TREATING ADHD/ADD IN CHILDREN AND ADOLESCENTS

Solutions for Parents and Clinicians

GENE CARROCCIA, PsY.D.

Foreword by Patricia O. Quinn, M.D.

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TREATING ADHD/ADD IN CHILDREN AND ADOLESCENTS

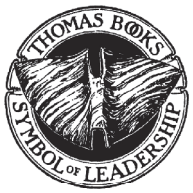
Solutions for Parents and Clinicians

An ADHD*ology* Book

By

GENE CARROCCIA, PSY.D.

With a Foreword by
Patricia O. Quinn, M.D.



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This book is dedicated to Kirsten, my amazing wife,
who has supported and encouraged me on this journey,
and to all the families who are touched by ADHD.

FOREWORD

Parents raising a child with ADHD can often feel quite lost and alone, and may struggle with the many difficulties they face. ADHD is a chronic, neurobiological condition and the great variability in symptom presentations can often cause confusion in both parents, educators, and professionals. The diagnosis of ADHD is made by a professional using a set of criteria that look at specific symptoms and their pervasiveness across a variety of settings over time. However, once a diagnosis is made, the prognosis for a positive outcome is extremely hopeful as ADHD can in most cases be effectively managed with a comprehensive treatment program.

Dr. Carroccia provides such a program with his ADHD*ology* approach to ADHD. In *Treating ADHD/ADD in Children and Adolescents: Solutions for Parents and Clinicians*, this approach is covered in detail and is one of the few books on the topic that presents a long-term, organized, and comprehensive view on the treatment of ADHD.

Treating ADHD/ADD in Children and Adolescents will not only help parents navigate the evaluation process, but also assists them in finding the most effective ways of dealing with ADHD at home and at school. This includes strategies to manage behaviors, handle sleep issues, and choose a medication to treat ADHD symptoms. Clinicians may also find this book to be useful in their diagnostic and treatment approaches with children, adolescents and families who are struggling with the challenges of ADHD. *Treating ADHD/ADD in Children and Adolescents: Solutions for Parents and Clinicians* is highly recommended to help families find a path to success!

Patricia O. Quinn, M.D.

Behavioral Pediatrician; Co-Founder and Director of the Center for Girls and Women with ADHD; Author and co-author of multiple books on ADHD, including *Putting on the Brakes: Understanding and Taking Control of Your ADD or ADHD* and *Understanding Girls with ADHD.*

PREFACE

We are all surrounded by one or more children, adolescents, and adults who struggle with ADHD. As a licensed clinical psychologist and doctor of clinical psychology, I have evaluated and treated hundreds of children, adolescents, families and adults with ADHD, as well as ADHD-like presentations and other co-existing conditions and disorders. I discovered that parents and clinicians needed an effective treatment framework to navigate the ways to address and manage ADHD. I have seen many children and teens with long treatment histories who were not diagnosed with ADHD when they had true ADHD. Some were also misdiagnosed with ADHD when they really had other medical, sleep, neurodevelopmental, and/or psychological conditions, or had undiagnosed co-existing conditions along with true ADHD. Over time, I have realized that many clinicians and parents did not understand or address ADHD sufficiently because they were not aware of these many other conditions.

Whether new or seasoned to ADHD challenges, this book is for parents and close relatives of children and teens with ADHD. Behavioral and medical practitioners, teachers and education professionals should also find this book useful in addressing the different facets of ADHD. For the most effective results, this book is best used along with clinicians as part of the diagnostic and treatment process. It provides the information and teaches skills to be more effective in addressing the many hurdles that ADHD presents. To accomplish this, the comprehensive ADHD*ology* treatment model is presented. This powerful six phase approach can help families successfully address, manage and transform ADHD. This treatment model approach should help maximize results in the following ways:

1. Know how to obtain an accurate ADHD evaluation or assessment, including exploring the numerous medical, sleep, psychological, and neurodevelopmental conditions that may be causing ADHD-like symptoms or co-exist along with true ADHD.
2. Assist parents to better understand and accept a child or teen with ADHD.

