ADDitude
ATTENTION DEFICIT

SPECIAL COLLECTION

Living with ADD

Great Articles from the Archives

ADD & School • Conquering ADD in the Workplace
Parenting Tips • What A Coach Can Do
How to Get the Sleep You Need • Women & ADD
Nutrition and Your Child

contents

Living with ADD is a special publication of *ADDitude* Magazine (ISSN-1529-1014). *ADDitude* is published bimonthly by New Hope Media LLC, 42 West 38th Street, Suite 901, New York, NY 10018.

the Surprising Secret to Happy Days

[Hint: It's all routine]

BY PETER JAKSA, PH.D.

Every parent of a child with AD/HD has heard the routine about routines: All kids need structure, and kids with AD/HD need even more. Set up a morning routine to get out the door on time. Make sure homework happens at the same time and in the same setting daily. Do something fun to unwind before a regular bedtime. On paper, this seems pretty basic. But when you're raising a child with real attention difficulties in the real world, setting and maintaining such routines can seem downright hopeless. Yet there is hope—even happiness—in sight. The keys: belief in the power of family routines and a long-term commitment to them.

Well-intentioned parents may start out enthusiastically, yet throw in the towel after a few weeks (or even days). "Billy just won't listen. He doesn't want to go along with it."

Routines can't work if parents give up too soon. To make structure truly effective, routines must be seen and implemented as a way of life.

Multiple Benefits

Routines affect life positively on two levels. In terms of behavior, they help improve efficiency and daily functioning. A predictable schedule offers structure that helps kids feel safe and secure.

In addition, your whole family will benefit psychologically. We experience less stress when there's less drama about when you'll eat and where you'll do homework. And family identity is solidified when everyone has a role (Anna sets the table, Brian clears the dishes).

In these hectic times, a structured life may seem impossible. Everyone is juggling schedules: work, school, piano lessons, soccer practice, and so on. Yet in such times, structure becomes most important. A review of 50 years of research, recently published in *The Journal of Family Psychology*, shows that even infants are healthier and exhibit better-regulated behavior when the family sticks to predictable routines.

Effective routines take commitment and consistency, with all family adults presenting a united front. Routines should be established when children are young and applied consistently as they grow—but it's never too late to start. Above all, don't give up.

Here are suggestions to get you started. Just remember that success takes time—sometimes months or years. But the benefits will last a lifetime.

Good Mornings

The goal each morning is to get everyone ready and out the door on time. Preparations made the night before, such as packing bookbags and laying out clothes, are crucial to a smooth morning. Because many AD/HD children (and adults) are highly distractible, avoid stimuli that are likely to throw the routine off course. For example:

- Leave the TV off in the morning.
- Don't get on the computer to check your e-mails.
- Ignore that new magazine or catalog until the evening.

Homework Helper

It's often said that the only consistent thing about children with AD/HD is their inconsistency. This is particularly problematic when it comes to academic effort. Not surprisingly, parent-child homework battles are common. But an established study routine (time, place, methods) goes a long way toward decreasing their frequency and intensity—if not eliminating them entirely.

- Enforce a consistent start time. Make homework a habit.
- Stay close to your child. Many children with AD/HD concentrate better when an adult works with them or is nearby.
- Take breaks. Short breaks help alleviate the boredom and mental fatigue that result from the struggle to maintain focus.
- Have fun afterward. Your child is more likely to apply herself to homework when she knows that a fun activity, such as playing a game or watching TV, will follow.

Dinner's Ready

For hundreds of years, family members have forged bonds around the dinner table. In this age of the Internet and TV movies on demand, a dinner ritual is still beneficial, if not crucial.

Ideally, mealtimes should be a pleasant social time, with business, school, or family problems left off the

table. It takes time and work to prepare a family meal, but you'll find the benefits are well worth the effort:

- Family members stay connected to one another's lives.
- Events are discussed and plans get made with everyone's input.
- Responsibility is encouraged through the regular chores of setting and clearing the table.

Good Nights

Your goal at bedtime is to help your child wind down and get to sleep at a usual time. Research shows that children with regular bedtime routines fall asleep sooner and awaken less often during the night than those without them.

Children with AD/HD fight bedtime because, quite simply, going to bed is boring to them. Routines that offer rewards and encourage relaxation can overcome the boredom. Things to try:

- Have a light, healthy snack, like an apple or a rice cake.
- Play a quiet, low-stakes game, or read a book.
- Have a sweet and personal nightly lights-out ritual.
- Try to get your child into bed at the same time each evening.

There's no question that establishing family routines takes a great deal of time and effort. You may ask yourself, "Can we afford the time and the energy to do all of this?" A better question might be, "Can we afford not to?"

Dr. Peter Jaksa is the Parenting Editor and a Scientific Advisor for ADDitude *Magazine. He is president and clinical director of ADD Centers of America and a board member of the Attention Deficit Disorder Association.*

Top 10 Routine Builders

1) **Give specific instructions. "Put away your toys on the shelf in the closet." Be consistent—if the toys are stored on the shelf one night, they should be put there every night.**
2) **Assign tasks that your child is capable of doing on his own. Success builds confidence. The goal is to teach your child to do things independently.**
3) **Involve your child in discussions about rules and routines. It will help him understand goals and teach him to accept responsibility.**
4) **Post routines, broken down into two to five tasks, in a visible location (refrigerator, bathroom mirror) and review lists regularly with your child.**
5) **Be realistic about time. Make sure you've set aside enough time for all the steps. To be safe, add an extra five minutes.**
6) **Expect gradual improvement. It takes time to change old habits.**
7) **Praise effort—not just results. If your child set the table but forgot the napkins, acknowledge that she's trying. Reward good behavior more often than you punish bad.**
8) **Allow for free time in daily routines. Kids—and adults—need downtime.**
9) **If your child isn't taking to the routine, seek help from a counselor who specializes in AD/HD. A pro can help get you on track.**
10) **Stay focused on the long-term goals. Above all, don't give up!**

Mothering without Smothering

When Conscientious Parenting Is Too Much of a Good Thing

BY PETER JAKSA, PH.D.

I first evaluated Donny* for AD/HD shortly after his eleventh birthday. Like many other parents, his mother, Christine*, had a mixed reaction to diagnosis. There was sadness that her son was not "perfect," but relief at finding answers that finally made his inattentiveness, impulsivity, and tantrums understandable. There was hope for a better future based on a treatment plan that would include academic accommodations, therapy, and medication. Most of all, there was a powerful determination on Christine's part to do whatever was necessary to help her son.

Donny's mom soon became his champion, protector, and advocate. She read books and browsed the Internet for information. She coordinated with Donny's teachers, school counselors, soccer coaches, piano teachers, and parents of friends to make sure that they understood and treated him fairly. She attended IEP (Individualized Education Plan) meetings and helped shape his academic planning. She established morning, homework, and bedtime routines to make life at home more structured, predictable, and manageable. The caring and supportive structure helped Donny thrive. He was still a handful compared to others his age, but

he became a more successful, better-adjusted, happier child.

I saw the family again about four years later. Donny was backsliding. At home, he was angry and defiant. At school, his grades were suffering because of his procrastination, disorganization, and poor planning. Getting him to do anything was a battle of wills. He wanted to stop taking medication and refused after-school academic support. Grounding and other forms of discipline had little effect on his behavior.

Christine was also worried about his choice of friends. They were not, she was certain, a good influence. He was withdrawing from family life and spending more time alone in his room or hanging out with peers. Christine was still the concerned and motivated parent, but Donny wasn't responding anymore. What happened, she wondered?

What happened is that Donny grew up. At 15, he wasn't the same youngster he had been at 11. His perceptions, expectations, and needs changed—some of them drastically so. Donny now described his caring and dedicated mother as controlling and demanding, someone who constantly nagged him. She was always looking over his shoulder, he said, always bugging him about his friends. And she treated him like a baby; all of his friends' parents gave their children much more freedom. Couldn't she get a life and get off his back?

