

Alternatives to medication in ADHD treatment

Stimulant medication has long been the first choice in treatment of Attention Deficit/Hyperactivity Disorder, despite concerns of many parents. Research has consistently shown it to be effective, and to reduce long term risk of more serious outcomes such as school failure and substance use. However, many parents continue feel uncomfortable or unwilling to place their children on these medications long term. In a thorough review of existent literature, Pelham and Fabiano (2008) highlighted three psychosocial treatments for ADHD that have been proven effective with or without concurrent medication therapy.

Both Behavioral Parent Training and Behavioral Classroom Management have been shown to reduce negative effects of ADHD on children's behavior and learning. In these programs, a clinician works directly with parents and teachers to set up behavior monitoring systems with consistent rewards and consequences, as well as environmental changes to reduce distractions and triggers to hyperactivity. Children's social skills training programs, while found ineffective in outpatient settings such as weekly group therapy, showed great promise in intensive day/summer camp settings. In these programs, children learn skills and are coached in carrying them out in real social settings. These 3 programs showed nearly equal or even greater change than medication treatment.

Pelham and Fabiano conclude that psychosocial treatments focused on changing concrete behaviors are viable alternatives to medication therapy. The downside they find with these treatments is that they require more time, effort and cost than medication. They conclude that for most children, the best program continues to be a combination of medication therapy and behavioral management strategies in home and school.

Pelham, W. E & Fabiano, G. A. (2008). Evidence-based psychosocial treatments for Attention Deficit/Hyperactivity Disorder. *Journal of Clinical Child and Adolescent Psychology*, 37, 184-214.

Managing Defiant Behaviors

One of the more common concerns of parents is how to deal with defiant or aggressive child behaviors. These are typically treated by teaching parents new strategies for disciplining children, including communication styles and consistent rewards and consequences. Lavigne and colleagues (2008) conducted a study to determine the most effective way to help parents adopt new behavior management strategies. Overall, they found that parents who were given books on behavioral management fared as well as parent sent to training groups. However, there was a significant relationship between number of sessions of the groups attended and child improvement. Parents who attended few groups fared no better than those who read at home, but those who attended and participated in at least 7-9 of the 12 sessions reported significantly fewer problem behaviors in their children.

Lavigne, J., LeBailly, S, Gouze, K., Cicchetti, C, Pochyly, J., Arend, R et al. (2008). Treating Oppositional Defiant Disorder in primary care: A comparison of 3 models. *Journal of Pediatric Psychology*, 33, 449-461.

Defining Pediatric Bipolar Disorder

Pediatric Bipolar Disorder (PBD) has become increasingly commonly diagnosed in children, despite lack of consensus on how it should be defined. Youngstrom, Birmaher and Findling (2008) conducted a review of existing literature looking for areas of consistency and support for this diagnosis in children. They noted several key symptoms that are common in pediatric bipolar but not in other childhood disorders: Elated or euphoric mood, racing thoughts, decreased need for sleep without evidence of sleepiness, and labile mood. Other symptoms, while common in PBD, are frequently found in other childhood conditions and are not sufficient to make the diagnosis: irritability, poor concentration, increased motor activity and aggression. They noted that PBD has similar cycling patterns to adult BD, with long episodes of low or elevated mood, but that children's episodes are more likely to be marked with mood swings within each episode (e.g. mood mostly down, with spikes or elated/irritable mood). Authors also noted that the diagnosis has demonstrated solid clinical utility, in that it leads to treatment models that have been shown to be effective. These usually consist of a combination of medication with mood stabilizers or antipsychotic medications plus behavioral management techniques and cognitive therapy. Youngstrom, Birmaher and Findling recommend thorough assessment for bipolar disorder when any of the following conditions are present with symptoms described above:

- Family history of Bipolar Disorder
- Episodes of aggression combined with manic symptoms
- Early onset depression resistant to treatments
- Mood difficulties combined with any psychotic features
- Clear episodic presentation of ADHD like symptoms
- Mood becomes markedly less stable after trials of stimulant or antidepressant medications.

Youngstrom, E.A., Birmaher, B. & Findling, R. L. (2008). Pediatric Bipolar Disorder: Validity, phenomenology, and recommendations for diagnosis. *Bipolar Disorders*, 10, 194-214.

Do DSM-IV diagnoses fit child data?

With efforts to develop the next Diagnostic Manual of mental Disorders underway, Lahey and colleagues set out to show how well current diagnostic categories fit the psychological symptoms children exhibit. They examined ADHD, behavior disorders, major depression, and several anxiety disorders. Overall, their data support separate diagnostic types of inattentive and hyperactive for ADHD, as well as a distinction between Oppositional behaviors and conduct disturbance. However, their data indicate that at least in children, major depression and generalized anxiety overlap to such a degree that distinguishing between them is not clinically relevant. Other anxiety disorders appeared to be separate but related to a common factor - fears. Lahey and colleagues also attempted to distinguish between internalizing (emotional) and externalizing (behavior) disorders, and found that children with depression/generalized anxiety tended to have features of both classes of disorders.

Lahey, B., Ratgouz, P, Van Hulle, C., Urbano, R., Krueger, R., Applegate, B, et al. (2008). Testing Structural Models of DSM Symptoms of common forms of child and adolescent psychopathology. *Journal of Abnormal Child Psychology*, 36, 187-206.

