**ADHD: Alternative Interpretations and Treatment**

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| **Diagnostic Criteria**  When constructing the ADHD diagnosis, researchers are essentially saying, "Let's study a group of people who are out of sync with others due to hyperactive/impulsive and distracted behaviors that lead to chronic and pervasive problems in school, social life, and work. If the subject is an adult, the problems must be present in childhood and consistent throughout development (DSM IV). We can then call this group Attention Deficient Hyperactivity Disorder (ADHD) and study correlated biological characteristics and other associated difficulties. Some functional delays associated with the group might be evident prior to qualifying for the diagnosis, while some associated problems might occur long after a person receives the diagnosis. However, progenitors can tweak the criteria to better align with particular biological anomalies and functional delays to their liking at any time. Establishing criteria for the diagnosis is always a work in progress.  As it now stands, people assigned to the ADHD group often have a variety of other problems in common (i.e., driving problems, anxieties, executive functioning problems, fine motor difficulties, learning problems, failures to complete schooling, “hotheaded” dismissals at work, problems doing homework, depressed mothers, and atypical patterns of brain biology and particular genes, etc.). However, the behavioral criteria are the only way to establish a diagnosis because no dysfunction or biological trait can serve as a diagnostic marker (Barkley, 2006). That is, a person may have an ADHD diagnosis, but not have any of the associated problems or dysfunctions correlated with the group, and a person might have a functional difficulty associated with ADHD, yet not qualify for diagnosis. What goes unnoticed, however, is that the ADHD category of people transforms into people "having" ADHD. Qualifying for the criteria, "magically" converts into "having" something else even though nothing else is identified for the people meeting the diagnostic criteria.  **Critique**: So when people say that ADHD is a chronic and pervasive developmental problem, of course it is. The criteria require it to be. And when we find that people qualifying for the criteria have other problems in common, why are we surprised? Not only can we tweak the criteria to make it that way, but quite often people behaving in similar ways share other problems and traits in common. For example, a cab driver in London is more likely to have a larger visual-spatial cortex because navigating the streets throughout the day develops that aspect of brain biology (Maguire et. al, 2000).  Cab drivers, moreover, are likely to share a variety of problems in relation to driving on busy city streets for long periods. They might also show exceptional talent during tests of motor coordination and mapping, and share a variety of biological characteristics (including molecular biology) that increase the likelihood of functioning competently while driving a cab. However, none of this means that biology is causing the cab driving to occur or that these individuals possess a “cab driving gene.” Their biology and impressive learning curves may increase the likelihood of driving competence, but that it is not "written in stone." Many different outcomes are possible as living in the world takes place with each individual.  **Alternative:** While we are willing to say that people “have” ADHD, it seems peculiar to say that people “have” cab driving. ADHD is a category name (i.e., a description of a behavioral pattern), not an explanation even though people frequently use it in that fashion.  **The Fragile Pillars of Biological Causality**    Our first task is to dispel the belief that ADHD represents a fixed inherited neurological delay that forever keeps a person from showing competency in self-management. This commonly accepted belief rests on three research findings. (1) ADHD runs in families; often identical twins are the same when it comes to ADHD, and there are genes that increase the likelihood of ADHD. (2) The brain biology of people with ADHD is different from those without an ADHD diagnosis. (3) Medicine (which alters biology) ameliorates ADHD.  **(1) ADHD is genetic.**  There are individuals with ADHD who do not have the genes associated with ADHD. There are people without ADHD who have the genes associated with ADHD. The occurrence of these false positives and negatives indicates that genetics are not a causal source. In Psychology, we expect that an ADHD diagnosis will run in families. People in families have similar bodies and experiences, so they are likely to learn in similar ways. This (of course) amplifies with identical twins.   **(2)**   **Brain biology is different for those with ADHD.