The family's dilemma was similar to many I've seen over the years. An ordinary mother becomes Supermom in an attempt to build a decent life for her challenged child. But the interdependency becomes so entrenched that Mom can't let go when it's time. She's spent so many years protecting him from the blows of the outside world, she fears he'll fall to pieces without her constant support.

Whether or not a child has AD/HD, a take-charge, proactive parenting style—no matter how well-intended—feels like controlling and smothering to teens. Teens don't want to be taken care of. They want independence and autonomy.

Donny felt embarrassed that his mother checked with his teachers every week to monitor his schoolwork. He was mortified that she wouldn't let him take driver's ed until his grades improved. The schedules and routines at home made it feel like living in a cage. All household rules and, for that matter, taking medication, felt like ways of controlling him. In fact, Donny was tired of everything about AD/HD.

Donny wanted more responsibility and found his way blocked by—of all people—his caring and well-meaning mother. By trying too hard to be helpful, Christine was keeping her teenage son a dependent child.

Something had to change—and it had to start with Christine. Nothing major, just a gradual loosening of the apron strings that would foster Donny's independence without constantly getting him into hot water. Here are the Ten Rules of Mothering Without Smothering that I suggested to help Christine become the parent that her teenage son needed now.

1 **Keep your goals realistic.** AD/HD cannot be "cured." The goal is to manage the disorder as effectively as possible. Your AD/HD child will never be perfectly behaved (nor will any other child). Expecting too much will only frustrate both of you.

2 Don't let guilt or fear make you overprotective. AD/HD is nobody's "fault." Your child is not doomed to a life of failure if you don't protect her from every danger and solve her every problem. Overprotecting is smothering.

3 Don't bail out the child from every mistake. Let the child live with "safe" mistakes in situations that won't cause irreparable damage. Let him learn from the natural consequences that result from his behavior. To learn responsibility, there must be accountability.

4 Respect the child's need for privacy. Everyone needs some space that is private and personal. Knock on closed doors before entering. Don't search the child's room or go through her possessions unless there is good reason to believe you'll find something unhealthy or unacceptable.

5 Don't try to choose your child's friends. This strategy usually backfires, particularly with teens. Before you forbid your child to see a certain friend, be sure that you can follow through and enforce your decision.

6 Provide monitoring based on the child's needs and developmental level. Children with AD/HD need to be monitored more closely, and up to an older age, than children without it. Lack of monitoring increases the chance of getting into serious trouble. Too much monitoring causes conflicts, resentment, and rebelliousness. Take your cues from the child's behavior.

7 Allow freedom and privileges based on your child's developmental level. As he demonstrates an ability to behave responsibly, increase privileges and freedoms. "If you abuse it, you lose it" is a good rule of thumb.

8 Encourage and support independence. Our ultimate job as parents is to raise a child who no longer needs us. Confidence, self-esteem, and the ability to tackle life's challenges come from feeling competent and self-sufficient.

9 Don't misinterpret teenage independence and mild rebelliousness as disrespect or rejection. Individuation, developing one's own sense of identity separate from parents, is the major developmental task of adolescence. Allow your teen to express mild rebellion in "safe" areas.

10 Pick your battles. Not everything is worth fighting over. Otherwise, everything becomes a battle. Take a stand on the important issues, and don't sweat the small stuff.

Once Christine realized that Donny was no longer the helpless, fragile child she'd started out with, she adjusted her parenting style to fit his current needs. He still needs structure at home, but not the kind of structure that's designed for a 12-year-old. He still needs to have his schoolwork monitored, but not as much as when he was younger.

And he also needs the freedom to make his own decisions, possibly fail, but then learn to regroup—much more so than when he was younger.

No doubt there will be mistakes along the way. Let some of those slip-ups happen while you're still in a good position to help your child make sense of his mistakes and learn from them.

Dr. Peter Jaksa is the Parenting Editor and a Scientific Advisor for ADDitude *Magazine. He is president and clinical director of ADD Centers of America and a board member of the Attention Deficit Disorder Association, and the author of* 25 Stupid Mistakes Parents Make.

BY PETER JAKSA, PH.D.

Be Your Child's Strongest Advocate!

For the parent of a child with AD/HD, advocacy is not a role of choice—it is a responsibility thrust on us the day the child is born. The question is not whether the child will need us to speak for his or her educational needs, but rather when, with whom, and to what purpose.

Being an effective advocate for your child requires:

- Fully understanding your child's strengths, weaknesses, and needs.
- Knowing about educational rights, how the system works, and what resources are available.
- Communicating effectively and working cooperatively with your child's educators.
- Involving the child in planning and decision-making, to demonstrate unequivocally that you are on the same side all the way.

UNDERSTAND YOUR CHILD For the past 15 years, I've given parents the same message: "I have a Ph.D. in psychology and I'm an expert on human behavior, but YOU are the expert on your child." There is no substitute for parental insights about the nuances and details that make a child unique.

To be an effective advocate, you must understand your child's strengths and weaknesses from both the "clinical" and the personal perspectives. Beyond that, it is vital to communicate your knowledge about your child's needs to educators and other professionals. You will share your information with many educators over many years until the child grows up.

ONLINE RESOURCES FOR ADVOCACY

>> Wrightslaw: **www.wrightslaw.com**.

>> The Advocacy Institute: **www.advocacyinstitute.org**.

>> *ADDitude*'s Classroom Accommodations to Help Students with AD/HD: **www.additudemag.com/PDF/Accommodations.pdf**.

LEARN THE LAW Every parent of a child with AD/HD should be familiar with the legislation contained in IDEA (Individuals with Disabilities Education Act) and Section 504 of the Americans with Disabilities Rehabilitation Act.

COMMUNICATE EFFECTIVELY The most effective advocacy is collaborative, not a battle between parents and educators. The parent who is assertive, considerate, and respectful will likely make more progress than one who goes in with an aggressive or confrontational stance.

Sadly, there are exceptions. In some instances, the child's needs are clear, reasonable accommodations or services are requested, and the parents run into an implacable teacher or school administrator. The parents' task at that point is to fight like a tiger for the child's needs.

INVOLVE YOUR CHILD The most important person in this process is your child. It can be daunting for a child of any age to be singled out for special interventions, but it is even worse if the reasons are not clear to the child and he doesn't feel included in the decision-making. Their parents and teachers are asking them to do things that none of their friends have to do! Younger children may internalize the feelings of shame and the sense of being "bad." Older children feel stigmatized and react with resentment and noncompliance.

It is better to feel like a participant than a pawn. Even very young children will accept interventions when the reasons and benefits are explained in a way that makes sense to them.

Equally important is the parent's attitude about advocacy and intervention. It's not enough to provide discipline and guidance. ("It's time to start working on your homework; turn the TV off.") Let your child see you as cheerleader and knight in shining armor. ("I believe in you, I want the best for you, I'm behind you all the way.") Educational interventions always work best when children see their parents as a source of unflagging support.

>>>> **THE REST OF THE SECTION** on school is adapted from *ADDitude*'s back-to-school booklet, *Ready to Learn*. The next five pages describe three behaviors associated with AD/HD, and offer practical, time-tested strategies for helping your child succeed in the classroom and at home. Read on to learn how to handle distractibility, disruptive behavior, and disorganization, and see the box on page 15 to learn how to order a complete copy of *Ready to Learn*.

Distractibility

BY ELLEN KINGSLEY

THE PROBLEM: The student doesn't seem to be listening or paying attention to class material. He may daydream, look out the window, or focus on irrelevant noises or other stimuli. As a result, he misses lessons and instructions.

THE REASON: AD/HD is not just an inability to pay attention. It is an inability to control what one pays attention to. Studies suggest that children with AD/HD have a lower level of brain arousal, and are easily distracted when an activity is not sufficiently stimulating. They are unable to tune out distractions, both internal and external.

