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Is Your Teen Having Trouble Staying Focused in School?

An Update on Attention-Deficit/Hyperactivity Disorder

By By Samuel L. Judice, MD., Child & Adolescent Psychiatrist

The most common reason for parents to consult with a child psychiatrist is concern their child may have Attention-Deficit/Hyperactivity Disorder (ADHD). Usually the child's teacher or school counselor is the first to voice such concerns. In my experience, many parents are frightened as to what this label or diagnosis means and how it will impact their child. This article will help separate the fact from the myths so parents may be more informed when seeking help.

It is estimated that between 5 and 20 percent of children and adolescents in the United States suffer from ADHD. Diagnosis is made through a clinical interview where the child and adolescent psychiatrist, psychologist, or pediatrician gathers information from the parent, the student and the school about age inappropriate behaviors. With the present state of technology, there are no blood tests or brain

scans with which to make the diagnosis. Psychological and educational testing may be helpful to quantify the extent and severity of the impairment, but by themselves these tests are inadequate to make a diagnosis.

Behaviors related to ADHD
Of the three subcategories of ADHD, impulsive and hyperactive behavior is more commonly found in boys than girls. A child in this category may be fidgety and have difficulty waiting his turn in sports or games. This child may also inappropriately intrude into conversations or interrupt others who are already talking. Impulsive and hyperactive children and adolescents are frequently loud and get into trouble at school for talking when they need to be quiet and listening. Children with these symptoms tend not be liked by their peers and often do not get invited to parties or other social events.

Teachers frequently see these children as disruptive to the class. Consequently, teachers and school administrators complain to parents, who are at a loss as to what to do to help their children. Parents report to me that they feel humiliated that they cannot stop these behaviors despite heroic efforts on their part. They often start to believe that they must be bad parents. Out of desperation, schools may take draconian measures to try to stop the disruptive behaviors. Schools are often relieved when this child transfers to another school.

The second subtype, consisting of problems focusing and paying attention, is more commonly found in girls. These children and adolescents frequently lose things such as books, articles of clothing, homework, assignments, car keys, wallets, and bankcards. These students are also very disorganized with resultant messy rooms, book packs, and desks. One parent described her adolescent daughter's room as so messy and chaotic with papers strewn everywhere that she could not see the carpet. These children and adolescents frequently have a glazed look on their face when others are speaking to them as if they are daydreaming. They have

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By Stephanie Levin, Parent, International High School

On October 16, 2006, Sharon Ellison met with interested parents at the fall Parents' Coalition of Bay Area High Schools forum held at San Francisco Day School. Ellison is the author of *Taking the War out of our Words: The Art of Powerful Non-Defensive Communication* and the Director of The Institute for Powerful Non-Defensive Communication. Ms. Ellison carries her message to teachers, educational institutions, corporations and to parents. She instructs her audience how to recognize defensive behavior and how to defuse it by underscoring the dynamics of communication when engaged in a power struggle. She sees these struggles as the most pervasive addiction in our lives. In the course of the day, power struggles surface over a range of issues from getting out of bed in the morning, homework, curfews to picking up dirty clothes.

Ellison greeted the audience with a story about her daughter Amy, now 36 and working with her mother. Ellison dropped Amy, then 15, off at her ex-husband's house for the weekend. Perhaps Amy was disgruntled over something her mother had said on the ride over, or perhaps she was just being a teenager, but when Ellison wished her a good weekend, Amy slammed the car door and stomped off in a huff, without saying goodbye. "Has anyone here experienced this kind of behavior from your teenager?" asked Ellison. Hands shot up like rockets.

Our children's actions as well

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as their words can be delivered with tremendous sting. Sometimes the verbal wallop is calculated; sometimes it is not. The same is true for us. The manner in which we deliver our message to our children in the heat of a power struggle can both complicate and accelerate the problem.

What is a Power Struggle?
It is essentially a fight in which we use our words, tone of voice, and body language as weapons of war in order to gain control over someone else. The struggle can be for influence over a family member, a classroom, a community or a cluster of friends.