3. Become more focused and effective in the management of difficult behaviors at home, including sleep challenges.
4. Better address homework and school challenges, as well as obtaining appropriate official school plans and services.
5. Partner with physicians to get the most from ADHD medication.
6. Learn about potent additional and alternative ADHD treatment approaches.

There's another ADHD*ology* book that compliments this work. It is entitled *Evaluating ADHD in Children and Adolescents: A Comprehensive Diagnostic Screening Tool.* It addresses how to comprehensively evaluate ADHD in children and teens. While *Evaluating ADHD* is mostly for clinicians, it has diagnostic checklists for the many other medical, sleep, psychological, and neurodevelopmental conditions that can cause ADHD-like symptoms or coexist with ADHD. It teaches readers how to efficiently evaluate ADHD, and parents may use these checklists to assist clinicians working with their children and teens. If children or teens have ADHD, but are still struggling and not improving with treatment, parents and clinicians are urged to consider obtaining further evaluations or psychological testing to explore and treat other possible conditions.

G.C.

INTRODUCTION

I knew the Unger family (not their real name) was going to be a handful only moments into my first phone conversation with the mother. I just started discussing my evaluation and therapy services for children and teens with behavioral difficulties when I started to hear the chaos in the background. The mother said she needed help with Jimmy, her nine-year-old son. She said Jimmy was getting D and F grades at school and had frequent visits to the principal's office. His behavioral problems at home were escalating as well, while she and his father were arguing more and more about his difficulties. This took her some time to relate due to the screaming and yelling in the background. "See," his mother said in a sarcastic tone, "this is what I deal with every day." She asked when was my soonest appointment.

I have worked with many families like Jimmy's, so I wasn't surprised by what I heard. As a clinical psychologist working with children and teens who have behavioral problems and ADHD, my job is to figure out what is going on diagnostically, provide psychotherapy treatment, and possibly make additional referrals for other needed services. I also help families better understand the child's behavioral health conditions, motivate the parents to become more effective in their parenting, and assist the family to obtain appropriate school services and accommodations. To accomplish all of this for children and teens with ADHD, I use the comprehensive ADHD*ology* treatment model, which is the core of this book. Each chapter of the book discusses aspects of the six phases of this approach.

The first is the evaluation phase. The mother, father, Jimmy and his older sister came to my office for the initial session. They were a Caucasian family and the parents were in their early forties. The mother was a mid-level manager at a successful technology company, the father was "between jobs," and the sister was sixteen. As I walked into the waiting room to greet them, the mother and Jimmy were bickering viciously because Jimmy was begging for snacks from the vending machine in the hall. "No, I said no! Why do I have to keep repeating myself!! No means no! I told you this a thousand times!" The father was busy doing something on his cell phone.

As I introduced myself and ushered them to my office, the family seemed irritated and frustrated. I noticed the boy had a large carrying case that had a zippered mesh top. I asked about the case. Jimmy said proudly that this was his pet iguana "Ziggy" who just came from an appointment with a veterinarian. Jimmy held the case up so I could see him better. "Can Ziggy learn to calm down too?" Jimmy asked me. "I hope so" I replied.

After they all sat down in my office, his mother immediately informed me that Jimmy had a long history of behavioral problems and complaints from teachers that started in preschool. She said his reading has been terrible, and he didn't seem to understand much of what he read. Also, he had difficulties with his homework. She said he often wouldn't bring it home and took hours to complete it when he did. Jimmy's handwriting was awful as well, and he struggled to stay in the lines when writing or coloring pictures. Additionally, he had trouble sitting still. In prior years he had run out of the classroom, would hit peers, and even hit the teacher when upset. The mother complained that the school hadn't done anything to help him, despite promising this for years. His current teacher seemed overwhelmed by his behaviors.

