Agenda

The challenge(s) that ADHD/PTSD diagnoses present
Research & Etiology
Assessment Limitations
Putting it all together
Trauma Informed Assessment Case Examples
Intervention Strategies

So confusing!!!!
PTSD Assessment/Diagnosis

According to the DSM-IV-TR

Remember that the DSM just started including children under this PTSD diagnosis within the past 15 years.

3 subcategories of PTSD
- Re-experiencing
- Avoidance
- Arousal

Also, if these symptoms and reactions are noticed during the first 4 weeks following a traumatic incident it is normal. It isn’t until after that time we would consider PTSD if these symptoms and reactions were still observable/reported.

Posttraumatic Stress Disorder

<table>
<thead>
<tr>
<th>Reexperiencing</th>
<th>Avoidance</th>
<th>Arousal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flashbacks</td>
<td>Dissociation</td>
<td>Cognitive Dysfunction</td>
</tr>
<tr>
<td>Intrusive Thoughts</td>
<td>Attachment/Numbing</td>
<td>Hyperarousal</td>
</tr>
<tr>
<td>Images</td>
<td>Not wanting to talk about it</td>
<td>Attachment Reaction</td>
</tr>
<tr>
<td>Traumatic Dreams</td>
<td>Diminished Interests</td>
<td>Startle Responses</td>
</tr>
<tr>
<td>Difficultly Sleeping</td>
<td>OCD-like behavior</td>
<td>Sleep Difficulty</td>
</tr>
<tr>
<td>Physiological Reactions – Headaches, etc.</td>
<td>Panic-like behavior</td>
<td>Irritability</td>
</tr>
<tr>
<td>Self harm</td>
<td>Aggression</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Assaultive-like behavior</td>
<td></td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>Inattention</td>
<td></td>
</tr>
</tbody>
</table>
PTSD DSM 5 Changes

Posttraumatic Stress Disorder diagnosis. Being added is:

1. a pre-school subtype for children age six and under,
   Posttraumatic Stress Disorder in Preschool Children
2. a dissociative symptoms subtype and lastly,
3. a 6-month requirement for children for the bereavement related subtype has been added.

NOT SURE —— Developmental Trauma Disorder, the proposed diagnosis long supported by TLC, remains "under review," and work groups will make a recommendation about its inclusion after further assessing the evidence.

ADHD Diagnosis

According to the DSM IV TR

Some Statistics (CDC, 2011)

• 5.4 million children each year
• Diagnoses increased an average of 3% per year from 1997 to current
• Boys are twice as more likely than girls to be diagnosed with ADHD
• When compared with children who have excellent or very good health, children who have fair or poor health status are more than twice as likely to have ADHD (8% compared to 21%)
Some Statistics (CDC, 2011)

- 2.1 children between ages of 5 – 11
- 3 million between ages 12 – 17
- White – 4.1 million children
- African American – just under 1 million children
- Hispanic – 650,000 children

ADHD Diagnosis Subtypes

1. ADHD combined type
2. Predominantly Hyperactive-impulsive subtype
3. Predominantly Inattentive subtype
   (being added in 2013 – restrictive/attentive)

ADHD
Attention Deficit Hyperactivity Disorder

<table>
<thead>
<tr>
<th>Inattention</th>
<th>Hyperactivity/Impulsivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inattention to details/mistakes</td>
<td>Fidgeting, squirming</td>
</tr>
<tr>
<td>Difficulty sustaining attention</td>
<td>Frequent wandering</td>
</tr>
<tr>
<td>Does not listen to when spoken to</td>
<td>Running or climbing excessively in inappropriate situations</td>
</tr>
<tr>
<td>Does not follow through/finish work</td>
<td>Difficulty playing or engaging in leisure activities quietly</td>
</tr>
<tr>
<td>Difficulty organizing tasks or activities</td>
<td>Frequently &quot;on the go&quot;: Appears to be &quot;driven by a motor&quot;</td>
</tr>
<tr>
<td>Frequently loses items necessary for tasks or activities</td>
<td>Excessive Talking</td>
</tr>
<tr>
<td>Easily distracted</td>
<td>Blurt’s out answers before questions completed</td>
</tr>
<tr>
<td>Forgetfulness in daily activities</td>
<td>Interrupts/intrudes</td>
</tr>
</tbody>
</table>
ADHD diagnosis – current - 2013