The primary goal of a power struggle is winning, or always being right. Winning an argument becomes far more valuable than gaining understanding or resolution. "Sometimes the compulsion to win outweighs caring for the other person," she says. Others, who avoid conflict out of fear, do not bring about resolution either. On the contrary avoidance allows frustration, anger, and hurt to linger, also affecting relationships adversely.

Ellison notes that an interesting dichotomy occurs in a power struggle. We become simultaneously bound to and alienated from the other person at the same time. The tug-of-war escalates into a compulsive pattern: a great deal of energy is expended in thinking about our opponent, complaining to others, rehashing the last battle and planning for the next all binding us inextricably to the person we are estranged from.

How we engage in power struggles
When we are defensive, we build emotional barriers and see the other individual as an adversary," cautions Ellison. If we avoid talking about our own feelings, our beliefs, our thoughts or actions, we build an emotional wall. When we move into lecture mode in response to a question our teens ask us, we come off as trying to fix the problem instead of working together to solve the problem. When we don't work cooperatively with our adolescents, we deprive them of the opportunity to take accountability for their lives.

"Sometimes the compulsion to win outweighs caring for the other person,"

Ellison points out communication is trickier with our teenagers when our seemingly innocent questions irritate them. She tells us teens hear our questions, not as questions but as statements, often of our own agendas or judgments. While their annoyance with us may not abate anytime soon, Ellison offers insight on ways in which questions are commonly construed as statements.

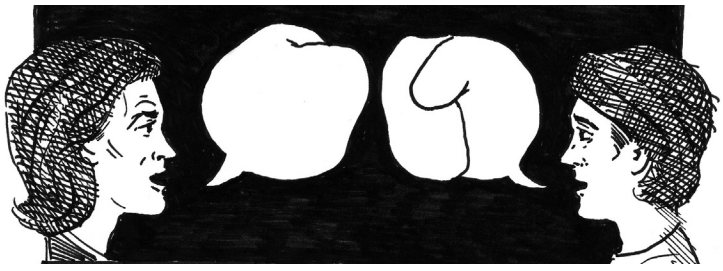
Check your tone of Voice.
Questions can sound harsh or accusatory to a teenager. Some examples are: You left your books at school again? Or we unconsciously accent key words: Must you always do that? Or we speak rapidly clipping our words: What da ya say? Listen for the pitch of your voice at the end of a question. A rise in pitch frequently gives the question a tone of increased urgency: You did WHAT?

Body language is as powerful a communicator as our words are. Think about your body message, do you shake your head from side-to-side when asking a question, or nod your head up and down in agreement? Does your teen shrug as if your question is unimportant? Does the head and neck jut forward when asking a question? The most common form of body language occurs in our facial expressions--frowning intensely, squinting, opening our eyes wide, raising our eyebrows to wrinkling our forehead.

Innocuous words added for emphasis, such as really, ever, always, never, only and all make a question sound defensive. Can't you ever be on time? You always get up late!

"When we engage in a power struggle with our teen, he or she shuts down. How parents use their authority varies, but how children respond to it doesn't vary much. Parents have the authority, teens do not. Yet how we use our authority is the key to maintaining harmony," says Ellison.

Classic Power-struggle Dynamics When setting the rules, are you consistent with authority or do you vacillate? Parental permissiveness offers a child no clear boundaries. And without boundaries, we resort to coaxing. In the spirit of good will, we try to be democratic, but that is not a clear boundary. Often because we love our children so much, they learn they can manipulate us into being permissive by using their power to reject us.



• The combination of coaxing and being authoritarian, then exploding is the worst of permissive and worst of authoritarian.

• Another tact used is labeled bullying permissive: The authoritarian says: You'd better do it, or else." But the authoritarian doesn't follow through with the threat. Using authority in this fashion causes the child and the parent to feel pain making everyone's life unbearable.

• The big guns punisher decides the child or teen can't go out all weekend as punishment, thus creating a struggle. There's no winner here.

• Some parents resort to the positive reinforcement/reward syndrome. If the adolescent does what is desired, she is rewarded later. It's better to monitor behavior on a daily basis, rather than offer some future reward.