THE OBSTACLES: Children with AD/HD struggle to stay focused on any tasks that require sustained mental effort. This distractibility may appear intentional—which works against their getting the help they need. Remarks such as "Earth to Amy!" will not correct this attention deficit. If they could pay better attention, they would.

WHAT HELPS IN THE CLASSROOM: Where you place a student with AD/HD in the classroom is very important.

What is considered preferential seating may vary among youngsters, but keeping AD/HD kids close to the teacher and away from doors or windows is usually best.

To prevent singling out the AD/HD child, let everyone in the class try study carrels, privacy dividers, earphones, or earplugs to block distractions during seat work or tests.

Try to alternate between high- and low-interest activities. Using a variety of strategies to accommodate different learning styles allows every student to learn the way he learns best.

- Try to include visual, auditory, and kinesthetic facets to all lessons, as well as opportunities to work cooperatively, individually, and with the group.
- Keep lesson periods short, and

vary the pacing from one lesson to the next.

- Students who become distracted should not be reprimanded, but redirected in a way that does not cause embarrassment. Sometimes, asking the child a question you know he can answer, or giving nonverbal cues, such as patting the child on the shoulder, can bring him back into focus.

WHAT HELPS AT HOME: Help your child avoid distractions and procrastination that interfere with homework. First, establish a daily homework routine. Maybe your child needs a break between school and homework. Some children need frequent breaks between assignments.

- AD/HD kids may need more "setting up" help than others their age. Some need a distraction-free environment, while others do better with music in the background. Experiment until you find out what works best.
- Sit down with your child and make sure he understands what is required.
- AD/HD children may need constant adult supervision to keep on task. As situations improve, and the child matures, however, a parent can check in frequently, rather than sitting by the child's side throughout the process.
- Providing short breaks between assignments, and allowing the child to stretch or have a snack, often makes the workload seem more manageable.

If your child feels overwhelmed, he's likely to become distracted. Break down a large assignment into a set of smaller, easier tasks with stretch or snack breaks in between. Divide the task up with your child, and designate a clear end point for each segment.

Alert the teacher if you think your child does not have the skills to complete an assignment, or if it seems to take an inordinately long time.

Disruptive Behavior

BY ELLEN KINGSLEY

THE PROBLEM: Children with AD/HD are often labeled unruly or aggressive because of their impulsive physical and social interactions. Though these children can be caring and sensitive, they have trouble controlling their impulses.

THE REASON: Children with AD/HD act before they think, often unable to control their initial response to a situation. The ability to "self-regulate" is compromised; they can't modify their behavior with future consequences in mind. Some studies show that differences in the brain in those with AD/HD are partly responsible for this symptom.

THE OBSTACLES: Many children with AD/HD seem to spend their lives in time out, grounded, or in trouble for what they say and do. Lack of impulse control is perhaps the most difficult symptom of AD/HD to modify.

WHAT HELPS IN THE CLASSROOM:

Posting rules and routines lets the child know what's expected of him throughout the day. It is also a visual reminder for children who act before they think.

- Some children need "behavior cards" taped to their desks ("Raise hands before speaking," etc.). If privacy is an issue, tape the cards to a sheet of paper that remains on the desk during class but can be stored inside the desk.
- Writing the day's schedule on the blackboard and erasing items as they are completed give AD/HD students a sense of control about their day. Alert the class in advance about any revisions to the daily routine.
- Transitions are another stress point. Avoid meltdowns by giving the class a five-minute warning, then a two-minute notice of an impending transition, so that AD/HD kids have adequate time to stop one activity and start another.
- Some children need teachers to anticipate potentially explosive situations, such as those that can happen in unstructured play. Overstimulation—lots of noise and running around—can overwhelm AD/HD kids.
- Have a plan ready in case lack of structure or another circumstance sets off an impulsive reaction. Give the AD/HD child a special job such as "monitor" or "coach" to help him stay focused on self-control.
- Discipline can and should be used in certain situations. While AD/HD is an explanation for bad behavior, it is never an excuse. AD/HD may explain why Johnny hit Billy, but it did not make him do it. Children with AD/HD need to understand their responsibility to control themselves.
- Discipline should be immediate, short, and swift. "Natural consequences" (such as detention) tend to be delayed, which doesn't work for kids who have difficulty anticipating future outcomes. Consequences must be instantaneous. If he pushes another child on the playground, suspend recess for 10 minutes. If he uses foul language in class, respond with a quick time-out.

- Provide immediate, positive feedback for good behavior. Be specific in labeling what AD/HD kids are doing well, such as sharing ideas with a partner, raising their hand, or waiting their turn.
- With younger children, establish at the beginning of the year the behaviors you expect and post them in the classroom ("Respect

Others," "Use an Indoor Voice," etc.) as visual reminders.

- Younger children often respond well to a "point system" in which they earn pennies or stickers each time they demonstrate a positive target behavior. They can redeem their points at the end of the week for a prize.

WHAT HELPS AT HOME: Always provide AD/HD kids with clear, consistent expectations and consequences. Children with AD/HD have difficulty making inferences about right and wrong, so parents must be specific.

Telling your child to "be good" is too vague. Be explicit: "In the store, don't touch the dishes, look with your eyes." "At the playground, wait in line for the slide, and don't push."

- Be proactive in your approach to discipline. Recognize and remark on positive behavior. Respond to positive actions with praise, attention, and rewards.
- Holding your child accountable for his actions is imperative in molding a responsible adult. However, punishment that takes place long after the fact may prevent a child from fully understanding its relationship to the misbehavior. Punishment must come soon after the misbehavior.
- Let the punishment fit the crime. Hitting calls for an immediate time-out. Dinnertime tantrums can mean no dessert. Keep punishments brief and restrained, but let them communicate to your child that he's responsible for controlling his behavior.
- Let minor misbehaviors slide. If your child spills the milk while pouring a glass, talk to him about the importance of moving slowly and carefully, help him clean up the mess, and move on.

Disorganization

BY ELLEN KINGSLEY

THE PROBLEM: The child forgets to bring the right books and supplies home or to school. His desk, locker, backpack, and notebook are in disarray. He forgets deadlines and scheduled activities.

THE REASON: The neurological process that keeps us organized is called "executive function." This is the ability to organize, prioritize, and analyze in order to make reasonable decisions and plans. Children with AD/HD and related neurobiological problems have impaired executive function skills due to abnormal dopamine levels in the frontal lobe of the brain.

THE OBSTACLES: Punishment will not change disorganized behaviors related to brain pathology. It's confusing to teachers and parents when students with AD/HD are inconsistent in their ability to organize. Such children are sometimes labeled "sloppy" or "lazy." If a child handles one task in an organized way, it is tempting to believe he can always be organized "if he wanted to."

WHAT HELPS IN THE CLASSROOM: AD/HD medications may somewhat

improve ability to stay organized; however, kids still need teachers and parents to provide support and teach compensatory skills. The key to helping kids stay organized is constant communication among teachers and parents.

- Provide the student with two sets of books and supplies—one for home and one for school—so he has less to remember. This helps conserve the mental energy the child needs for his most important task: learning.
- Never penalize AD/HD children for messiness or forgetting supplies. These behaviors are symptoms of their disability. However, helping children become more organized is an admirable and partially achievable goal.
- Provide a special assignment notebook with larger-than-usual spaces in which to write. A special "Trapper Keeper" binder with pockets in which to stuff papers is better than the standard three-ring binder.
- Teachers should give assignments in writing, or check what the child has written himself, to ensure accuracy.
- Color-code books and supplies by subject. For example, use yellow for all geography book covers, notebook dividers, and files. Use red for everything related to history class, and so on.

WHAT HELPS AT HOME: Organizational skills rarely come naturally. Spend some time with your child teaching the basics of planning and organization.

