ADHD: The Child’s Perspective

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Outline

• Who cares?
• What do we know?
• Practice implications

Post-modernism

• a cultural, intellectual, or artistic state embodying complexity, contradiction, ambiguity, diversity, and interconnectedness

Who cares?

• Rights
• Attributions
• Successful outcomes


Article 3
1. In all actions concerning children… the best interests of the child shall be a primary consideration.

Article 12
1. …. the right to express his or her own views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article 24
1. … the right of the child to the enjoyment of the highest attainable standard of health
Attribution

• “I’m bad / lazy / stupid”
• “I have an illness”
  – “I have no control over my behaviour”
  – “I am not responsible for my behaviour”
  – “If I improve it’s only b/c of the medication”
  – “Efforts at self-change are futile”

Therapeutic alliance

• Meaningful targets / outcomes
  – Developmental limits of children eg difficult for to see beyond present / immediate future
  ⇒ parents / teachers / health pros as surrogate decision makers
• Rationale for intervention
  – impairment
• Monitoring of benefits and adverse effects of interventions

What do we know?

• 1976 (Whalen & Henker, Psychological Bulletin)
  – The meaning hyperactive children attach to their drug therapy may significantly affect degree of success

What do we know?

• 1978 (Baxley, Turner Greenwald J Ped Psychol)
  – structured interview 26 boys age 7-16 (mean 11.5)
  – Knowledge / attitudes toward drug therapy & perceptions / conseq’s of treatment
Results:
  – generally knowledgeable about purpose of med’n
  – mixed attitudes about having to take
  – associated not taking with negative consequences

What do we know?

• 1982 (Sleator et al Clin Peds. “How do Hyperactive Children Feel about Taking Stimulants and Will they Tell the Doctor?”)
  – interviews with 52 subjects over 8 yrs (mean 11.7), 47 boys
  – all had received stimulants > 1 year
Results:
  – many disliked med’n & often tried to avoid taking it
  – physician interview does not always provide reliable info on children’s feelings, attitudes & behaviours

What do we know?

• 1982 (Cohen & Thompson, Can J Psychiatry [Toronto])
  – interviews with 15 hyper children (age 6-13, mean 8.8, middle-upper mid class) & their mothers 6 mths after commencing stimulants (all responders)
  – Knowledge, perceptions & attitudes toward treatment
  – Self-worth, locus of control
Results:
  – Both children & mothers had mixed feelings about med’n
  – Most children felt continuing med’n was important
  – Self-esteem and locus of control increased over 6 mths
What do we know?

• 1998 (Efron, Barker & Jarman, J Paed Child Health)
  – 102 children (93 boys, age 5-15, mean 8.9) participating
    in a crossover trial of two stimulants, 2 wks each
  – Subjects & parents rated at end of each period how felt
    compared to normal self
Results:
  – 19% felt worse than usual on DEX, 13% on MPH
  – children and parents disagreed in global rating of
    response in \(\frac{1}{4} - \frac{1}{2}\)
  – \(\frac{1}{4}\) parent viewed child as responder, child rated self as non-
    responder

What do we know?

• 2005 (Exley, Faculty Education QUT, unpublished?)
  – Response to “behaviour crisis” in Qld schools: tchrs payouts for psych illness
  – Detailed interviews with 2 boys aged 6 & 8 “who were
    labelled by medical specialists as having ADHD”
  – Knowledge, perceptions & attitudes toward treatment
Results:
  – Boys had misunderstandings produced by
    “recontextualized medical discourses”
  \(\rightarrow\) Socially constructed ADHD identities as deviant &
    diseased, & requiring medication

What do we know?

• 2006 (Traywick et al, [E Carolina] J Attention Disorders)
  – Preferred outcomes questionnaire – 18 possible
    outcomes, 100mm VAS
  – 27 children (age 7-16, 18 boys) and their parents (24
    mothers), 2/3 African American, 2/3 poor (<$20K)
Results:
  – Ch’n rankings: better in school, listen better, be good
  – Parent rankings: feel good about self, listen better,
    remember, better in school
  – Correlation good; main diff: “to stop taking medication”
    (74% ch’n, 54% parents)

What do we know?

