Parenting the ADHD Child: Symptoms, Struggles and Successful Behavioral Strategies

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The task of parenting can be both arduous and joyful, but when a child is diagnosed with ADHD, lifelong challenges exist for parents, the child and others involved in the child’s development. Attention Deficit Hyperactivity Disorder (ADHD) is characterized by a lack of attention/focus, impulsivity and distractibility that impairs daily functioning (DSM-V, 2013). The disorder can be debilitating and affects the majority of children at varying degrees into adulthood. Recent studies suggest that thirty to sixty percent of children show ADHD symptoms into adulthood and that children are more susceptible to negative outcomes such as substance abuse, depression, decreased educational attainment and lack of employment (Harpin, 2005). Although the statistics seem severe, there is hope for parents who are willing to put forth an effort to help their distractible child using behavioral, therapeutic and medical interventions.

ADHD has gained attention recently because of the increased rates of diagnoses in children. The Centers for Disease Control (2014) reported that the percentage of children with an ADHD diagnosis continues to rise; 7.8% in 2003 to 9.5% in 2007 and to 11.0% in 2011. The rate of those children reported by parents in 2011 to have ADHD in the state of Massachusetts is right on target with the national increase rates as well as those medicated for ADHD; 8.8% of US children and 9.6% of children in Massachusetts.

ADHD is usually diagnosed through a combination of observation, reporting, educational testing, completion of scaled evaluations and in some cases, brain imaging (SPECT & PET scans), and encephalography (EEG). SPECT scans created by Dr. Daniel G. Amen have yet to be used as a definitive tool for diagnosis, although brain activity can be observed through these images (Jensen, 2000). According to Aamodt & Wang (2011), distinctive patterns can be seen in a brain of a child with ADHD as there is a difference in alpha, beta and theta rhythms in comparison to children without ADHD.

Specific causes of ADHD have not yet been identified but there are certain factors that educators and doctors speculate that may contribute to the disorder such as heredity, insufficient brain chemicals (neurotransmitter dopamine), head injury, physiology of the brain and its under activity and lack of blood flow to the frontal lobes and prefrontal cortex (Jensen, 2000). In addition, there are certain risk factors associated with ADHD such as prenatal smoking and low birth weight. The frontal lobes of the brain hold decision making skills, impulsiveness and short-term visual memory. Interestingly, Jensen, (2005) stated that, “Researchers have found that we can take in only three to seven chunks of information before we simply overload and begin to miss new incoming data” (pg. 42). So, children with ADHD, are already at a disadvantage in comparison to how a “normal” functioning brain works because their frontal lobe is already impaired so to speak.

There are many facets of ADHD including brain differences, diagnosis, school involvement and participation, medication and behavioral therapies, natural alternatives, productive and unproductive interventions, learning strategies and comorbid disorders. According to Aamodt & Wang (2011), the strongest evidence is that ADHD is linked to genetics and occurs in five (5%) of children world-wide. In order for ADHD to be diagnosed, there are certain criterion that requires parental and school input and medical/developmental history on the child.

During childhood, it could be said that many children have a lack of focus and exhibit impulsive choices and hyperactive behavior. Many children are curious, show great intelligence and have a propensity for fun and risky behavior. These factors do not make diagnosis the easiest for some parents and educators. Yet, Sonna (2005) stated that “questionable behaviors” must be more frequent and severe than other children of the same age.

According to the Centers for Disease Control (2014), the newest edition of the DSM-V was released in May 2013. It included some changes to the diagnostic standards of ADHD including the age of child when symptoms occur and need for symptoms to be present in more than one setting than just impairment in more than one setting. There are new descriptions of the changes that take place into adulthood, and in younger children only five symptoms need to be present instead of six when diagnosing (refer to addendum on DSM-V Criteria for ADHD, 2013).

There are many factors that could also influence the same symptoms of behavior such as moving, a divorce, a new child in the family, a traumatic event or a death. However, the differential diagnosis has to include specific factors in an ADHD diagnosis. Symptoms must present before age twelve (12), for at least six months and interferes in two or more settings such as school and home. The American Psychiatric Association's Diagnostic and Statistical Manual, Fifth edition (DSM-V) characterizes all of the symptoms of ADHD and five out of the nine must be present in order to complete a firm diagnosis. In addition, there must be clear evidence of significant social, academic or occupational functioning (Sonna, 2005).