- Double-check assignment notebooks to make sure that homework is in its proper place once completed.
- Make multiple copies of all permission slips, event announcements, and other paperwork to post in several areas of the house. These will serve as visual reminders of important dates and deadlines.
- Keep a three-hole puncher on your child's desk, for punching papers to be inserted into the school binder.
- Check belongings daily and organize weekly by cleaning out and reordering backpacks, assignment notebooks, and binders.
- Set up a color-coded file system, with colors matching the system devised for school, to store related papers that don't need to be toted around every day.
- Provide a place for everything: a box for school supplies, a storage rack for CD's, a shelf for books, a bulletin board for announcements, an under-bed box for old artwork and papers.

If your child rejects your efforts to help him stay organized, impose logical consequences. If he loses a CD, for example, you don't have to replace it.

Log on to **www.additudemag.com/additudebooklets.asp** to order *Ready to Learn*. The 16-page booklet contains nine mini guides to AD/HD behaviors (including the three you just read) and an outline for success at school. We encourage you to share and discuss the information with your child's teacher!

THE HANLONS:

"Better Late Than Never"

BY PHYLLIS HANLON

We knew early on that there was something different about our son. Kevin had more than the usual number of bumps and bruises. There were disastrous fights with his siblings; angry outbursts; and impulsive, attention-getting behavior. But teachers and medical professionals assured us that these "behavioral problems" would improve in time. We began to feel that maybe our expectations were unrealistic or, even worse, that our parenting style was flawed. Despite our concerns, we had to admit that he brought much delight to our home.

DEALING WITH LATE DIAGNOSIS Ten years passed before the situation broke wide open. One fall evening, we received a call saying that Kevin, then 16, had been arrested for a potentially serious prank at his high school. It was during the blur of court appearances, lawyer meetings, compulsory community service hours, and counseling sessions that the term "AD/HD" arose. Deconstructing the puzzle of his life—his uncontested title of class clown, short attention span, low self-esteem, refusal to conform, rocky relationships, sometimes dangerous and accident-prone behavior—it became clear that this was likely the underlying cause.

Why hadn't his teachers sensed this? How could his pediatrician, a medically trained professional, be unaware of the problem? But wondering why the

diagnosis was so late was useless. The task at hand was to help our son.

SEARCHING FOR ANSWERS We began to untangle the legal situation while consulting with one behavioral health counselor after another. Trying to make sense of disparate suggestions regarding medical therapy, disciplinary methods, and assigning or withholding privileges made our heads reel.

With Kevin, we began meeting weekly with a psychologist. For the most part, the sessions were uneventful, if not unproductive. The psychologist's gentle manner proved ineffective in the hostile atmosphere of mandatory visits. By the time the sessions ended, we had taken mere baby steps toward a solution. Our understanding of AD/HD had been enhanced, but no clear-cut answers had been found.

WHAT FINALLY WORKED The end of family therapy coincided with Kevin's graduation from high school. College held no appeal for him—he was thrilled to escape boring lectures on subjects he thought were irrelevant to his life. Entry into the real world and a place of his own were eventually more effective than any book or therapist.

After drifting aimlessly for a while, he found an occupation that excites him, and married a wonderful young lady. Although he'll always be the life of the party and the one to blurt out statements that shock, Kevin has become a focused, motivated young man with meaning and direction in his life. His relationships with his siblings, formerly tense, have taken on a comfortable, adult quality. Unwavering family support, thousands of prayers, and the excitement and encouragement of a love worked their magic on him.

Had Kevin received an AD/HD diagnosis at an earlier age, our lives might have been very different. However, once the problem was identified, ongoing efforts to help the entire family acquire understanding and learn coping methods produced a happy ending to what might have been a tragic story.

Phyllis Hanlon is a freelance writer in Charlton, Massachusetts.

Are They Ready to Be on Their Own?

"Young adults with AD/HD must reach the level of maturity where living, working, and relating to others like an adult is possible," says Larry Silver, M.D., chairman of *ADDitude*'s Scientific Advisory Board. Dr. Silver recommends that, before moving out, the young adult and the family should all feel confident that he or she can:

- Manage his AD/HD through behavioral/medical intervention and be fully educated about the disorder.
- Practice basic life skills—the ability to eat right, get to work or school, budget finances, keep her home environment "livable." and plan meals.
- Earn a living. Once on the job, the adult needs to be dressed and groomed appropriately, and work up to an employer's expectations. The ability to think in an organized manner, problem-solve, and maintain a positive attitude should be in place before entering the workforce.

Bedtime Battles

BY WILLIAM W. DODSON, M.D.

Ah, the thought of getting a good night's rest, of falling asleep easily, staying asleep through the night, and then waking up easily—and refreshed. For most people, this scenario is achievable. But for many with AD/HD, it seems only a dream.

People with AD/HD know how their sleep can be disturbed by mental and physical restlessness. But, as with most of our knowledge about adult AD/HD, we're only beginning to understand a stronger AD/HD-sleep link.

Sleep disturbances caused by AD/HD have been overlooked for a number of reasons. Sleep problems did not fit neatly into the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) statement that all AD/HD symptoms must be present by age 7. Sleep disturbances associated with AD/HD generally appear later in life, at around age 12. The arbitrary age cutoff prevented recognition of sleep disturbances in AD/HD until recently, as studies of adults become more common. Just as AD/HD does not go away at adolescence, it does not go away at night either. It continues to impair life functioning 24 hours a day.

Many researchers expect sleep disturbances to return as a diagnostic criterion when adult AD/HD appears in the DSM V in 2010. For now, sleep problems tend either to be overlooked or to be viewed as coexisting problems, with an unclear relationship to AD/HD itself. Sleep disturbances have been incorrectly attributed to the stimulant-class medications often used to treat AD/HD.

THE FOUR BIG SLEEP ISSUES

Even though no scientific literature on insomnia lists AD/HD as a prominent

cause of sleep disturbances, adults with AD/HD know that the connection between their condition and sleep problems is real. Sufferers often call it "perverse sleep"—when they want to be asleep, they are awake; when they want to be awake, they are asleep.

The four most common sleep disturbances associated with AD/HD are:

1 INITIATION INSOMNIA Three-fourths of all adults with AD/HD report inability to "shut off my mind so I can fall asleep." Many describe themselves as "night owls" who get a burst of energy when the sun goes down. Others report that they feel tired throughout the day, but as soon as the head hits the pillow, the mind clicks on. Their thoughts bounce from one worry to another. Unfortunately, many of these adults describe their thoughts as "racing," prompting a misdiagnosis of bipolar mood disorder.

Prior to puberty, 10 to 15 percent of children with AD/HD have trouble getting to sleep. This is twice the rate found in children and adolescents who do not have AD/HD. This number dramatically increases with age: 50 percent of children with AD/HD have difficulty falling asleep almost every night by age 12; by age 30, more than 70 percent of adults with AD/HD report that they spend more than one hour trying to fall asleep at night.

2 RESTLESS SLEEP When individuals with AD/HD finally fall asleep, their sleep is restless. They toss and turn. They awaken at any noise in the house. They are so fitful that bed partners often choose to sleep in another bed. Sleep is not refreshing, and they awaken as tired as when they went to bed.

3 DIFFICULTY WAKING More than 80 percent of adults with AD/HD in my practice report multiple awakenings until about 4 a.m. Then they fall into "the sleep of the dead," from which they have extreme difficulty rousing themselves. They sleep through two or three alarms. AD/HD sleepers are commonly irritable, even combative, when roused before they are ready. Many say they are not fully alert until noon.

4 INTRUSIVE SLEEP Paul Wender, M.D., a 30-year veteran AD/HD researcher, relates AD/HD to interest-based performance. As long as persons with AD/HD were interested in or challenged by what they were doing, they did not demonstrate symptoms of the disorder. (This phenomenon is called "hyperfocus" by some, and is often considered to be an AD/HD pattern.) If, on the other hand, an individual with AD/HD loses interest in an activity, his nervous system disengages, in search of something more interesting. Sometimes this disengagement is so extreme as to induce drowsiness to the point of falling asleep. Marian Sigurdson, Ph.D., an expert on electroencephalography (EEG) findings in AD/HD, reports that brain wave tracings at this time show a sudden intrusion of theta waves into the alpha and beta rhythms of alertness. We all have seen "theta wave intrusion," in the student in the back of the classroom who suddenly crashes to the floor, having "fallen asleep." This was probably someone with AD/HD who was losing consciousness due to boredom rather than falling asleep.