1. 6 symptoms in either the inattention or hyperactivity-impulsivity group for at least 6 months to a degree that it is maladaptive/inconsistent with development
2. Have the presence of some of these symptoms before the age of 7
3. Significant impairment from the symptoms in at least two settings (usually school and home)

ADHD diagnosis changes with DSM 5 (Spring, 2013)

- Change onset from 7 years old to 12 years old
- Adding a 4th subtype (restrictive inattentive)
- Removing PDD from exclusions
- Need at least two informants

Challenges

1. There are many overlapping symptoms of PTSD and ADHD
2. The diagnoses of ADHD and PTSD are not mutually exclusive – it could be BOTH
3. Several Current Assessment Limitations
Overlapping Symptoms
Weinstein, 2000

Symptom Overlap
(Weinstein et al, 2000)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>ADHD</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypervigilence</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Inattention</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Detachment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Irritability</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Anger Outbursts</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Distracted</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Restless</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Impatient</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Impulsive</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Limited sense of future</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Difficulty Concentrating</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Symptom Overlap

Both PTSD and ADHD share prominent symptoms

- Poor Concentration
- Behavior Dysregulation
- Attention Problems

Is it PTSD or ADHD? Abused children often exhibit high levels of hyperactivity
Hyperactivity and Inattention

Inattention is one of the cardinal symptoms of ADHD but inattention may also be the result of re-experiencing trauma, hyper-vigilance and or the avoidance of stimuli as a result of trauma (the 3 subcategories of trauma) (Weinstein, 2000)

Hyper-arousal could be misinterpreted as hyperactivity (Giod & Teicher, 1996).

Is it Trauma or ADHD?

Abused children have activity levels that are similar to children with ADHD (Load & Teicher, 1994)

Stress/Trauma might worsen a pre-existing disorder (ADHD) or move a child from a subclinical syndrome to a disorder

Most agree that persons with ADHD are born with a genetic predisposition to these behaviors, they also point out that for the disorder to develop the person is usually exposed to a highly stressful environment.

Hyperactive or Hypervigilant?

Hyper-vigilant

- Children are looking for dangers or threats.
- Children are exquisitely attuned to sights, sounds and especially the facial expressions or tones of voice that might be linked to impending trouble.
Hyperactive or Hypervigilant?

- **EXAMPLES**
  - You can see then how hyper vigilance can look like hyperactivity or inattentiveness in school because these children are paying attention to “distractions” like the teacher’s face or another child’s movements, not their schoolwork.
  - i.e. – a slammed door might prompt a child to jump from their seats – and cause a fight or flight response that might seem to be aggressive or defiant.
  - What is going on out the window? Door? Neighborhood? (hearing gunshots)

Inattention or dissociation?

Children may space out and appear like they are daydreaming.

They may lose contact with reality and become involved in an internal world and the teacher/parents sees a child that “never pays attention” but maybe it is post-trauma reaction.

- i.e. – still has math book on desk and rest of the class is on to history.”

Don’t Rely on Observation Only

When we rely on observation only - it limits our assessment.
Example...

Many children with primary anxiety disorders appear classically hyperactive however they do not meet any other criteria for PTSD or ADHD.

Also Consider the Research that shows...

- Children diagnosed with ADHD are often prone to risk taking behaviors (more exploratory, more curious)
- Children with ADHD are less “rule conscious” than children without ADHD
- Children with ADHD are more accident prone

Knowing this it would be logical to think that a number of children may have PTSD in addition to ADHD post-accident (risk taking)

For Example -

Don’t talk to strangers (ADHD kids often can’t remember this rule when new and exciting situations arise)

Don’t touch that – it is dangerous – they can’t ignore the impulse and do it anyway.
Or is it an Attachment Disorder?

There is evidence that supports that ADHD is associated with inconsistent parenting (think of Ghosts from the Nursery)

Attachment Deficit Hyperactive Disorder

Some have proposed that in order for self control and emotional regulation to develop, someone must care (attachment) about the child – not the case in Neglect/Abuse situations.

Attachment

The prevalence of maternal insecure and unresolved attachment representations increases with the degree and severity of ADHD symptoms (Kissgen et al, 2009).

A note about ODD

If diagnosed with ODD in the absence of ADHD children should be assessed for trauma.

The incidence of ODD alone is LOW it usually occurs with either ADHD (41% of the time) or Trauma exposure.
A note about Bipolar Disorder

Children with ADHD and Bipolar disorder (especially mania) typically have an increased rate of trauma exposure.