At this point in the session the father looked up from his phone and said their home was "a disaster." Jimmy refused to go to bed when asked and had been "staying up way too late." Also, he often would sneak his cell phone into bed to play games and listen to music. His mother said he was often irritable and he could argue "forever" when he was confronted about his misbehavior. Additionally, he had terrible tantrums when things didn't go his way or when he heard "No!" Further he had been lying about his homework and when things were missing at home. His older sister said that she often found her stolen things hidden in his room. He refused to do chores and had a habit of running out the door when confronted. Both parents agreed he was very clumsy at home, and did poorly at sports, avoiding them whenever he could.

"Sports aren't for me," Jimmy said dryly. He was kicking his chair and looked bored. "And everyone hates me anyway, you know."

I asked how the family addressed and handled his unwanted behavior. The sister said, "Oh, that's easy. My parents yell and threaten to take away his phone, but never do. Then they go in the basement and start screaming at each other."

The mother shared that the father "doesn't do a damn thing about it," and complained that she is the bad guy at home. She added, "His father is just another child I have at home. He doesn't help with anything. Look at him now! He's selfish and keeps losing jobs!"

The father looked up from his phone and gave her a dirty look. He turned to me and said, "Look, I was just like him when I was a kid. This kid

doesn't need all this nagging and strict rules that make him worse. He just needs some encouragement." Eventually both parents agreed they can be "hot heads," and needed to calm down more. But because they can't agree on how to handle his behaviors, they would just lecture, yell, and give up.

I asked Jimmy for his perspectives on the situation. He said that when his parents argued with each other, his mom would bring up divorce. He said he knew he was going to make the divorce happen. Jimmy said he didn't know why he hated school and homework so much, but that it was just too boring. Reading was "way too much work" and he only liked fun things. He said he wanted more friends and knew he had to stop hitting others. He also felt badly about stealing things at home, and tried to apologize, but no one believed him. Jimmy told me he knew he was a bad kid. "Only music makes me feel good at night in bed. That, and holding Ziggy." The lizard made some noise in the case.

I asked everyone if they knew what was going on with Jimmy. His mother said he had an anger management problem. His father said Jimmy was a slow reader and had a bad teacher. His sister said he was brat and got away with everything. In the past, his teachers were vague with his mother when she asked them why he had school problems. Several years ago, his pediatrician said he was immature for his age, and the family should "wait and see" for his difficulties to improve. At the last visit however, the pediatrician suggested he receive some counseling to address his low self-esteem and anger issues. This is why the mother called me.

I have seen many similar variations of this family's situation. It is always sad to see an entire family suffering. However, I know that there is often a way for a better life for all if they can hang in there and work with me.

Using the ADHD*ology* treatment model, we completed the first phase after five sessions. During this evaluation period, I used a diagnostic approach to explore if Jimmy truly had ADHD, which I suspected, as well as check to see if he had any other conditions. During the ADHD evaluation process, I reviewed the child and family's history, gathered more information about the problems at home and school, and obtained ADHD and other psychological measures completed by his parents and teachers. I also used the ADHD*ology* Comprehensive Diagnostic ADHD Screening Tool (CDAST) to explore if he had any potential medical, sleep, psychological, or neurodevelopmental conditions that may be co-existing or causing his ADHD-like symptoms.

I determined that Jimmy did truly have Combined ADHD, which means he had a brain-functioning condition that caused his inattention, hyperactivity, and impulsivity difficulties. However, like many other children and teens with true ADHD, Jimmy had additional undetected conditions as well. He also had oppositional defiant disorder (ODD), a secondary behavioral con-

dition that seems to grow out of ADHD and causes children to be much more difficult to manage. Also, he appeared to have signs of a visual processing disorder, which is a sensory processing condition that affects the eye-to-brain connection. It can cause serious reading difficulties, sloppy handwriting, and clumsiness with sports. Additionally, Jimmy had partial sleep deprivation, getting only about seven hours of sleep a night when a boy his age required between 9 to 12 hours per night. I believed this chronic lack of sleep was worsening to his inattention, irritability, and low frustration tolerance at school and home. He also suffered from negative peer and familial relations, low self-esteem, and exposure to parental discord.