WHAT'S GOING ON HERE?

There are several theories about the

causes of sleep disturbance in people with AD/HD, with a telling range of viewpoints. Physicians base their responses to their patients' complaints of sleep problems on how they interpret the cause of the disturbances. A physician who looks first for disturbances resulting from disorganized life patterns will treat problems in a different way than a physician who thinks of them as a manifestation of AD/HD.

Thomas Brown, Ph.D., longtime researcher in AD/HD and developer of the Brown Scales, was one of the first to give serious attention to the problem of sleep in children and adolescents with AD/HD. He sees sleep disturbances as indicative of problems of arousal and alertness in AD/HD itself. Two of the five symptom clusters from the Brown Scales involve activation and arousal:

- Organizing and activating to begin work activities.
- Sustaining alertness, energy, and effort.

Brown views problems with sleep as a developmentally-based impairment of management functions of the brain—particularly, an impairment of the ability to sustain and regulate arousal and alertness. Interestingly, he does not recommend treatments common to AD/HD, but rather recommends a two-pronged approach that stresses better sleep hygiene and the suppression of unwanted and inconvenient arousal states by using medications with sedative properties.

The simplest explanation is that sleep disturbances are direct manifestations of AD/HD itself. True hyperactivity is extremely rare in women of any age. Most women experience the mental and physical restlessness of AD/HD only when they are trying to shut down the arousal state of day-to-day functioning in order to fall asleep.

The fact that 80 percent of adults with AD/HD eventually fall into "the sleep of the dead" has led researchers to look for explanations. No single theory explains the severe impairment of the ability to rouse oneself into wakefulness. Some AD/HD patients report that they sleep well when they go camping or are out of doors for extended periods of time. Baltimore-based psychiatrist Myron Brenner, M.D., noted the high incidence of AD/HD individuals among the research subjects in his study of Delayed Sleep Phase Syndrome (DSPS). People with DSPS report that they can experience a normal sleep phase—get into bed, fall asleep quickly, sleep undisturbed for eight hours, and awake refreshed—but that their brains and bodies want that cycle from 4 a.m. until noon. This is a pattern reported by more than half of adults with AD/HD. Brenner hypothesizes that DSPS and the sleep patterns of AD/HD have the same underlying disturbance of circadian rhythms. Specifically, he believes that the signal which sets the internal circadian clock (the gradual changes in light caused by the sun's setting and rising) is weak in people with AD/HD. As a result, their circadian clock is never truly set, and sleep drifts into the 4 a.m.-to-noon pattern or disappears entirely, until the sufferer is exhausted.

One hypothesis is that the lack of an accurate circadian clock may account for the difficulty that many with AD/HD have in judging the passage of time. Their internal clocks are not "set." Consequently, they experience only two times: "now" and "not

now." Many of my adult patients do not wear watches. They experience time as an abstract concept, important to other people, but one which they don't understand. It will take many more studies to establish the links between circadian rhythms and AD/HD.

HOW TO GET TO SLEEP

No matter how a doctor explains sleep problems, the remedy usually involves something called "sleep hygiene," which considers all the things that foster the initiation and maintenance of sleep. This set of conditions is highly individualized. Some people need absolute silence. Others need white noise, such as a fan or radio, to mask disturbances to sleep. Some people need a snack before bed, while others can't eat anything right before bedtime. A few rules of sleep hygiene are universal:

- Use the bed only for sleep or sex, not as a place to confront problems or argue.
- Have a set bedtime and a bedtime routine and stick to them.
- Avoid naps during the day.
- Get in bed to go to sleep. Many people with AD/HD are at their best at night. They are most energetic and think clearest after the sun goes down. This is their most productive time. Unfortunately, the jobs and families to which they must attend in the morning are not easy to handle on inadequate sleep.
- Avoid caffeine after dinner. Although many people without AD/HD report that coffee actually helps them sleep, there is usually a fine line between the right amount and too much caffeine.

TREATMENT OPTIONS

If a patient spends hours a night with thoughts bouncing and his body tossing, this is probably a manifestation of AD/HD. The best treatment is a dose of stimulant-class medication 45 minutes before bedtime. This course of action, however, is a hard sell to patients who suffer from insomnia. Consequently, once they have determined their optimal dose of medication, I ask them to take a nap an hour after they have taken the second dose. Generally, they find that the medication's "paradoxical effect" of calming restlessness is sufficient to allow them to fall asleep. Most adults are so sleep-deprived that a nap is usually successful. Once people see for themselves, in a "no-risk" situation, that the medications can help them shut off their brains and bodies and fall asleep, they are more willing to try medications at bedtime. About two-thirds of my adult patients take a full dose of their AD/HD medication every night to fall asleep.

What if the reverse clinical history is present? One-fourth of people with AD/HD either don't have a sleep disturbance or have ordinary difficulty falling asleep. Stimulant-class medications at bedtime are not helpful to them. Dr. Brown recommends Benedryl, 25 to 50 mg, about one hour before bed. Benedryl is an antihistamine sold without prescription and is not habit-forming. The downside is that it is long-acting, and can cause sleepiness for up to 60 hours in some individuals. About 10% of those with AD/HD experience severe paradoxical agitation with Benedryl and never try it again.

The next step up the treatment ladder is prescription medications. Most

clinicians avoid sleeping pills because they are potentially habit-forming. People quickly develop tolerance to them and require ever-increasing doses. So, the next drugs of choice tend to be non-habit-forming, with significant sedation as a side effect. They are:

Melatonin, a naturally occurring peptide released by the brain in response to the setting of the sun. It is available without prescription at most pharmacies and health food stores. Melatonin may not be effective the first night, so several nights' use may be necessary for effectiveness.

Periactin. The prescription antihistamine works like Benedryl but has the added advantages of suppressing dreams and reversing stimulant-induced appetite suppression.

Clonidine. Some practitioners recommend a 0.05 to 0.1 mg dose one hour before bedtime. It exerts significant sedative effects for about four hours.

Antidepressant medications, such as trazadone (Desyrel), 50 to 100 mg or mirtazapine (Remeron), 15 mg are used by some clinicians for their sedative side effects. Due to a complex mechanism of action, lower doses of mirtazapine are more sedative than higher ones. More is not better. Like Benedryl, these medications tend to produce sedation into the next day, and may make getting up the next morning harder.

PROBLEMS WAKING UP

Problems in waking and feeling fully alert can be approached in two ways. The simpler is a two-alarm system. The patient sets a first dose of stimulant-class medication and a glass of water by the bedside. An alarm is set to go off one hour before the person actually plans to rise. When the alarm rings, the patient rouses himself enough to take the medication and goes back to sleep. When a second alarm goes off, an hour later, the medication is approaching peak blood level, giving the individual a fighting chance to get out of bed and start his day.

A second approach is more high-tech, based on evidence that difficulty waking in the morning is a circadian rhythm problem. Anecdotal evidence suggests that the use of sunset/sunrise-simulating lights can set the internal clocks of people with Delayed Sleep Phase Syndrome. As an added benefit, many people report that they sharpen their sense of time and time management once their internal clock is set properly. The lights, however, are experimental and expensive (about $400).

Disturbances of sleep in people with AD/HD are common, but are almost completely ignored by our current diagnostic system and in AD/HD research. These patterns become progressively worse with age. Recognition of sleep disturbance in AD/HD has been hampered by the misattribution of the initial insomnia to the effects of stimulant-class medications. We now recognize that sleep difficulties are associated with AD/HD itself, and that stimulant-class medications are often the best treatment of sleep problems rather than the cause of them.