A note about Autism

ADHD is the most common co-morbid disorder with Autism Spectrum Disorders.

Common Etiology – PTSD/ADHD

- PTSD and ADHD are both a result of dysregulation (Behavior dysregulation & Attention Problems)
- However the ADHD-like symptoms of PTSD differ from conventional ADHD and instead are related to hyper-arousal
Current Assessment Limitations

Current ADHD assessments do not systematically include an assessment of trauma history.

The *DSM-IV-TR* does not include a differential diagnosis for PTSD (it does list under ADHD criteria that there *may* be a history of interpersonal trauma).

Current Assessment Limitations

The *DSM-IV-TR* uses onset of symptoms prior to age 7 when this is not always the case (proposal to change this in the *DSM-V* has been accepted).

Both ADHD and PTSD are only diagnosed by observation of symptoms which makes diagnosis difficult.

There is not a blood test that determines whether or not a person has ADHD.

Don’t focus only on Hyperactivity and Inattention

Found across diagnoses including anxiety, ADHD, PTSD and Bipolar disorder.
Executive Functioning

Executive Function refers to brain functions that activate, organize, integrate and manage other functions.
(Difficulty with shifting (transitioning), self-regulation, initiating and following through on tasks.)
Most common cognitive deficit in adolescents with ADHD –
Most use BRIEF diagnostic tool (Barkley) to assess executive functioning.

What does research tell us?

History of abuse/early childhood stress are risk factors for future psychopathology (including ADHD) (Palaszynski & Meeroff, 2009; Weinstein et al, 2000)

There is significant research showing a high overlap between ADHD and PTSD in populations of abused children (Merry & Andrews, 1994)

Maltreatment and ADHD

ADHD symptoms occur in 25-45% of severely maltreated children (This is well above the 9% rate of ADHD in the general population) (Glied & Teicher, 1996).
ADHD is significantly more common among abused children with PTSD (37%) than in children without PTSD (17%) (Tamulano, 1996).
Physical and sexual abuse is more common in 6-12 year old girls with ADHD than without ADHD (Briscoe-Smith, et al, 2006).
The most common diagnoses in sexually abused children are ADHD (46%) and PTSD (43%) (McLeer et al).

68% of sexually abused children in one study met the criteria for PTSD and 20% met the criteria for ADHD. All children with ADHD met criteria for PTSD.

35% of kids diagnosed with ADHD have a history of abuse (Ackerman, 1998).

Developmental Trauma Disorder

2009 Proposed Diagnostic Category for DSM-V

“Whether or not they exhibit symptoms of PTSD, children who have developed in the context of danger, maltreatment and inadequate care giving systems, are ill served by the current diagnostic system, as it frequently leads to…….”

DTD Continued

…no diagnosis

multiple unrelated diagnoses,
an emphasis on behavioral control (meds) without recognition of interpersonal trauma and lack of safety in the etiology of symptoms,

and a lack of attention to ameliorating the developmental disruptions that underlie the symptoms.”

(Bessel van der Kolk, MD; Robert Pynoos, MD; et al. February, 2009)
Most Common Reasons for Misdiagnosis

Relying only on observation
Perceptions of the observers could be quite different (various environments yield different results – Dad’s home, Mom’s home, School, Camp, Babysitter etc.)
Overlap in symptomatology
Thinking that ADHD and PTSD are mutually exclusive

Assessment Recommendations

✓ Utilize multiple sources when gathering information.
✓ Try to obtain a family/maternal history which may provide information about potential risk factors for both ADHD and PTSD.

✓ Include a careful and detailed history of a child’s early development, behavior and attachment.
✓ Routine inquiries about trauma histories are strongly recommended. (Life Events Checklist)
Use Multiple Sources

Behavior Observation
From multiple sources (Parent, Caregiver, Teacher, Daycare Provider, Grandparents) (the new DSM 5 will require at least 2 sources)
Interview/Made phone calls
Obtain a Behavior History

Rating Scales
Do they work?
Tailored for each child?
Keep in mind...
Any given child may be acting in the way that is similar to others but for very different reasons.
What are the several causes of Chest Pain? (acid reflux, pneumonia, asthma, gall bladder issues, shingles, muscle strain, broken rib, heart attack?)