Ellison steadfastly believes all children, regardless of age, need firm boundaries. "It's essential to their security. If you let kids speak rudely half of the time, and punish them for speaking rudely the other half, kids learn tenacity." To teach limits, Ellison favors temporary restrictions. For example:" I'm not willing to give you permission to go to the movie until you finish the task." DON'T put a time limit on the task; there's no accountability with a time limit, advises Ellison. Children will learn faster if they can have control over when the restriction ends by being respectful and doing their part.

Physiology of Defensiveness
When a person becomes defensive he feels like a victim. Physiologically the brain fires a prompt to the amygdale, the brain's emotional center, and the body reacts. Noticeable physiological reactions that occur when the brain goes into defensive mode are voice rising, throat tightening and the jaw clamping down. The brain will release from the perceived threat but it can take thirty

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minutes or so before it does.

Avoiding power struggles
By becoming familiar with the styles of defensive behavior parents can more easily sidestep a power struggle, making a real difference in their relationships with their sons and daughters. Learning how to ask and set clear boundaries that communicate nurturing and firmness are the building blocks for a relationship based on core values of respect and reciprocity. If teens learn to "do their part" and do it with a generous attitude, they develop the ability to become creative members of their community.

Sharon Ellison recommends the following steps parents can take to increase powerful, non-defensive communication:

• Pick a limit you can enforce the first time. It might be as simple as "If you speak to me rudely, then I won't answer you or consider your request." If you speak to me respectfully, then I'll answer you and consider your request." With limit setting, the parent can use authority firmly, yet always gently, not with anger.

• When asking questions or making statements, parents can speak to their teenagers as peers by having real conversations without trying to lecture or direct their choices.

• Learn to ask questions in a neutral way and notice that teenagers and other adults are more likely to drop their defenses. Communicate that the purpose of your questions is to gather information by speaking with a calm, neutral, firm voice.

• Ask fact finding questions that are meant to get at the heart of an issue quickly. And ask them at a neutral time in an inviting manner. For example, a parent might ask a teen who procrastinates, "Do you feel more pressure when you wait to get a job done, or do you put it out of your mind completely?" If the question is asked with no agenda and not for the purpose of influencing her behavior, the parent may be surprised at how much awareness she has of the impact procrastination has on her. Even if the answer is noncommittal, she is more likely to think about it when she doesn't feel pushed to change.

• Parents can set limits with statements that communicate confidence by speaking clearly and honestly. Expectations around homework could be stated as follows, "When I hear you say you can handle your homework without me being involved, and at the same time, I see you slip further behind, then it seems to me that you are setting yourself up to fail. I'm not willing to stand by while things get worse. I care too much about you to do that. So I will be clear about having your homework done before your free-time privileges. I hope that you'll find that you feel better and freer too."

Ms. Ellison reminds us that we are practicing non-defensive communication when we ask questions, make statements and predict consequences in an open, sincere way and without trying to control how other people respond. The benefit is that the recipients of our open and honest communication will more likely respect us, thus strengthening our very important relationships with our children. **P**

difficulty following lectures in class or following directions and frequently make careless errors.

Many of these children are very bright but their grades do not reflect this. Given the difficulties they have with school, many avoid educational activities and prefer to withdraw into an inner world of fantasy and creativity. Unfortunately, they are unable to utilize or harness this creativity in a productive way.

The third subtype of ADHD is a combination of the two mentioned above and is most frequently seen in adolescents, especially boys.

Will my child outgrow this? Studies indicate that over 50 percent of children and adolescents will continue with these symptoms into adulthood. Without knowing conclusively which factors are predictive of the persistence of the symptoms, research indicates that if one parent has symptoms of ADHD as an adult, it is more likely that the child will continue to have symptoms as an adult. Underlying genetic vulnerabilities are a major predictive factor, however treatment consisting of appropriate interventions may alter or mitigate genetic vulnerabilities. The goal of any treatment of ADHD should be to alleviate suffering by improving both academic and social functioning to a developmentally appropriate level. School and peer relations are a vital part of any adolescent's life as they spend the majority of their day in school, doing homework or socializing. Adolescents with ADHD know they have difficulties and are not like their peers. They do not feel good about being so different and being overwhelmed by the demands of every day life.