Dr. William W. Dodson is a board-certified psychiatrist in Denver, Colorado. He specializes in the treatment of adults with AD/HD. His research interests are in sleep disorders and in the application of theoretical research to everyday practice. An earlier version of this article appeared in ADDvance, *the online e-magazine for women with AD/HD:* **www.addvance.com.**

"I'm Not Hungry, Mom"

BY GWEN MORRISON

AD/HD medications often trigger loss of appetite and, thus, loss of weight. Here's what you can do for your child.

About a decade ago, when we started our daughter on medication, we knew there would be challenges. But back then, information about AD/HD wasn't as accessible as it is today. One thing we weren't prepared for was her immediate loss of appetite and weight.

Our pediatrician dismissed our concerns with a brief explanation that, during the first few weeks of medication, we should expect our daughter to be less hungry. We later found the real explanation for our daughter's weight loss: AD/HD stimulants may give patients the feeling of being full and, at the same time, drive up their metabolic rate. Fortunately, after a few months on stimulants, she began to gain back the weight she had lost. But for the next decade, our (now) 17-year-old daughter experienced cycles of weight loss and gain due to a variety of medications. And she's not alone.

WEIGHT MATTERS AD/HD medications and appetite disruption often go hand in hand. "The main group of medications used to treat AD/HD are called psycho-stimulants," says Larry B. Silver,

M.D., a clinical professor of psychiatry at Georgetown University Medical Center in Washington, D.C. "These drugs, methylphenidate (Ritalin), dextro-amphetamine (Dexedrine), and mixed dextro- and levo-amphetamine (Adderall), can cause a loss of appetite, which may lead to weight loss if the medication is continued." But the effects needn't be extreme, especially if monitored by a physician and handled with understanding by parents.

Katerina Cole-Slaughter's son, now 14, was diagnosed with AD/HD at age 6 and was prescribed 5 mg of Ritalin, three times a day. The immediate side effect was loss of appetite, within 30 minutes of taking the drug.

Cole-Slaughter combated this by giving her son breakfast before he took his medication and holding his next dose until after lunch. It worked, and he experienced no weight loss. "After getting up to 60 mg of Ritalin a day, we switched him to Adderall, three times a day. Again, the side effect was lack of appetite for several hours after taking it. And he made up for his lack of appetite during the day at dinnertime!"

This is not uncommon, says Andrew Adesman, M.D., associate professor of pediatrics at Albert Einstein College of Medicine in New York City. "All medications have the potential to cause side effects. With stimulants, one of the side effects is decreased appetite, but this usually occurs only at midday." Dr. Adesman says that the effect on weight is modest, usually seen in the beginning of treatment. "Parents can minimize the effects by being flexible with meal schedules. Don't force your child to eat, but offer him snacks whenever he is hungry. He may eat later in the day, and snack in the evening."

Numerous studies have shown that

Hunger Management

- **FEED NUTRIENT-DENSE FOODS.** Pack a lot of nutritional value into a single serving with foods like avocado, yogurt, peanut butter, turkey, and granola.
- **FILL UP ON BREAKFAST.** Offer your child a high-protein, high-calorie breakfast before the medication takes effect—food first, pill second.
- **OFFER LIQUID MEALS.** High-protein drinks, shakes, and smoothies are a fun way to ensure that your child gets his share of daily nutrients. Vary flavors to add interest.
- **ENCOURAGE GRAZING.** Eating four to five small meals a day can keep her well-fed. Snacks should be healthy—avoid refined foods with empty calories.
- **LIMIT JUICE INTAKE.** Discourage your child from drinking more than eight ounces of juice each day, especially with meals, or she may feel too full to eat.
- **SCHEDULE OUTDOOR PLAY BEFORE MEALS.** Fresh air and physical activity help spark your child's metabolism, prompting him to feel hungry.
- **TRY NEW FOODS.** Engage your child in the choice and preparation of new recipes to raise her interest in eating.
- **GIVE VITES.** A daily multivitamin helps protect against nutrition deficiencies.
- **BUY FORTIFIED FOODS.** Milk's not the only fortified item on the market anymore. Look around your grocery store for enriched breads, calcium-infused juices, or snack bars with a full day's dose of several vitamins and minerals.

decreased appetite generally tapers off over the first several weeks of a medication regimen. Observe your child's eating patterns, try to get him to eat a good breakfast, and accept the fact that lunchtime may not be his hungry time. Feed your child nutrient-dense foods to pack a lot of nutritional value into a single serving [see "Hunger Management" on previous page].

Meds Adjustment

If your child experiences more than a 10 percent weight loss over a few weeks, his dose may need to be adjusted or the regimen changed entirely. The side effects of stimulants vary by child. Not all kids will lose weight, and some will have to try several medications before finding the one that provides benefits without adverse reactions.

"For patients who don't tolerate amphetamine-based stimulants well, there are alternatives, such as Strattera," says Lisa Routh, M.D., director of medical health at the University of Texas Medical Branch at Galveston. Often, the slower-acting drugs are better for kids. "Appetite suppression is still an issue with the amphetamine derivatives, but longer-acting drugs seem to have a milder effect on appetite."

When dealing with my daughter's ups and downs, I often felt more like a pharmacist than a mother when it came to monitoring medications and the resulting weight changes. Staying open to new options, and being patient with the current regimen of medication helped us all survive.

Gwen Morrison is an Atlanta-area writer whose work has been been published in several national magazines. Her article about her daughter appeared in the November/December 2003 issue of ADDitude.

THE OTHER SIDE OF WEIGHT LOSS

The American Academy of Pediatrics estimates that nearly half of all children with AD/HD also suffer from depression, learning disabilities, or anxiety disorders. The treatment of these co-existing disorders often includes medications that can cause weight gain. For teens already struggling with complex social issues, this can be devastating. What can you do?

>> CONSULT YOUR PHYSICIAN ABOUT YOUR CHILD'S MEDICATION options, and be sure to note the side effects of any new medication, suggests Dr. Lisa Routh. Several mood stabilizers have lower metabolic impact. Sometimes the benefit of a new medication doesn't outweigh the side effects. Weigh all the options before changing medication.

>> BE AWARE OF WHAT YOUR CHILD IS EATING. A medication may cause increased appetite in children, so it's up to you to have nutritious foods on hand to feed his cravings.

>> WATCH THOSE EATING HABITS. "Food should not be used as a reward," says Carmen de Lerma, M.D., medical director of South Miami Hospital's Child Development Center, in Florida. Also, have your child practice mindful eating by dining at a table, not in front of a TV, computer, or video machine.

>> ENCOURAGE PHYSICAL ACTIVITY. Exercise releases pent-up energy, burns calories, and improves mood. "Be creative in choosing physical activities so your child won't get bored," adds Dr. de Lerma. Adjust for different weather scenarios, time of day, days of the week, and solo versus group activities."

Stuck? Unproductive? Disorganized? Can't Get Started?

Is It Time to Get a Coach?

BY ELLEN KINGSLEY

Kelly Bentley* wasn't being paranoid. She was really about to be fired. The law firm was no longer willing to cut the 33-year-old attorney any slack. She wasn't billing her share of hours, she was chronically late for court, and she could barely get to her desk by 11 a.m. And she had no idea how to make things right.

To make matters worse, her personal life was in shambles. Kelly wanted to get pregnant, but to do that, you have to spend time with your spouse. That rarely happened because she was so hopelessly backed up with work at the office. Although she desperately tried to catch up, the cycle continued because she was too exhausted to be effective.

How did a savvy lawyer get into this mess? And how would she ever get out?

Enter Nancy Ratey, the Harvard-trained educational psychologist who, along with her colleague Sue Sussman, is credited with creating a new profession: coaching adults with AD/HD.

"Most of my clients are stuck in the spin cycle," says Ratey, who has AD/HD herself. "People with AD/HD lose sight of their goals easily. I help people get out of their own way and move forward." As for Kelly, the task was formidable, but she now meets her billable hours and is expecting a baby soon.