Recommended Rating Scales
Trauma
• TLC’s PTSD CAQ
• Briere Trauma Symptom Child Checklist
ADHD
• Anxiety Disorders Interview Schedule for Children and Parents
• Achenbach Youth Self Report and Child Behavior Checklist (YSR/CBCL)
• Behavior Rating Inventory Executive Functioning (BRIEF)
Family History

Children with ADHD often have one or more parents (and other family members) who have had ADHD and other impulse control problems (Comer, 2010).

Statistics:
- Mother and Father with ADHD  3.1 million
- Mother with ADHD 1.7 million
- Father with ADHD 178, 000
- Neither mother nor father 316,000

Maternal History

Risk factors for ADHD
- Antisocial behavior
- Young mother (<20)
- Smoking during pregnancy
- Maternal post partum depression

Developmental History

There is consistent support that ADHD is associated with insecure attachment in children (Clarke et al, 2002).

The quality of attachment should be assessed when children present with ADHD like symptoms.
Developmental History

If an insecure relationship is found some recommend that treatment should include activities that help promote and ameliorate parent/child interactions.

HOWEVER, remember we must consider a diagnosis of ADHD when we see symptoms in a child even with a trauma history and resist the temptation to automatically attribute symptoms to PTSD/Attachment Disorder – it might be ADHD too.

Behavior History

Early onset of ADHD symptoms (from daycare, sitters, grandparents, etc.)

Immature in kindergarten?

School problems such as concentration difficulties, mood swings, episodic anger?

Bottom line...

We really need more research.

It is very difficult to determine what is true co-morbidity vs. spurious (something else that simulates symptoms) co-morbidity.

BUT until then...
Putting It All Together

When all evidence points to a child that was reasonably well adjusted and well behaved at home/school prior to a traumatic event and then the concurrent symptoms of ADHD/PTSD present, it is most likely a result of the trauma.

When there is a history of ADHD-like behaviors that become worse following a traumatic event it is most likely both PTSD and ADHD (if + family history of ADHD then increases likelihood of ADHD prior to trauma).

If symptoms improve with trauma intervention it is most likely PTSD only - if not, then may want to initiate medication and trauma intervention.

Children with symptoms of poor concentration and hyperactivity
- Screen for history of trauma exposure
  - If positive Hx then should screen for trauma symptomatology (using CAQ, Briere, etc.)
- NOTE: Be careful to address issues related to who is “reporting” attention problems (may want to get multiple impressions – parent, teacher, siblings, etc.) - parents often over-report symptoms, teachers under-report.
Clinical Implications for misdiagnosis

Treatment of PTSD is quite different than treatment of ADHD.

PTSD Treatment - Trauma Intervention would aim to provide mastery over trauma specific themes, creation of trauma narrative, cognitive reframing – REDUCE AROUSAL which will improve attention, focus, etc.
ADHD Treatment – Parent training, medication

Medication

I would never advocate using medication to rule out a diagnosis. Not all kids with ADHD respond to stimulants and many of them require trials of several different types of stimulants.

Also, the side effects of stimulants include sleeplessness and sometimes rebound agitation, effects that could exacerbate an already vulnerable individual should the symptoms be better accounted for by exposure to trauma.

Case Example 1 - Luca

How trying medication to “see if it helps” can backfire.
Case Example 2 - Maria

How relying on inconclusive evidence can backfire

Take Home Messages About DX

Take a very careful and deliberate history. Screen for Trauma History/Exposure.
Interview multiple sources!
Compare self reports vs. Parent/Caregiver reports.

What can you do to help??????

Trauma Informed Interventions
Behaviors and Solutions – Classroom

<table>
<thead>
<tr>
<th>When you see this Behavior</th>
<th>Try this Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easily distracted by classroom activity or by activity visible through door or windows</td>
<td>Seat student front and center, away from distractions</td>
</tr>
<tr>
<td>Acts out in class to gain negative attention</td>
<td>Seat student near a good peer role model</td>
</tr>
<tr>
<td>Is unaware of personal space; reaches across desks to talk to or touch other students</td>
<td>Increase distance between desks</td>
</tr>
</tbody>
</table>

Behaviors and Solutions – Assignments

<table>
<thead>
<tr>
<th>When you see this Behavior</th>
<th>Try this Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is unable to complete work within given time</td>
<td>Allow extra time to complete assigned work</td>
</tr>
<tr>
<td>Does well at beginning of an assignment but quality of work decreases toward the end</td>
<td>Break long assignments into smaller parts; shorten assignments or work periods</td>
</tr>
<tr>
<td>Has difficulty following directions</td>
<td>Pair written instructions with oral and/or visual instructions</td>
</tr>
</tbody>
</table>