The goal of any treatment of ADHD should be to alleviate suffering by improving both academic and social functioning to a developmentally appropriate level

Should I medicate my child? This is a very personal issue for parents, causing tension in many couples. Research indicates that 90 percent of children and adolescents with ADHD do significantly better with medications such as Ritalin, Adderall, Strattera, and Tenex. Basically, children and adolescents on ADHD medications perform better in school, get into less trouble, and have better relationships with their parents and peers. Unfortunately 10 percent do not get significantly better with the medications available today. There is no blood test or brain scan available that will predict which medication to use or at what dose. Clinicians determine the correct medication and dose by trial and error. Common side effects from Ritalin and Adderall include reduced appetite, weight-loss, problems with sleep, and decreased or stunted growth. Common side effects from Tenex and

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Strattera are sedation, fatigue and headaches. For many adolescents, these side effects are temporary and mild.

For some parents, the thought of medicating their child with a psychiatric drug is terrifying or may not conform to their values. However the risk of using a psychiatric medication must be weighed against the risk of not using medication. Research indicates that adolescents with ADHD who are not medicated are more prone to fatal automobile accidents, engaging in risky sexual behaviors, using recreational drugs, school failure, depression, anxiety, frequent fights with parents and difficulties with peer relations.

Medications are of limited help because they do not provide adolescents with interpersonal coping skills. Although ADHD medications help adolescents to focus and utilize the resources around them, various types of therapy or interventions are often required to help the adolescent develop more successful organizational, social, planning and communication skills. School interventions or modifications are also frequently required as many adolescents with ADHD also have learning disabilities.

Neurofeedback as an alternative to medication

For adolescents with ADHD who do not respond to medications, cannot tolerate medications, or who refuse to take medications, neurofeedback (also called EEG biofeedback) may be a potential option. Neurofeedback has been studied as an ADHD treatment for 30 years with promising results. Improvement in attention, concentration, and working memory has been reported in up to 75 percent of the cases but no controlled research has been conducted.

Neurofeedback teaches an individual to regulate the electrical activity of his or her brain with mental exercises. EEG frequencies generally can be divided into four basic rhythms:

- Beta rhythm is alert and focused
- Alpha is relaxed
- Theta is between awake and asleep
- Delta is deep sleep.

The adolescent with ADHD aims to spend more time in the alert beta rhythm and less time in the slower, more relaxed rhythms by thinking thoughts that generate the appropriate rhythm. More time spent in beta rhythm allows for better attention and concentration. A computer monitoring EEG frequencies helps the participant learn to regulate his or her brain rhythms.

What you can do to help

If your child is already diagnosed with ADHD, you can ensure that your child is eating a healthy diet and getting enough sleep. Research is showing promising results that essential fatty acids such as Omega 3s (fish oils) combined with a specific protein (Acetyl-L-Carnitine) may be beneficial for children with ADHD. Also iron supplementation may be helpful for those children and adolescents who have low iron levels as indicated by a specific blood test measuring ferritin levels. A recent study found that 50 percent of all children who had their tonsils removed and were diagnosed with ADHD before the surgery, no longer met the diagnostic criteria a year later. These children's sleep habits improved after removal of their tonsils.

Parents who suspect that their adolescent may have ADHD should enlist the help of a child psychiatrist or pediatrician to evaluate their child and to make treatment recommendations. **P**

Parents' Coalition Forums for 2006-2007:

Monday,January 22, 7:30 PM at The Waldorf School, 245 Valencia at 14th Street. Some onsite parking is available. Madeline Levine, author will speak on her latest book, The Price of Privilege.

Monday,March 5, 7:30 PM at the San Francisco Day School, 350 Masonic at Turk. An annual event where teens share their views on issues relevant to their lives.

Monday,April 23, 7:30 PM at The Bay School, 35 Keyes in the Presidio. Jane McClure will share her thoughts on preparing your children for college.

All parents and their teenage children are welcome.

Coalition Mission

"To support, educate, and inspire parents of adolescents in order to promote the health and safety of our youth."

If you or your school would like to be involved or if you have comments or questions, please call Eliska Meyers at 415.282.4380.

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