No Miracle Cure

Coaching doesn't cure your AD/HD, and it doesn't have an impact on your symptoms. In fact, coaches frequently work in tandem with clients' psychologists and psychiatrists, who continue to pro-

vide patients with needed mental health and medical care. Coaching is simply a way of getting help with figuring out what you want in life and develop strategies to get there—step by step.

Nancy begins by analyzing a client's life on a daily basis. In Kelly's case, AD/HD was causing problems every step of the way.

DISTRACTIBILITY Even when Kelly got to the building on time, distractions kept her from getting to her office. Often, the culprit was the fresh flower arrangement in the hallway. Kelly would stop to rearrange it, and get stuck on the task for hours.

PROCRASTINATION Kelly spent a lot of time on things she didn't need to do, leaving inadequate time for the things she did have to do. The backlog was visible in the stacks of paper on her desk.

TRANSITIONS Kelly had difficulty switching from case to case, which might be required several times a day. Since she couldn't handle the process of putting one thing away and starting on another, she'd often avoid it altogether.

DISORGANIZATION Kelly never developed a system of tracking her billable hours. Even though she might work 10 billable hours a day, it never showed up on her time reports.

POOR TIME MANAGEMENT Kelly couldn't predict how long it would take to review a case for court. She usually started too late, and was often tardy for her scheduled court appearances.

FIGURE IT OUT Nancy Ratey is expensive, as coaches go. Her rates range from $60 to $300 an hour—more than many physicians charge. But good coaches—and Nancy is one of the best—are insightful and efficient. She predicted it would take about nine months to get Kelly on track.

The process is intense at first. Someone like Kelly may need coaching every day. But sessions aren't long—usually less than half an hour—and take place over the phone or by e-mail.

"Coaching is getting a person to figure out how to do things for themselves so that, after a coach is finished, the skills will last a lifetime," says Nancy. "A coach should never tell a client what to do."

When you hear Nancy coaching Kelly, it's clear she's doing her job.

KELLY: *Hi, Nancy. It's eight a.m. and I'm sitting at my desk.*
NANCY: *Okay. As your coach, what do you want me to do?*
KELLY: *Ask me which project I'm avoiding.*
NANCY: *Okay. What next?*
KELLY: *Ask me to take that folder on my desk and open it.*
NANCY: *Can you identify the next step now that the file is open?*
KELLY: *To call the opposing attorney.*
NANCY: *Can you do that right now and call me back?*
KELLY: *Yes, I'll do that right now.*

Kelly hangs up, calls the attorney, and calls Nancy back.

NANCY: *Great. Now, can you name the next three steps?*

Kelly names the next three steps, lists her other priorities for the day, and promises to report back to Nancy at five.

"You know you've done your job when the person has learned to ask themselves the right questions, and can avoid their instant gratification distractions," Nancy explains. "Kelly is finally

in that groove."

SUCCESS NOT GURANTEED Clearly, Kelly is strongly motivated to change—and that's a requirement if you want Nancy Ratey as a coach. "I retain the right to fire clients and end the coaching process," says Nancy, who works with clients about four hours each weekday. "The client has to be in a position to develop goals, follow through, and be accountable. Otherwise, it's not going to work.

"I won't coach people with marital issues. I can't coach someone who is severely depressed or addicted to drugs or alcohol. Coaching is a partnership, and clients must be ready, willing, and able to fulfill their end of the deal." In short, if you aren't willing to be accountable to Nancy Ratey, you're out.

Likewise, there are many coaches who aren't up to par. Coaching is an unregulated field. Anyone can hang out a shingle, which is why it's important to check coaches' backgrounds and training, and how much they know about AD/HD. "ADD coaching is totally different from other kinds of coaching," says David Giwerc, an ADD coach and founder of the ADD Coach Academy in upstate New York. "You need to understand the particular ways in which the ADD brain is 'different,' the frequent habit of negative thinking, and the kinds of things people tell themselves that stand in the way of success."

Sometimes, for example, a problem isn't exactly what it seems. "With AD/HD, what sometimes looks like procrastination is actually a problem initiating something because they don't know how to break down a task," says Nancy Ratey. "As a coach, you get them to identify the first, smallest thing they can do. That usually gets them started.

"The disasters I've seen usually stem from the coach not understanding AD/HD," she says. "They may tell their clients, 'try harder' or 'you're just too willful,' or 'you're not motivated enough.' There has to be a balance between pushing and encouraging."

To coaches like Sandy Maynard, *ADDitude*'s Coach on Call, encouragement is at the heart of the profession. "One client called because she had just cleaned out her refrigerator. She was so excited! She kept saying, 'Sandy! Sandy! I finally did it!' Cleaning out the fridge was a big step for this woman. She never threw anything away, ever. I was glad to hear that she had learned how to use a trash can. Together, we celebrated her clean refrigerator. No victory is too small a step."

"If she had called her mom, her mom would only have said, 'Well, it's about time.'"

Finding a Coach

- >> ADD Coach Academy: **www.addca.com**
- >> American Coaching Association (ACA): **www.americoach.org**
- >> *ADDitude*'s Coach Directory: **www.additudemag.com/self-help.asp?DEPT_NO=407&SUB_NO=1**
- >> Optimal Functioning Institute (OFI): **www.addcoach.com**
- >> ADDA Yellow Pages: **www.add.org/help/professionals/coaches.html**
- >> A.D.D. Consults: **www.addconsults.com**

Ten Keys to Conquering AD/HD in the Office

BY SANDY MAYNARD

Here are 10 easy ways to reduce the stress related to communication and organization difficulties for adults with AD/HD:

1 COMMUNICATE CLEARLY Ask questions to be sure you fully understand your assignment. Repeat directions to make sure you heard them correctly. Ask for specific deadlines and start early, so you're not forced to bring work home.

2 STOP PROCRASTINATING Don't let perfectionism thwart your ability to get things done. Focus on the most important tasks and delegate others. Try calling instead of e-mailing.

3 CURTAIL PHONE CONVERSATIONS Time flies when we're on the phone. Preface each call with a limit: "Hi, Tom. I only have five minutes, but I wanted to ask you...." The person you called will most likely keep remarks short and to the point.

4 USE ONE TIME-MANAGEMENT SYSTEM Use the same system (notepad, PDA) for both work and personal appointments. Choose one location at work and one at home to keep it, so you'll always know where to look.

5 CHECK YOUR AGENDA SEVERAL TIMES A DAY Set a timer if you think you might get engrossed in an activity and forget to go to a scheduled meeting. Make it a habit to check your schedule every time you get a cup of coffee, take out the trash, or check the mail. Habits form by consistency and frequency.

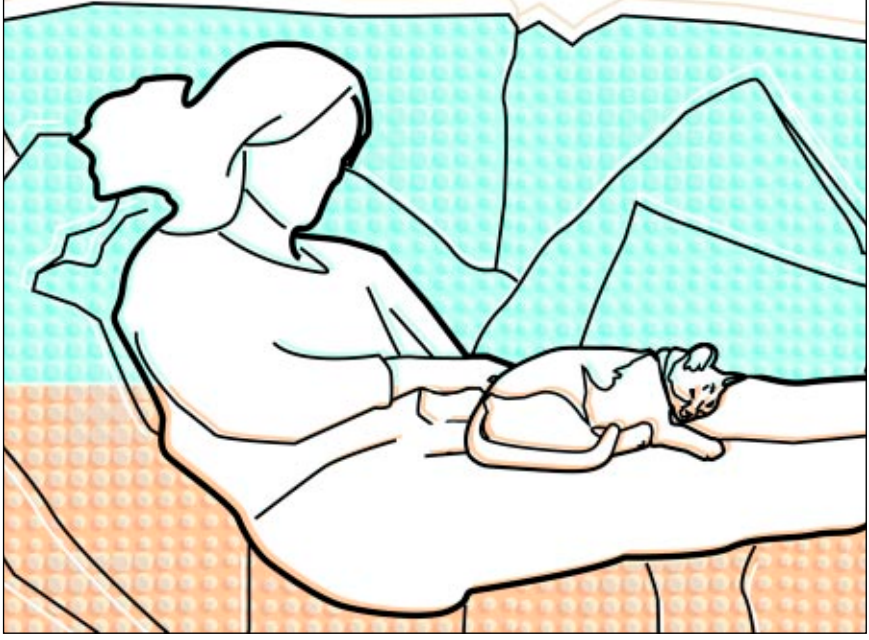
6 WORK AT PROFESSIONAL DEVELOPMENT Twice a year, pick one professional or social skill to improve upon. Being a good conversationalist can be learned, but it takes practice. Practice giving others a chance to respond before reacting. Ask a trusted friend what areas she thinks you need to improve on.