Behaviors and Solutions – Distractibility

<table>
<thead>
<tr>
<th>When you see this Behavior</th>
<th>Try this Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to keep up during discussions</td>
<td>Encourage to ask questions and engage in discussions</td>
</tr>
<tr>
<td>Complains about being bored</td>
<td>Engage/involvement in activity</td>
</tr>
<tr>
<td>Is easily distracted</td>
<td>Come up with a private signal to cue child to stay on task (wink or hand motion)</td>
</tr>
<tr>
<td>Careless</td>
<td>Slow down directions and tasks</td>
</tr>
</tbody>
</table>
Behaviors and Solutions – Behaviors

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constantly engaging in attention-getting behavior</td>
<td>Ignore minor inappropriate behavior</td>
</tr>
<tr>
<td>Fails to see the &quot;point&quot; of a task or activity</td>
<td>Increase immediacy of rewards and consequences</td>
</tr>
<tr>
<td>Blurs out answers or interrupts</td>
<td>Encourage &quot;excuse me&quot; and practicing waiting turn to talk</td>
</tr>
<tr>
<td>Needs reinforcement</td>
<td>Give daily and weekly reinforcement of goals/behaviors in visual format</td>
</tr>
<tr>
<td>Needs long-term help with improving behavior</td>
<td>Set up a behavior contract and track visually</td>
</tr>
</tbody>
</table>

Behaviors and Solutions – Moods and Socialization

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is unclear as to appropriate social behaviors</td>
<td>Practice social skills and set up reward system</td>
</tr>
<tr>
<td>Does not work well with others</td>
<td>Put in group or dyad with good role model/peer</td>
</tr>
<tr>
<td>Is not respected by siblings, peers</td>
<td>Assign social responsibilities in presence of peer group/siblings</td>
</tr>
<tr>
<td>Has low self-confidence</td>
<td>Compliment positive behavior and work, give opportunities for leadership</td>
</tr>
<tr>
<td>Appears lonely or withdrawn</td>
<td>Encourage social interactions</td>
</tr>
<tr>
<td>Is easily frustrated</td>
<td>Encourage taking time to master</td>
</tr>
<tr>
<td>Is easily angered</td>
<td>Practice coping responses</td>
</tr>
</tbody>
</table>

What else can we do?

Praise achievement and good behavior
Spend quality time – connect and interact
Routine!
Establish clear rules and enforce them consistently
Teach child responsibility
Encourage interests in sports, music, art
Be nurturing and comforting
Teach relaxation strategies – breathing, progressive muscle
INSTRUCTIONS AND SCORING
Behaviors are counted if they are scored 2 (often) or 3 (very often).

- Inattention: Requires six or more counted behaviors from questions 1–9 for indication of the predominantly inattentive subtype.
- Hyperactivity/impulsivity: Requires six or more counted behaviors from questions 10–18 for indication of the predominantly hyperactive/impulsive subtype.
- Combined subtype: Requires six or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.
- Oppositional defiant and conduct disorders: Requires three or more counted behaviors from questions 19–28.
- Anxiety or depression symptoms: Requires three or more counted behaviors from questions 29–35.

The performance section is scored as indicating some impairment if a child scores 1 or 2 on at least one item.

FOR MORE INFORMATION CONTACT
Mark Wolraich, M.D.
Shaun Walters Endowed Professor of Developmental and Behavioral Pediatrics
Oklahoma University Health Sciences Center
1100 Northeast 13th Street
Oklahoma City, OK 73117
Phone: (405) 271-6824, ext. 123
E-mail: mark-wolraich@ouhsc.edu

The scale is available at http://peds.mc.vanderbilt.edu/VCHWEB_1/rating~1.html.