Sonna (2005) offers some common school behaviors that students with ADHD exhibit such as: poor planning, frequent distraction, calling out answers and interrupting, moving or fidgeting, lack of foresight/hindsight, unorganized personal space, impatience, poor planning skills and impaired sense of time passage. Many of these behaviors can be witnessed by teachers and according to Bernstein (2007), teachers play a pivotal role in school success. Students who have developed a personal relationship are more motivated to work for his/her teacher. Although success can be impacted later in life by life demands as an adult, ADHD limits continuous positive peer relations for children (Bernstein, 2007).

The brain is a complex mechanism and many areas in the brain are dedicated to attention. “Pay attention” is commonly heard when adults require children to attend to visual and auditory signals when it seems that they are not. According to Jensen (2005), paying attention is difficult because the areas in the brain that manipulate attention is multifaceted and variable. Jensen (2005) states, “Maintaining attention requires highly disciplined internal states and just the right chemical balance” (pg. 35).

Children rarely get training in mindfulness or skills on how to be reflective and calm. Focused learning can occur if the following conditions are met: students choose relevant, meaningful learning, students can hear the teacher well above random noises, student get enough sleep and avoid drugs/alcohol, and students do not have attention deficit or central auditory processing disorders (Jensen, 2005). A child with ADHD is already at a learning disadvantage because it is already difficult to eliminate external stimuli to focus in a typical functioning brain.

Many areas of a child’s life are affected by the disorder. Executive function skills impact organization and impulsivity can contribute to difficulty in relationships with family members, teachers and peers, as well as the self-esteem of the child. Children with ADHD have

the capacity to focus and pay attention, but they lack the ability to control where their attention is focused (Aamodt & Wang, 2011). Children in general can struggle with fitting in, forming his/her identity and figuring out how to navigate friendships. They may also question his/her place in family relationships and peer relations within the school environment.

The primary school years are pivotal to developing appropriate social skills to foster positive peer relationships. Children with ADHD tend to be noticed differently than their peers because they may ignore social cues, are less attentive and react impulsively without thinking an action through, causing rejection (Bernstein, 2007). According to a study reported by Harpin in 2005, compared to the national norm of boys, boys with ADHD had lower self-esteem, more learning disabilities, lower social/emotional functioning and less emotional support and parental involvement. The CDC, reports grim statistics that parents of children with a history of ADHD reported almost 3 times as many peer problems as those without a history of ADHD (21.1% vs. 7.3%) and ten times as likely to have difficulties that interfere with friendships (20.6% vs. 2.0%) compared to peers (2014).

It is difficult to be a parent of a child who has ADHD because his/her condition impacts the entire family. To be an effective advocate, a parent needs to be well informed, up to date on research and treatments, and focused on gaining the right diagnosis and help through appropriate medical care. They need to be able to balance frustration and provide self-care for themselves as well as their child. Evaluators of the article written by Harpin (2005) which studied the effects of ADHD on families reviewed the evidence and concluded that “the presence of a child with ADHD results in increased likelihood of disturbances to family and marital functioning, disrupted parent-child relationships, reduced parenting efficacy and increased levels of parent stress, particularly when ADHD is comorbid with conduct problems” (pg. 4). There is obviously much stress involved when caring for a child with ADHD. It is important that families be educated and trained to create a harmonious environment conducive to a child with this disorder.

It can be overwhelming for parents to be told that their child is diagnosed with ADHD even if they have been in the pre-diagnostic phase for a while. ADHD is considered a neurological disability according to Aamodt & Wang (2011), so it is quite common for parents to have difficulty addressing the problem because of the medical needs of the child. They may not be aware or understand what the child needs behaviorally. Although the research on the disadvantages of ADHD can be alarming, there are many positive strategies that can be utilized to encourage success in children and families dealing with ADHD.

Dr. Jeffrey Bernstein, a licensed psychologist and author, specializes in child and family therapy and is educated in assisting in understanding childhood disorders. Bernstein (2007) works directly with parents to educate that distracted children can be resistant, at times defiant and have negative perceptions of self and others. He also explained that distractible children can be perceived as defiant because they do not follow instructions, but most of the time they are too distracted to follow through and focus on details. Frustrations from family members although understandable, can create barriers to improvements in family functioning and the child’s wellness. It is important according to Bernstein (2007), “…to keep in mind that your child did not choose to develop a distraction problem, and without your help he likely won’t overcome it” (pg. 107).

An important piece of supporting an ADHD child is to try to understand what it is like to be in his/her shoes and to approach each interaction in a calm, firm, consistent and non-controlling way (Bernstein, 2007). It is not easy to approach children in a non-emotional way especially since so many parents are connected to their child and take his/her actions personally; as a reflection of self. According to the views of Dr. Kazdin who educates on best parenting practices, he feels that what works best to change and shape behavior is not always what comes naturally and easily (2008). Kazdin states, “In the normal course of family life, parents are frustrated not just by their children’s misbehavior but also by a sense that their own ineffectiveness has much to do with shaping that mis-behavior”.