7 LEARN TO DELEGATE Decide what others can do for you and let them do it. Moving ahead often means mastering the fine art of delegating. Make a list of things others can do to help you.

8 KEEP YOUR PRIVATE LIFE PRIVATE Don't broadcast your personal business at work, or let excessive family responsibilities and phone calls make a bad impression on your boss.

9 LET YOUR WORK STAY AT WORK Likewise, leave your work worries at your desk when you clock out for the day. You'll actually feel like tackling them tomorrow morning if you've had a chance to spend time on what's important to you outside of work.

10 PUT YOUR PERSONAL HEALTH FIRST Let your mental and physical health come first. Find work that is meaningful to you personally, and watch the weekdays fly by. Can't cut the dullness from your job? Nourish yourself at home with hobbies you enjoy. Take time for yourself whenever possible to rejuvenate your spirit—and use those vacation days!



AD/HD in Women

BY BOB SEAY

Somewhere along our way toward an egalitarian society, we lost sight of the fact that women are different from men. Likewise, AD/HD in women does not always look like AD/HD in men. Applying male symptoms, like aggression and hyperactivity, to a female with AD/HD doesn't provide an accurate frame of reference for diagnosis.

Noticing the Difference

Girls with AD/HD don't usually stand out in a classroom. "They're the ones sitting in the back, looking out the windows, twirling their hair," says Terry Matlen, vice president of the National Attention Deficit Disorder Association and host of ADDconsults.com (**http://addconsults.com**). "People write them off as space cadets." As far as AD/HD is concerned, these girls are neglected children. They grow up to become neglected women.

Sari Solden, whose book, *Women with Attention Deficit Disorder*, is a must-read for any woman with AD/HD, talked about this neglect in an interview conducted at an ADDA conference. "A significant number of women with ADD weren't picked up for diagnosis because they weren't hyperactive and didn't cause problems at school."

According to Solden, these women are often misdiagnosed and treated for something other than AD/HD. "Even if they complain to their doctor or therapist of feeling overwhelmed or disorganized, they're more likely to be given a diagnosis of depression instead of ADD."

A woman who has AD/HD may also have depression, but treating the depression is only part of the solution. Once the depression is under control, she is left with untreated ADD.

Living with it

The first step is to get an accurate diagnosis from someone who understands AD/HD in women. Doctors, psychologists, psychiatrists, and other mental health care professionals can make the diagnosis. In choosing a professional, ask how many adult ADD patients he has and how many of those are women. What treatments has he tried, and how successful have those treatments been?

Keep in mind that AD/HD can occur simultaneously with other disorders, such as depression or PMS. Ask about possible co-existing conditions, known as "comorbidities," and how much experience the doctor has in treating someone who has more than one problem.

Kathleen G. Nadeau offers more suggestions about living with AD/HD in her book, *Adventures in Fast Forward*. Her first suggestion is to give yourself a break. Women are taught to be "pleasers," and often put unrealistic demands on themselves as they try to balance family, career, and other responsibilities. Accept the facts that houses get messy and some things don't get done. Just do the best you can. Enlist the help of other family members for household chores.

One step toward eliminating the need for Superwoman is to simplify your life. Decide what is important and what isn't. Reduce commitments that drain time and energy. Learn to say "no," or, at the very least, "I'm sorry, but that doesn't work for me."

Christine A. Adamec talks about learning to choose your responsibilities in her book, *Moms with ADD*. "When anyone asks you to perform any task that is due after today and that requires more than five minutes, hold yourself back from saying 'yes' immediately. Instead, say that you must think about it. Resist the pressure that may emanate from others: that you've 'always' done this, that it's easy, that it won't take much time, etc. Tell the person you must think about it and let them know."

This technique gives you time to decide whether or not you can—or want to—do this. If you decide that you can do it, say "yes." If not, then call the person and tell him or her that you won't be able to do it.

Working Through it All

Most women have a lot of pressure, working a full-time job and then coming home to a second full-time job of caring for others. For women who have ADD, this workload can be especially stressful. But with proper diagnosis and treatment, you can learn to manage both your home and your AD/HD.

Resources for Girls and Women with AD/HD

WEB SITES

- National Center for Gender Issues and AD/HD (**www.ncgiadd.org**).
- ADDvance (**www.addvance.com**).

BOOKS

- *Women with Attention Deficit Disorder*, by Sari Solden
- *Understanding Women with AD/HD*, ed. Kathleen G. Nadeau, Ph.D., and Patricia Quinn, M.D.
- *Understanding Girls with AD/HD*, by Kathleen G. Nadeau, Ph.D., Ellen Littman, Ph.D., and Patricia O. Quinn, M.D.

Find these books and more at the *ADDitude* bookstore, online at **www.additudemag.com**.

50 Things to Love About ADD

by Bob Seay

1. Innovative.
2. The drive of hyperfocus.
3. Creativity.
4. Insomnia makes for more time to stay up and surf the net!
5. Ability to meet someone, fall deeply in love, fight, hate, and break up—all in about 35 minutes or less.
6. A sparkling personality.
7. Can drop names like Edison, Einstein, Walt Disney, and Beethoven in conversations.
8. Can fixate on one object while the rest of the world goes down the toilet.
9. Can see all of your worldly possessions at one time…because they are all over the floor.
10. Generosity with money, time, and resources.
11. Enthusiasm.
12. Ingenuity.
13. Having a strong sense of what is fair.
14. Willingness to take a risk.
15. Resiliency.
16. Making far-reaching analogies that no one else understands.
17. Joining the ranks of artists, musicians, entrepreneurs, and other creative types.
18. Spontaneity.
19. Keeping business meetings lively.
20. Possessing the mind of a Pentium—with only 2MBs of RAM.
21. Aesthetically oriented.
22. Constantly and pleasantly surprised by finding clothing you had forgotten about.
23. Ability to tie seemingly unrelated ideas together.
24. Being goofy.
25. Independence.
26. Ability to see "The Big Picture" while others stumble around in the dark.
27. Demanding to know Why?
28. Being the last of the romantics.
29. Constantly and pleasantly surprised by finding money you had forgotten about.
30. Being a great conversationalist.
31. Having an innately better understanding of intuitive technologies, such as computers or PDAs.
32. In class popularity contests, always voted "Most Entertaining, " "Most Energetic," or "Most likely to Self-Immolate."
33. Great improviser.
34. Honestly believing that anything is possible.
35. Quickly assimilating new information.
36. Rarely being satisfied with the status quo.
37. Empathy.
38. Can replace missing childhood photos with panels from *Calvin & Hobbes*.
39. Being an unstoppable dynamo of human energy.
40. Optimism.
41. Compassion.
42. Persistence.
43. Spunk.
44. Constantly and pleasantly surprised by finding spouses you had forgotten about.
45. Always able to provide a different perspective.
46. Visionary.
47. A tolerance for chaos.
48. Willingness to fight for what you believe in.
49. Excellence in motivating others.
50. Being highly organized, punctual, and generally responsible ...**(OK, so I lied!)**