I suspected that his father had an undiagnosed ADHD-Combined condition as well, due to his apparent childhood and adult ADHD-like difficulties. Since ADHD is highly genetically transmitted and more common in males than females, it is not uncommon for fathers to have ADHD when their children have this.

I shared my diagnostic findings with the family. The parents were amazed to learn that Jimmy had specific conditions causing many of his problems. I informed them that I only screened him for a visual processing disorder, but a specially-trained optometrist would need to evaluate him further. I said the good news is that this condition may be improved with vision therapy. I also discussed his other difficulties, and what could be done to address and improve these.

We moved to the second phase of ADHD treatment, which was education for the family. When they received the handouts about ADHD and ODD, they said the descriptions sounded exactly like Jimmy and they better understood how his conditions impacted him and the family. We discussed the grieving process of accepting his conditions. After learning that ADHD is a neurobiological brain functioning condition that is a disability, and that his behavior was often not his choosing to be difficult, his parents seemed to have more compassion for him. The mother shared that she believed his father had ADHD as well. The father reluctantly agreed.

Next, we began addressing and managing ADHD at home, which was the third treatment phase. His parents acknowledged they were ineffective in dealing with Jimmy's unwanted behaviors, and they learned more productive parental behavioral management approaches. They were taught how to stop yelling and lecturing, use of time outs for misbehavior, and how to use a written plan of behavioral expectations and consequences for his unwanted and positive behaviors. They also learned about using sleep hygiene practices, and immediately changed their bedtime approach with him. He started going to bed earlier with a set time and without his cell phone or electronic screen devices in his room.

As part of the fourth treatment phase of addressing school problems, I instructed the family how to request a case study evaluation from his school to obtain special school services. I wrote a letter to the school with my clinical findings to aid them in this process. The school responded and he received an Individual Education Plan (IEP) that provided individual tutoring for reading and social work services to improve his social skills. His teachers seemed to respond to him more positively as well. His mother also utilized an effective homework notebook system that improved his daily homework challenges.

During this time, Jimmy obtained a visual processing evaluation from a developmental optometrist who diagnosed him with a visual processing disorder. The optometrist explained that his eyes and brain were not working together properly, and he began twice a week vision therapy with the optometrist.

Eventually, his father agreed to obtain his own treatment for ADHD. He told me he was tired of struggling with many things in his own life, and wanted to "see what can be done." He went to a psychiatrist, was also diagnosed with Combined ADHD, and received a prescription for ADHD medication. The father shared that after a few days of staring at the bottle, he tried it and it helped enormously. "I feel normal now, for the first time in forever. I can think clearly and get things done much more easily." After this success, Jimmy saw a pediatric psychiatrist to receive his own medication. With some tweaking, he received an effective ADHD stimulant and dose that helped him. This medication focus was the fifth phase of the treatment model.

After about a month, Jimmy started obtaining better grades and had far fewer behavioral complaints at school. Over time, the vision therapy seemed to improve his reading skills, and his medication appeared to reduce his hyperactivity, impulsivity, and oppositional defiant problems at home and school. The lying and stealing behaviors ended. The family greatly enjoyed these improvements. The mother and father learned how to work together more with the behavioral techniques to better respond to his difficulties. The mother stopped threatening divorce, and the father got a new job, and kept it.