REFERENCE FOR THE SCALE’S PSYCHOMETRIC PROPERTIES
Vanderbilt ADHD Diagnostic Teacher Rating Scale

Name: ___________________________________________ Grade: __________________
Date of Birth: ______________ Teacher: ____________________________________ School: __________________________________

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

<table>
<thead>
<tr>
<th>Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fails to give attention to details or makes careless mistakes in schoolwork</td>
</tr>
<tr>
<td>2. Has difficulty sustaining attention to tasks or activities</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoken to directly</td>
</tr>
<tr>
<td>4. Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)</td>
</tr>
<tr>
<td>5. Has difficulty organizing tasks and activities</td>
</tr>
<tr>
<td>6. Avoids, dislikes, or is reluctant to engage in tasks that require sustaining mental effort</td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities (school assignments, pencils, or books)</td>
</tr>
<tr>
<td>8. Is easily distracted by extraneous stimuli</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
</tr>
<tr>
<td>11. Leaves seat in classroom or in other situations in which remaining seated is expected</td>
</tr>
<tr>
<td>12. Runs about or climbs excessively in situations in which remaining seated is expected</td>
</tr>
<tr>
<td>13. Has difficulty playing or engaging in leisure activities quietly</td>
</tr>
<tr>
<td>14. Is “on the go” or often acts as if “driven by a motor”</td>
</tr>
<tr>
<td>15. Talks excessively</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
</tr>
<tr>
<td>17. Has difficulty waiting in line</td>
</tr>
<tr>
<td>18. Interrupts or intrudes on others (e.g., butts into conversations or games)</td>
</tr>
<tr>
<td>19. Loses temper</td>
</tr>
</tbody>
</table>

(continued on next page)
Vanderbilt ADHD Diagnostic Teacher Rating Scale (continued)

<table>
<thead>
<tr>
<th></th>
<th>Problematic</th>
<th>Average</th>
<th>Above Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PERFORMANCE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Academic Performance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Reading</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Mathematics</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Written expression</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Classroom Behavioral Performance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Relationships with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Following directions/rules</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Disrupting class</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Assignment completion</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Organizational skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Case Study - MARIA

Part One

Alicia, a single parent, was concerned that her 10-year old daughter, Maria had ADHD. Painfully shy, Maria had struggled in school since first grade. Alicia arranged for Maria to be evaluated by a psychologist, who told Alicia that Maria indeed had ADHD. Alicia took Maria to her family doctor who too one look at the psychologist’s report and started Maria on stimulant medication.

Two years passed. Despite steady use of the medication, Maria continued to have problems in school and with her peers. At this point, with middle-school looming, Alicia called you.

What else would you want to know?
Part Two

You review the psychologist’s reports and it included several rating scales, completed by both Alicia and the psychologist that seemed “significant” in indicating ADHD. It also included a computerized test of Visual Acuity that was suggestive of ADHD. Yet the psychologist had never taken Maria’s developmental history, family or medical history that might be contributing to Maria’s social and academic difficulties.

What else do you want to know?
Part Three

Alicia tells you that she and her husband separated when Maria was three and had gotten divorced two years later. The marriage was stormy long before the separation, and the divorce was hostile. When you later ask Maria about her father’s new wife and her mother’s new boyfriend, Maria bursts into tears.

What else do you want to know?
Part Four

Teachers noted after being questioned about Maria’s mood and behaviors that Mondays were the most difficult days for Maria and that things got better as the week progressed. You learn that Maria stays with her father every other weekend, and that Alicia’s boyfriend was spending weekends at their home. The teacher reports, mother and father reports and Maria’s self report do not meet ADHD criteria.

What do you recommend?
Case Study Number One

Case Study - LUCA

Part One

Mr. and Mrs. Paxton are the parents of eight-year-old Luca. A few months ago, they met with Luca’s third-grade teacher, who expressed concern that Luca was having trouble sitting still in class. As the teacher explained, he often had to intervene to help Luca refocus on his work. “Even then,” he said, Luca rarely finishes his schoolwork.

When Luca’s parents shared the teacher’s observations with their pediatrician, she said, “Maybe we should try Ritalin.” After months of trying various doses of that medication, and later Adderall with no improvements, Luca’s mother contacted you for help.

What do you want to know?
Part Two

In your conversations with Luca and his parents, several themes began to emerge. For one thing, his first-and-second grade teachers had not deemed Luca inattentive or hyperactive. At home Luca exhibited these behaviors only when he was doing homework, he wasn’t hyperactive or inattentive during other times of the day, nor during weekends, holiday, or the summer break.

What else do you want to know?
Part Three

As you continue to work with Luca you find that he struggles with reading. His comprehension is poor, and he retains little of what he reads. After review of his first and second grade report cards his reading and writing skills were described as “still developing”.

Do you think the restless behavior and inattention were the result of frustration he felt over having to cope with his disability?

What would you recommend?