimulant medicines actually can provide real help in the late evening or even in the next day. There's actually this new stimulant, relatively new, it's been out for a couple of years now that you can take the night before, and it kicks in in the morning basically. So there are options, but that level of sophistication usually isn't in the hands of pediatricians. That's where you end up needing either a child psychiatrist or a behavioral pediatrician.

Cindy Lopez:
Also I think that when you're using medication, it's important for parents to communicate. It's important anyway, but it's important for parents to communicate with

the school, with the teachers. So that teachers can kind of see what's happening and give feedback about what's working and what's not working.

Dr. Glen Elliott:
Yeah, absolutely true. I was involved in a study called the MTA – Multimodal Treatment of ADHD, and it very much had teachers involved. And one of the things that we found that typically is lacking in usual care is exactly that link between teachers and caretakers. And particularly with stimulants most of the benefits happen during school and parents may just not see it. What's lovely about stimulants is they work within 20 minutes of when you give them and what's not so lovely is that they wear off at the end of the day. The advantage is you can skip weekends and holidays and that kind of stuff if they don't really need it.

But I had a colleague, one of the early researchers in this area, his avocation was teaching soccer, being the soccer coach for a group of kids with ADHD. And he would describe the difference between how the team did off medications versus on medications and the difference was profound. So again, I mean, you worry, boy, I'm just doing this for my convenience. His experience was that this allows the kids to succeed in a way that they wouldn't succeed otherwise. And I think that's the thing to keep focused. They do have side effects. What I tell people always is any effective intervention has the risk of side effects. And that includes behavioral interventions, that includes doing nothing. Everything has consequences and that's what you sort of have to balance. And it's perfectly alright to raise questions and you know, if you've got concerns that you ask about them, and they get dealt with, one can make changes.

I wanted to talk briefly about some very simple kinds of things that parents can do in collaboration with teachers to help promote communication. So one of the things that we often recommend, and we actually did in the study is you can create like three or four or five questions. These days it's done by email usually, of issues specific to your child. So is your child having trouble paying attention or sitting still in class or interrupting, whatever it is, and just make your own kind of scale, a one to five, no problems to woah was this a bad day, and ask the teacher to fill that out once or twice or three times a week and that gives you a lot more communication.

Our non-ADHD child went through periods in middle school he ended up probably having depression. I mean we were unaware of it at the time, but we didn't find out about it until January when we suddenly found out that he was failing and by that point he actually was over it and he was catching up again and everything was fine. And it took us a couple of years to see a pattern and by that point it went away, but it really taught me that no news is not necessarily good news and teachers are busy, they got

way too many students to have to worry about. So, sort of actively developing a collaboration with the teacher can be really, really important. They're not quite available yet, but I think pretty soon in the next few years, there're going to be applications that make it really easy for teachers to communicate directly with parents and physicians, in a pretty seamless way, and sort of minimally time-consuming way. What's fascinating about like the questionnaires is they don't need to be extensive. Ask the teacher, what are the three or four things that really are most difficult for my child, so that it's not a big task for them. And most teachers are willing to cooperate. I have to say there are some teachers who don't believe in ADHD, and that can be difficult, but I think that's less common now than it used to be, but it's important to know. I mean, if a teacher insists that this child is just a bad kid, that's not a good fit.

The other thing that can be really, really important particularly as kids get into real homework is some way of making sure that information gets to and from school in an organized fashion. I can't tell you how many things we found in the bottom of my child's backpack at the end of the year, permission slips and homework assignments that never got worked on, never turned in and all of that. So with younger kids, we often talk about a homework envelope that becomes part of a behavioral program. So they get points if they give it to the teacher and the teacher takes out whatever is in it and points when they bring it home, and that can really facilitate communication. And also, one of the most frustrating things for parents is that they've worked for hours with a kid getting homework done, and then discover that he or she didn't turn it in, and they don't get points for it. It's just needlessly catastrophic. When kids get older that has to be expanded.

Cindy Lopez:
Yeah and there are now school age, middle school, high school especially, there are learning management systems. Schoolology is one, Power School, there are many, so there are ways now I think for parents and teachers to stay in contact that are a little bit more seamless. So if you're a parent, ask about those kinds of tools.

Dr. Glen Elliott:
Yeah and also think about avoiding problems is better than solving them sometimes. So, I'm not sure how big an issue this is now, but earlier there were two things that were problematic: one is that the kid had no idea what homework assignments were and now a lot of schools just provide that online so you can get access to it. The other is that the child forgets to take textbooks from home to school or from school to home. So sometimes the families can afford it, buying two sets of textbooks. One that stays at school and one that stays at home may actually be the easiest solution to making sure that the child has access to whatever materials are needed, but again this is one of

those areas where telling the kid, you know, stop that, is not going to fix it. But thinking with the child, what is going to work, can be really, really helpful.

Dr. Glen Elliott:
I wanted to mention one other area that we haven't touched on. So a lot of kids with ADHD, particularly combined type, have peer relationship problems, and at least one of the correlations is with the number of interactions that they're expected to do. These kids do not do well in large groups. So, what I typically recommend and particularly for elementary school aged kids is keeping interactions initially one-to-one, one other child, maybe one to two, but even that sometimes is problematic. Do not put this kid in a group of six or seven other kids and expect him or her to succeed. What they're going to do is drift off, or they're going to annoy somebody and trying to sort of gain attention. So, this is another one of those, it's better to avoid the problem to begin with rather than deal with it afterwards.

Cindy Lopez:
Dr. Elliott, is there anything kind of closing you want to say?

Dr. Glen Elliott:
One is this is not the parents' fault. Unfortunately there are things the parents may have to learn to do that they wouldn't do normally, but it's not because it's their fault. It's because their child has special needs.

There truly is light at the end of the tunnel. It may be years away, but persistent, loving, unconditional concern and adjusting to the child's needs as they age really makes a huge difference and can lead to wonderful outcomes. So if you get discouraged as a parent, there's no shame in getting help yourself, so getting parenting advice. There're actually programs that are designed to sort of help think about you as a parent of an ADHD child. Those kinds of interventions can really give you the tools. If books aren't enough to sort of make it through the hardest time, and there will be hard times. There's no question about that. They tend to be fixable and then you move on until the next challenge arises.

Cindy Lopez:
Yeah, thank you. We do have a parent support group at CHC for parents of kids with ADHD that meets once a month. So, you can check that out online, chconline.org. Also what you just said Glen reminds me of that story, I'm sure you've heard it, and it's been told a million times that welcome to Holland story, where the parents are making plans to go to Italy, right? And they bought all the guidebooks and they've learned the language, and then they get on the plane and the plane lands in Holland, and they say,

“this is not where I was supposed to go.” So, you know, the kind of analogy here is like for many parents, this is not what they anticipated. It’s not what they wanted for their child. It’s not their trajectory that they expected. But the reality is, if you’re in Holland, like there are windmills and tulips and wonderful things about being in Holland. So just know that as a parent, it may be hard as Dr. Elliot just said, it may be hard and you’re gonna probably have to learn some new things and some different ways to communicate with your child and to support them, but again, reach out, there are lots of resources. So, to our listeners thank you so much for listening today, and we look forward to you joining us again for the next episode. Dr. Elliott. Thank you very much.

Dr. Glen Elliott:
My pleasure.