As our sessions tapered down, Jimmy still had some remaining inattention and behavioral difficulties. We entered into the sixth phase of the ADHD*ology* treatment approach, which is utilizing additional and alternative ADHD approaches and treatment options. I shared how improving his diet and obtaining neurofeedback, a special form of biofeedback, could help him. Neurofeedback is an alternative treatment that can improve ADHD for children and adolescents. The mother read about this and agreed to try it. We discussed other options to potentially address his ADHD, including increasing protein in his diet, taking Omega-3 fish oil supplements, eating

more organic foods, and reducing and eliminating foods with additives and preservatives. I encouraged the family to first discuss the food and supplement changes with his pediatrician or a dietitian. We had already addressed his sleep issues, and he was now consistently getting a solid ten hours of sleep per night. After four months of these new efforts, Jimmy improved even more. He started keeping friends in his neighborhood, and his grades continued to increase. He also joined a soccer team and was earning allowance each week for doing his chores. Due to this progress, we decided to end our ADHD therapy treatment. At our last session, Jimmy gave me a picture that he drew. I smiled as I saw that the green coloring was completely within the lines of a happy lizard sitting on a rock. "Ziggy thanks you!" was written under the image of the iguana.

Throughout this book I will use the term "ADHD." Some readers may say "my child has ADD and not ADHD. They aren't hyperactive or impulsive." The term "ADD" indicates Attention Deficit Disorder for a child or teen who has inattention problems without significant hyperactivity and impulsivity difficulties. However, for decades the correct term for this disorder has been "ADHD - Predominantly Inattentive Presentation." Therefore, in this book the term ADHD will refer to all the ADHD types, including ADHD with impulsivity and hyperactivity (Combined ADHD) and without these two difficulties (Inattentive ADHD). These conditions can present differently, have distinct brain signatures, and may require somewhat differing treatments. Children, teens, and adults with Inattentive ADHD often have fewer behavioral problems. However, since Combined and Inattentive ADHD conditions share many similarities, unless stated otherwise, the information presented on ADHD should be applicable to all forms of ADHD.

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CONTENTS

TREATING ADHD/ADD IN CHILDREN AND ADOLESCENTS

Chapter 1

TOWARD A BETTER UNDERSTANDING OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

We all know one or more children, adolescents, and adults who have ADHD. With ADHD occurring in about one in every ten children and teens, and approximately one in every twenty adults, ADHD touches us all. This book is designed to help readers better understand and overcome the challenges associated with children and teens with ADHD.

While some parts of this chapter may seem pessimistic or overwhelming, the hope is that the reader will learn and appreciate the realities of untreated ADHD. The more severe the ADHD, the more problems that can occur. Although this chapter presents some difficult facts about untreated ADHD, the rest of the book provides the answers, tools, and solutions to improve this condition. Just like Jimmy and the Unger family in the introduction, children and families with ADHD can make tremendous improvements and even thrive with the proper help and support.

ADHD IS A COMPLEX BRAIN-FUNCTIONING CONDITION

Understanding ADHD is one of the most essential aspects of addressing this condition. While almost all children and adolescents can present occasional signs or phases of ADHD-like symptoms, most individuals with true ADHD conditions have difficulties that persist over time and eventually impair their functioning. Those with ADHD have a complex neurobiological disorder that can affect their ability to control themselves, their behaviors, and their ability to focus their attention on things they are not interested in or don't like. Since ADHD can affect any age, from very young to the elderly, it is critical to understand that ADHD is not an emotional disorder,

but a brain-functioning condition where parts of the brain are underfunctioning and not working properly. People with ADHD have specific parts of their brains that are smaller, underactive, or underdeveloped in certain ways. They can also have networks of brain parts that are imbalanced and certain important brain chemicals called neurotransmitters that are not working correctly. For more details about ADHD braining functioning, please refer to the last section in this chapter.

Yet, ADHD is not just a condition that affects a person's attention, focus, or ability to sit still; rather, it is a chronic brain problem of executive functioning that impairs important areas of daily behavior. The impairments impact their organizational skills, concentration, motivation, self-discipline, time management, relationships with others, and performance at school and work. As a result of these challenges, ADHD can cause significant individual, family, and societal problems. Children and teens with ADHD can also suffer from additional co-existing disorders, academic and learning problems that require greater school needs, twice the health care costs than those without ADHD, and more injuries and accidents. Teens and adults with ADHD often have greater employment, substance abuse, and relationship difficulties. In addition to the psychological costs, the financial costs of ADHD are staggering. Collectively, the cross-sector costs associated with ADHD in the United States were conservatively estimated to be more than $78 billion each year (Visser et al., 2014).