• 2007 (Iser, Sciberras, Efron, submitted)
  – 47 child-parent pairs (45 boys, age 8-18, mean 10.4)
  – Self-perception, quality of life (QoL), What am I Like?
Results:
  – Self-perception lower than reference
  – Self- & parent-reported QoL lower than reference
  – Parent ratings signif lower than children (except physical fn)
  – Parent report of QoL inversely related to severity (parent-rated)
    – Not so for children’s self-report
  – Children generally reported behaviours & medication
    effects realistically; rated future optimistically

What do we know?

• Children do not undergo treatment for ADHD
  of their own accord (Hoza 2000)
• For adolescents, taking a medicine that
  profoundly affects their cognitive & emotional
  functioning requires that they integrate this
  awareness into their self-image (Weiss 2000)

Why might child report not be
reliable?

• Socially acceptable “response set”
• Embarrassment / shame
• Echo parents’ comments
• Social stigma assoc w taking meds
  \(\rightarrow\) spurious negative report (“Children with
  ADHD are reminded of their atypicality with every
  medication dose” Henker & Whalen)
What is truth? Nikolai Ge (1890)

What is truth?

- Children tend to “under-report” symptoms
  - Correlation between children with ADHD and their parents weak until mid 20’s (Barkley)
  - Correlation between 2 parents, parents and teachers also weak

Hamer. Science, 2002

Disorder & developmental stage: interactional effects

- symptoms of disorder vary over time
  - environmental factors
  - developmental stage (eg hyper → inner restlessness)
- characteristics of developmental stage meet vulnerability assoc with disorder
- comorbidities emerge / recognised when developmentally exposed
  - eg Asperger’s at preschool, LDs early primary, depression late primary
ADHD and adolescence

- Poor impulse control
- Disorganised
- Lack social judgement
- Easily frustrated
- Hormones
- Emotional reactivity
- Disregard for safety
- Defiance of authority

ADHD and adolescence

- Twice as adolescent as regular adolescents
- Have twice as much ADHD as they did before puberty
- Balance respect for privacy and promotion of independence with on-going parental / teacher surveillance & support

ANTICIPATORY GUIDANCE

Impact of having ADHD

- Home
- School
  - Classroom
  - Playground
- Recreation

Home

- Conflict - parents, sibs
- Socioeconomic disadvantage
- Parental mental health, subst abuse
- Limited community supports

Classroom

- An unhappy place for kids with ADHD
  - Organisational demands
  - Academic underachievement
    - Cognitive demands
    - Expectation of independence eg project work
  - Trouble
  - No extra supports

Playground

- Often an unhappy place for kids with ADHD
  - Social relationships increasingly complex
    - "emotionally immature", reactive
  - Conflict / exclusion - "bully-victims"
  - Isolation
Street

- Impulsivity
- Poor social judgement (easily led)
- Low self-esteem
  - trouble with law
  - substance abuse – smoking, alcohol, marijuana, ice
  - sexually exploited – preg, STIs
  - reckless driving

ADHD beyond childhood

- Improvement with time, but continues to affect fabric of daily life in most cases
  - 75% continue to have problems into adolescence, 50% into adulthood (Ingram 1999)
- Health care costs double controls (Chan 2002)
- Increased risk
  - academic failure / school drop-out
  - delinquency, crime & incarceration
  - unemployment
  - relationship difficulties
  - injuries eg MCA
  - substance abuse – 2 X risk (Biederman 1997)
  - antisocial personality disorder (Weiss 1986)

Goals (Castellanos)

- Prevent irreversible mistakes – motor car accidents, felony arrests, addictions, precocious pregnancy, death
- All reversible mistakes are learning opportunities
  – white matter volume increases into 4th decade

Treatment principles

- Manipulate environment
  – modified curriculum, sports / hobbies, vocational choices
- Self-management
  – gradually increase autonomy as YP demonstrates capacity for reflection / self-monitoring

Ethical dilemma – the patient doesn’t want to take treatment

- Adolescents – easy
  – Usual practice (autonomy, shared decision-making)
  – Non-adherence the norm
  – Strong language skills, assertive
- Pre-adolescents
  – challenging

Practice implications

- Listen to the kid!
- If disagreements – explore and address