In the journey of diagnosis, the first few steps is to acknowledge that the child has a disability and determine what behavioral/medical strategies and parenting approach will work best. This requires consultation with appropriate professionals who understand the child and what way the child will find the most success; whether it is a school teacher, counselor, pediatrician, developmental physician, and psychologist or a combination of. The conclusion of the research reported by Harpin (2005) confirms that healthcare professionals “have an important role in providing balanced and supportive information about ADHD and meeting the needs of affected individuals and families” (pg. 7).

Parents initially tend to bare the weight of the diagnosis and be the main providers in following through with care and advocacy for their child. A parent must first digest the ADHD diagnosis for their child and work through their own feelings regarding the disorder. Then, it is important that they inform themselves as to the rights of their child whether through an Individualized Education Plan (IEP), a 504 Plan, or any accommodations that the school can provide with a documented disability.

Authoritative parenting is seen as the most effective parenting method as it provides clear structure, consequences to improve behavior, and genuine instruction (Sonna, 2005) which can assist immensely in dealing with an ADHD child. The parent is usually the child’s first and best advocate if they are well informed, aware of his/her parenting downfalls and can put his/her own feelings of exhaustion and frustration aside and address the situation head on.

There are many other interventions for ADHD children and parents that are available. Biofeedback, stimulant medications such as Concerta and Ritalin, relaxation exercises, food elimination diets, herbal remedies, vitamins and supplements, and counseling strategies are options that may or may not have proven successful. It is up to the parents’ discretion as to what will work best for their child. In trying to change a child’s behavior it is recommended that a parent begin with the least restrictive and least invasive option (Dawson & Guare, 2009).

In determining the best treatment two ideas should be present. As part of normal development many children exhibit certain behaviors and it should be decided if these behaviors are interfering significantly and are considered beyond “normal”. According to Kazdin (2008), research shows that one in five children meet the criteria for a psychiatric disorder. If this is true to the population, then parents must decide whether the symptoms and signs are significant enough that the child’s functioning is severely impaired.

There are many strategies that can be utilized to reduce difficult behaviors and enhance a child’s ability to function. The effectiveness of the strategies depends on the parents’ consistency, understanding of the way their child responds best and communication with all of those involved. According to Kazdin, (2008) “if you can help the child in the short term to change her behavior, over time you will change the child. The research tells us that building up a better response... if the behavior is repeated often enough will in effect rewire the child’s brain…” (pg.6). Beyond the care and treatment of a doctor or through medication, parents can be the providers of finding what works best for their child at home and school. Much of the research on effective strategies focuses on behavior change and working with routines, schedules and reward systems.

ADHD children tend to be very reactive to situations and show frustration easily. This can make a parent also react quickly and aggressively to a child’s frustrated response. Parents should work on adapting their behavior to meet the needs of their child through behavior modification of their own or serious contemplation of how he/she usually reacts to the child. Sometimes, it is more that parents modify their own behavior before they attempt to change the child. At times, “the demands involved with meeting the needs of a distractible child influence parent to be demanding of their child, leading to more distracted behavior (Bernstein, 2007, pg. 48). As difficult as it might seem because the ADHD child can cause commotion and frustration, Bernstein (2007) suggests that parents realize that the child did not choose to develop ADHD and without help, the child cannot overcome it.

Sometimes the best parents need to be reminded of effective parenting skills. Managing a child with ADHD requires parents to be sensitive, empathetic, consistent, and patient although it is can be demanding, upsetting and overwhelming. Bernstein (2007) suggests that parents stay optimistic, set limits, participate with the school, advocate for the child and promote structure as, “Distractible children need their environment to structure externally what they can’t structure internally on their own”(pg. 95). Parents would benefit from their own education on ADHD through self-help and parenting books, understanding child development, consulting with counselors and specialized pediatricians, up to date research on medications and natural remedy options.

Counseling that focuses not only on the individual but the entire family can be beneficial in identifying what factors are causing frustration and what behavioral techniques can improve ADHD symptoms. Counselors can guide parents in understanding their child better and to acknowledge the barriers that might be impeding the child’s progress and the family relations. A counselor can also help the child not to use ADHD as an excuse but appropriately assign their distraction to their difficulties and become more aware of strengths (Bernstein, 2007).