THE PREVELANCE OF ADHD

ADHD exists all over the world, and not just in the United States. Studies have shown that it has been found in similar rates of children and adolescents worldwide (Polanczyk et al., 2007). Research presented by the Centers for Disease Control and Prevention (CDC) in 2016 found that about 9.4 percent of children and teens ages 2 to 17 in the United States had ever been diagnosed with ADHD. This is about one child in ten, about two children in every school classroom, and 6.1 million children nationwide. This rate has also increased since 2003 (Center for Disease Control and Prevention, 2018) and earlier. The rise may be a result of better awareness of ADHD by providers, but also possibly from increasing neurotoxins in the environment (Dendy, 2006). A Center for Disease Control and Prevention study from 2011 found that ADHD was two to three times more common in males than females. Additionally, the average ages for ADHD diagnoses appear to decrease with severity, with mild ADHD diagnosed at age 7, moderate ADHD at about age 6, and severe cases diagnosed at age 4-1/2 (Visser et al., 2014).

It seems that ADHD is both over diagnosed and under-diagnosed by

some professionals. Some reasons include improper or less thorough evaluations due to lack of time or inadequate training; ignoring or inappropriately delaying the diagnosis; lack of understanding ADHD (Hallowell & Ratey, 2005); and/or inaccurate diagnosing when other conditions are causing the ADHD-like difficulties.

CAUSES OF ADHD

ADHD has been correlated with a number of influences, including genetic factors, environmental components, as well as deficiencies involving neural brain pathways, brain structures, and brain chemicals called neurotransmitters (Herbert & Esparham, 2017). But despite being one of the most researched psychological disorders, the exact cause of ADHD is still not known. How ADHD develops is complicated, and multiple risk factors and causes seem responsible. ADHD is most commonly caused by heredity and a positive family history. It is considered one of the most heritable of all psychological disorders, with heritability estimates of about 70 percent. This means that for all the children and adults with ADHD, this condition is a result of genetic factors seven out of 10 times. For the remaining 30 percent, the ADHD is likely due to other factors, such as environmental influences. Research has suggested that ADHD seems to develop from a complicated interaction between a number of genetic risk variants (Tarver, Daley, & Sayal, 2014). It is considered a complex trait disorder affected by many susceptibility genes, with each gene contributing to the risk (Herbert & Esparham, 2017). If one parent has ADHD, the odds of a child inheriting this can range from about 30 to 50 percent (Dendy, 2006; Hallowell & Ratey, 2005). If both parents have ADHD, the risk is 50 percent or greater. If a sibling has ADHD, there is 30 percent probability that other siblings will have the condition (Hallowell & Ratey, 2005).

In addition to genetics, environmental factors can play a significant role in the development of ADHD, including exposure to alcohol, cigarettes or illicit drugs during pregnancy. Other causes or factors associated with increased rates of ADHD include head injuries (causing mild or traumatic brain injuries), premature births (about 36 weeks or earlier) and/or low birth weight (about 5 to 5.5 pounds or less), certain birth or pregnancy conditions (such as oxygen deprivation in infants with neonatal respiratory distress syndrome, preeclampsia, or inadequate oxygen before or after birth), certain vitamin and mineral imbalances (such as iron, zinc, magnesium, B and D vitamins, and copper), exposure to neurotoxic substances (such as lead, mercury, or cadmium), and exposure to certain artificial food and beverage additives and preservatives.

Since ADHD is not one single entity, it seems to be caused in complex ways. The interaction of multiple genetic and environmental factors appears to act together to create a spectrum of potential for its development. There is a growing amount of evidence that supports the idea that a number of these genetic and environmental factors interact during a child's early development to create a neurobiological vulnerability to the condition. This means that the more genetic and environmental risk factors a child experiences, the greater the potential for ADHD to occur (Curatolo, D'agassi, & Mover, 2010).