Sleep and Child Mental Health

Difficulty sleeping is a common symptom of many psychological conditions affecting all ages. Children can experience a wide array of sleep difficulties, from difficulty falling or staying asleep (insomnia), restless sleep, difficulty waking or oversleeping (hypersomnia), and nightmares. Two common conditions frequently associated with sleep problems in children are anxiety and depression. Chorney, Detweiler, Morris and Kuhn (2008) reviewed available literature on sleep and these conditions. They found that sleep disturbances are very common in both conditions, with 88% of anxious children showing some form of sleep difficulties (50% had at least 3), and up to ¾ of depressed children showing insomnia alone. The literature indicated that sleep problems are often one of the first symptoms seen in children who develop these disorders, occurring before marked changes in mood and behavior. In fact, one study showed that early childhood sleep disturbance was correlated with adult anxiety disorders 20 years later. Sleep difficulties appear to be part of a negative cycle - mild mood difficulties reduce amount and quality of sleep, which leads to less energy and ability to cope with difficult emotions. Children presenting with ongoing sleep disturbances beyond normal childhood trends (occasional nightmares, etc) may be helped by referral to a mental health professional for more in depth evaluation and treatment before problems intensify.

Chorney, D., Detweiler, M., Morris, T. & Kuhn, B. (2008). The interplay of sleep disturbance, anxiety, and depression in children. *Journal of Pediatric Psychology*, 33, 339 - 348.

Psychological Interventions to Improve Medical Compliance

Children and teens with chronic medical conditions often report difficulty complying with multidimensional treatment regimes (e.g. medication, dietary change and physical therapy), often leading to negative consequences for their physical health. Kahana, Drotar and Fraizer (2008) conducted a review of literature across a wide array of chronic child medical conditions to explore the best method for helping families comply with complex treatment regimes. They found that education alone, the most commonly used method in community practice, was rarely sufficient to help youths manage these routines at home, with negligible improvement in adherence. Behavioral interventions, which emphasize teaching problem solving and parent training around anticipated barriers to compliance, had the best success.

Kahana, S., Drotar, D. & Fraizer, T. (2008). Meta-analysis of psychological interventions to promote adherence to treatment in pediatric chronic health conditions. *Journal of Pediatric Psychology*, 33, 590-611.



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Summer Parenting Tips

With school out and the long, hot days stretching out before us, many parents report increased stress in their role as parents. With increased time together and a decrease in structured activities, sometimes minor problems can escalate into major family conflict. Here are some strategies to help keep the peace at home.

Managing boredom - After the first weeks of summer, children accustomed to the constant structure of school often run out of things to do. Children are often able to solve this problem on their own, but may not if parents always step in with an answer. Instead of jumping in to entertain your child, have a few low-key productive activities set aside - academic workbooks, reading, housecleaning projects, outdoor exercise, etc. If your child complains of being bored, offer these activities as a choice. If they repeatedly complain of being bored, chose one for them. They gain some structured activity time, and learn they cannot rely on you for creating entertainment. Over time they *will* find their own fun.

Managing sibling conflict - With more time together, siblings may have more trouble getting along. As with managing boredom, it is not often helpful for adults to step in and solve conflicts, as children learn valuable conflict resolution skills through these conflicts. If you must step in to save the peace of your household, be careful not to take sides. You can help them resolve the conflict themselves by asking open questions without showing anger ("What seems to be the problem?" "What are some options for resolving this?"), or you can separate the siblings and engage everyone in one of their productive activities until they calm down.

Managing parent-child conflict - With increased togetherness, parents and children also may find relationships strained. Often the key to managing these is to stay calm. If you find yourself slipping into a shouting match with your child, take a time out. Tell you child you need time to calm down before you can speak with them, and that you need absolute quiet. If necessary, assign them a productive task to create that quiet. You can also reduce the risk of conflicts by making sure you have some time off from your kids. Arrange for play dates with other families or relatives, and take turns giving each other a break. Community recreational activities and library programs also provide some structure and time away from home.

If you would like more tips, Advancing Minds clinicians are available for parenting consultation. Give us a call! (408) 294-9905

Gender and Learning

Differences in academic scores between boys and girls have long been reported with little understanding of the cause. Traditionally, boys have been shown to outperform girls in math, while girls outperform boys in reading. It has been unclear whether these differences were due to biological or to cultural differences between men and women. Guiso, Monte, Sapienza and Zingales conducted a cross cultural study of learning and gender attitudes across 40 countries. Learning was assessed through identical translations of tests in math and reading as part of a previous international study. Gender attitudes were assessed by various measures, including the World Economic Forum's Gender Gap Index as well as rates of employment in each nation. They found that gender equality variables were correlated with girl's test scores in both reading and math - the more equal men and women were, the higher girls scored in each area. In cultures with lower ratings of gender equality, boys outperformed girls in math and girls outperformed boys in reading, as had been seen in past research. In cultures with higher equality, girls and boys performed equally in math, while girls continued to outperform boys in reading by a larger margin. Results appear to indicate that the gender gap in reading skills is biological (or related to other cultural variables), while the gap in math scores is due to gender bias.

Guiso, L., Monte, F., Sapienza, P. & Zingales, L. (2008). Culture, gender, and math. *Science*, 320, 1164-1165.