If a child’s symptoms are affecting behavior in a pervasive way, it is useful to first choose what specific weakness is causing the most difficulty. This becomes the target behavior or target executive skill weakness to address. Implementing an intervention plan to adjust target behaviors, Dawson and Guare (2009) explain that children must be part of the process. The child should buy into the plan so he/she feels that they have control, understanding and ownership. They suggest that the parent “help the child own the plan, take opportunities to brainstorm, expect to have to tweak your strategies, practice and role-play, use lots of praise and positive feedback, use visual reminders, start small, and measure the result” (pg.126). Verbal praise to a child for appropriate behaviors and choices is a useful and easy reinforcement as long as it follows the behavior immediately and consistently (Dawson & Guare, 2009). Children desire acceptance and attention from parents. When parents are in-tune and involved, children can work harder for parent approval. Stay calm, firm and non-controlling in responses is the most appropriate way to handle a child who struggles with executive functioning skills (Bernstein, 2007).

In trying to alter a behavior, the child should be told that there is a behavior that needs to be changed to contribute positively to the family. The child should be asked what small rewards he/she would be interested in earning. A chart can be placed in a visually accessible place and when the child produces desired results, the reward is given either immediately or short term. The closer the reward is given to the desired behavior, the more the behavior will be modified. The visibility of the chart is an antecedent as seeing the chart reminds the child that good behavior will produce rewards (Kazdin, 2008).

Tasks that include getting ready for the day, homework preparation, chores or basic self-care tasks that may be simple for other children may be very difficult for those children with executive function weakness. There are many self-help books that offer strategies for children and parents. The underlying message is that check lists can prompt the child to complete the tasks so parents do not have to remind or nag. Some check lists are creatively made with such names as a “Nag Chart” or “Positive Order List”. Introducing a new chart or check list to the child’s daily routine, expectations should be clear and specific (Bernstein, 2007). Anything that is simple, creative and placed in an accessible location with a reward attached is a routine that the child can be part of.

One of the goals of parenting a child with ADHD is to help the child become independent and understand how to respond in situations. Dawson and Guare (2009) suggest rehearsing or role playing situations before they happen so a child knows what may happen and how to handle it. It is helpful for children who have difficulties with “flexibility, emotional control, or response inhibition” (pg. 87). There is not a specific or exact way to handle a child with ADHD as all children have varied temperaments, family situations and abilities. Yet, it is helpful for parents to take time to understand their child and what works best. Coaching the child to elicit rehearsed behavior, reminding to check a list or schedule and monitoring situations to prepare for triggers or stimuli can help the child move toward a goal of independence (Dawson & Guare, 2009).

Support and knowledge are two important aspects that will help parents move forward in making thoughtful and educated decisions. The ultimate goal is a peaceful family environment and a happy, well-adjusted child. The ADHD child requires reinforcement of skills through a consistent, firm but loving parenting approach (Bernstein, 2007). According to Bernstein (2007), parents should not get discouraged and not to be overly attached to results. Parenting an ADHD child takes commitment and the challenges will get easier over time with effective parenting and appropriate interventions. He utilized the slogan from Alcoholics Anonymous (AA) in his writing to reflect this notion of encouraging rather than demanding, “Seek progress, not perfection” (pg. 270). The more a parent can understand the complexity of the disorder and adhere to positive behavioral interventions, the more successful both parents and the child can be.

**DSM-5 Criteria for ADHD**

**People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development:**

* **Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:**
* Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
* Often has trouble holding attention on tasks or play activities.
* Often does not seem to listen when spoken to directly.
* Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
* Often has trouble organizing tasks and activities.
* Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
* Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
* Is often easily distracted
* Is often forgetful in daily activities.
* **Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person’s developmental level:**
* Often fidgets with or taps hands or feet, or squirms in seat.
* Often leaves seat in situations when remaining seated is expected.
* Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
* Often unable to play or take part in leisure activities quietly.
* Is often "on the go" acting as if "driven by a motor".
* Often talks excessively.
* Often blurts out an answer before a question has been completed.
* Often has trouble waiting his/her turn.
* Often interrupts or intrudes on others (e.g., butts into conversations or games)

**In addition, the following conditions must be met:**

* Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
* Several symptoms are present in two or more setting, (e.g., at home, school or work; with friends or relatives; in other activities).
* There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
* The symptoms do not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

**Based on the types of symptoms, three kinds (presentations) of ADHD can occur:**

*Combined Presentation*: if enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months

*Predominantly Inattentive Presentation*: if enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past six months

*Predominantly Hyperactive-Impulsive Presentation*: if enough symptoms of hyperactivity-impulsivity but not inattention were present for the past six months.

Because symptoms can change over time, the presentation may change over time as well.

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