TYPES OF ADHD

The two most common types of ADHD are ADHD-Combined and ADHD-Inattentive presentations. ADHD-Combined is most prevalent, and causes the classic problems with inattention, hyperactivity, and impulsivity. Individuals with this condition are more disruptive, excessively active, messy, noisy, immature, and more irresponsible than others their age. However, the hyperactivity and impulsivity symptoms may decrease to some degree by adolescence or young adulthood. While there is another type called ADHD-Predominantly Hyperactive/Impulsive, this form of ADHD mostly appears in younger, preschool, or kindergarten-aged children who have not yet had to demonstrate the longer attention spans required in first grade and beyond.

ADHD-Inattentive presentation is sometimes called "ADD." However, ADD is not the technical term, so it should not be used. Inattentive ADHD mostly causes problems with attention, daydreaming, motivation, and remaining focused, and typically has lesser to no hyperactivity or impulsivity problems. Inattentive ADHD tends to emerge around ages 8-12, and is often identified later or never. They tend to have less behavioral, defiance, and social problems. They are more passive and apathetic, and experience more depression and anxiety than those with Combined ADHD. Some with Inattentive ADHD may have had hyperactivity and impulsivity that decreased over time (Barkley, 2013). Inattentive ADHD may be underdiagnosed in females due to their desires to please others and lesser behavioral problems (Dendy, 2006).

Finally, there is another more recently researched but less recognized condition that appears similar to Inattentive ADHD known as Sluggish Cognitive Tempo (SCT) or Concentration Deficit Disorder (CDD). While additional research on this topic is needed, it is believed that many individuals who appear to have Inattentive ADHD really have SCT (Barkley, 2010). SCT will be addressed further in Chapter 3.

PROBLEMS ASSOCIATED WITH ADHD

ADHD can be dramatically complex. The most difficult dimensions can be hidden unless it is really understood (Dendy, 2006). It is not a common sense or straight forward condition. Those with ADHD often are confusing and frustrating to parents, teachers, and others who have not been educated about ADHD. Many people mistakenly think they know about ADHD. However, when people do not understand that ADHD is caused by brain problems, they may use inaccurate perspectives and labels such as "lazy," "a bad kid," or "they just aren't trying hard enough." Shifting perspectives to appreciate how the brain condition of ADHD is a disability that causes performance and behavioral issues is critical in obtaining a better understanding. It is important to remember that just because we cannot see these brain difficulties, it does not mean that they do not exist or are not real.

ADHD is a disability that can impact many areas of life. The difficulties listed in the following sections pertain more to those with untreated and unmanaged ADHD. They are generalizations, and the degree and types of problems will result from the type of ADHD and its severity. Those with Inattentive ADHD often have lesser levels of these difficulties than those with Combined ADHD. Obviously, each person is different and will have their own unique strengths and weaknesses.

ADHD is a Motivation Disorder

People with untreated ADHD have serious motivation problems and are usually not motivated to do things except what interests them in the moment. However, if they do like something, then they can often do it for longer periods. This is confusing because adults can witness children and teens with ADHD easily doing the things they enjoy, but then struggle with routine chores, tasks at home, school activities, following rules, and completing homework. Children and adolescents with ADHD are usually computer, screen media, and video game fanatics, and love to do these for hours each day. The way they approach life is "What's in it for me?" and "I want to do what I want to do right now!" They are often pleasure-seeking missiles who can become easily frustrated and confused when adults do not allow them to do what they want. Those with ADHD can be over-focused on the things they are interested in, and ignore or lack adequate focus on daily routine demands, causing them to be ineffective and unproductive.

ADHD is a Performance Disorder

Individuals with untreated ADHD have difficulty persisting with activities for as long as others, unless they like the activity. Therefore, they will