**  The finding that ADHD brains are different only shows a correlation between people who respond with ADHD behaviors and certain kinds of biological patterns. Cause and consequence are not determined. Certain biological characteristics might increase the likelihood of evolving an ADHD behavioral pattern, but doing ADHD behavior over time may alter biological development just like what happens to muscle development when people fail to exercise.   **(3)**   **Medicine works**  We do not know the etiology a problem just because medicine ameliorates the behaviors. For example, alcohol might help a person to become more sociable, but that does not tell us why the person was not sociable.  **Alternative:** Biology changes the probably of what is learned. For example, if a person is agile, he may enjoy playing sports and participate frequently. If he has a gene associated with ADHD, his probability of an ADHD diagnosis goes up a few percentage points (e.g., from 9% to 13.5%). However, much can happen along the way that might alter the course of development. Particular genes, early occurring problems (e.g., negative infant temperament, high activity levels, motor coordination problems), and patterns of biology do not seal an individual’s fate or doom the individual to an ADHD diagnosis. People with similar starting points can learn to live in the world in very different ways.  **The ADHD "Inhibitory Model"**  No one is debating that some people behave in ways that result in long-term problems or that some people qualify for the ADHD label. The issue is how to account for their atypical behaviors and whether the ADHD “inhibitory model” is believable.  Let’s explore this question by utilizing the example of a person who “blurts” out a “hot-headed” response towards his boss that gets him fired. This is the example used by traditionalists to illustrate the social devastation that ADHD creates. According to this view, ADHD makes it more difficult for this individual to suppress a response that is immediately gratifying (or emotionally charged). The biogenetic problem allegedly keeps a person from stopping and thinking before taking action. The person's failure to “inhibit” an impulse compromises his future well-being (Barkley, 2013).  **Critique:** When a person without ADHD acts appropriately when there is difficulty with his boss, does he first “suppress” an angry response and then acknowledge privately that angry responding could get him into trouble? Or does he instantly respond with deference because he is *conditioned*to do whatever it takes to keep his job and conform to social standards? Moreover, even if he were to experience covert anger (at times) and keep his emotions silent, might conditioning account for that reaction as well?  Patterns of deference or keeping anger private (in workplace settings) may develop in relation to what has happened during many years of socialization. The person who conceals or anxiously pleases at work may come home and repeatedly yell at his children (despite the fact that this also leads to longer-term problems), and the person diagnosed with ADHD may not “blurt out” at all when pressed by someone to admit wrongdoing.  Many factors come into play when accounting for whether a person is careful or behaving in ways that result in work termination. For example, does the person have a history of others providing support or rescue when getting into trouble at work? Does he want to rid himself of his job? Has a previous incident with his boss been gnawing at him? Does his boss trigger an intense unresolved problem from childhood (i.e., most of us over react when that occurs)? Have significant others modeled similar behaviors? Has he frequently gained dominance when combative? And does he believe that the outburst is his only recourse? Any one of these “living in the world histories” (i.e., patterns of conditioning) can reasonably explicate the increased intensity and frequency of the behavior in question. However, once a person has an ADHD diagnosis, his "ADHD" becomes the reason for the problem. No one examines other possibilities.  **Alternative**: Before we say that an individual has an underlying deficit, it is important to examine his unique history of reinforcement (i.e., much like what occurs in cultural anthropology). Many behaviors that initially seem chaotic, uncontrolled, or disorganized may seem sensible, adaptive and meaningful once we identify a history of conditioning. While the person's behavior might not meet an external standard, it is understandable within an historical context.  An analysis of learning history (rather than statements about biology) can help to predict the absence or presence of an ADHD response across varying situations. For example, when a 12-year-old female diagnosed with ADHD overheard that her therapy session was going to occur on a Friday, she immediately protested because she had the “time distant” association that her appointment was going to interfere with the possibility of having a “sleep over party.” Similarly, another child with ADHD knew that if he achieved passing grades in his new school, his parents would not allow him to transfer back to his current school (which he did not want to leave). Again, if he had the posited ADHD limitation of not stopping and identifying the future, why wasn't it impairing him then?  **A perplexing problem with the "inhibitory model":** *If you have to suppress to manage the future, how do you (or your brain) know when to suppress?* This dilemma renders the “inhibitory model” untenable. More specifically, it would seem that a person must *already* be aware that a situation is problematic when he pauses (and then privately introduces further content and/or subsequent information about possibilities). The discrimination of a potential problem is what stimulates the pause. The individual is already cognizant of the future *prior* to the pause; it is not that an “inhibitory response” enables future recognition.    **Alternative:** Rather than adopt the ADHD “inhibitory model”, let’s assume that people have immediate (or automatic) associations in certain situations (in relation to their learning history). Yes, unlike other animals, people may have associations about more distant events. However, these associations may occur just as immediately as associations about more current time events and do not require a precursor pausing response (e.g., seeing a store and immediately remembering items bought at the store many years ago, etc.). If or when a person is *aware*(through triggered associations)of a (short or longer-term) problem, he or she might have a pausing response (and additional ideation or problem solving), but it is not that the pausing response is necessary for future awareness.  **Immediate vs. Delayed Reinforcement**  To remain credible, the biological account must also answer a question asked by many parents: “Why can my child achieve so well when he is doing what he wants to do?” The competencies that these parents observe seem to contradict the assertion that the child has a coherent disorder. So how does a biological determinist deal with this frequently occurring observation?  Some ADHD experts, for example, theorize that children diagnosed with ADHD can perform well when doing tasks they initiate and enjoy (i.e., playing video games) because these activities *provide* "immediate reinforcement" or "instant gratification" (Barkley, 2000). The activities allegedly side step the motivational delays that ADHD creates. That is, when playing a video game, a person does not have to “inhibit” the urge to quit and then conjure up the longer-term reasons to stay on task. The activity *gives* immediate pleasure so there is no need to self-motivate. But this is only one way to understand the problem, and it has significant flaws.  **Critique**: First, many people respond differently to a task depending upon whether it is assigned by others or self-initiated. Think of the difference in the kinds of reactions that are typically provoked when *forcing* someone to eat as compared with *inviting* someone to have a taste of food. Or the difference between doing psychotherapy with a self-referred client as compared with doing therapy with a court ordered client.  Second, if video games "provide" immediate gratification, why do so many people avoid playing, stop playing very quickly, or report very little pleasure when they play? Depending upon many different factors, people may enjoy a particular activity or dislike it (even if the people designing the activity put in a great deal of effort into making it pleasurable and profitable).  Third, activities such as schoolwork can "provide" instant feedback (e.g., teachers often give students an immediate evaluative reaction), but the child might still avoid, provoke, give up quickly, or rush to finish. And many people can be fully aware of the negative longer-term consequences of their actions, yet still continue to behave in those ways (e.g., smoking, overeating, etc.).  **Alternative:** Depending upon a person’s history of reinforcement, some tasks may trigger ADHD behavior. But it has nothing to do with a task "providing" instant feedback. Tasks associated with success and discretionary authority are unlikely to trigger ADHD behavior, while tasks associated with adversity, failure, negative evaluation, and loss of authority are more likely to evoke ADHD reactions.  Yes, you can provide additional feedback (e.g., add rewards and punishments) while a person is completing a task, and those changes can influence ADHD behaviors. But that does not mean that the absence of those "extra consequences" is the reason for the occurrence of ADHD responding. You can also eliminate ADHD responding by resolving the negativity associated with a task and by diminishing contention. As noted by Hathaway, Dooling-Litfin, & Edwards (1998), ADHD is less probable when there is “interest”, and that may come to the fore in a variety of ways.  **Traditional Treatment Recommendations**  In the accepted view of ADHD, we tell people that they have a permanent disorder. They learn that their brains are less capable of doing self-management. They must accept the fact that they are inherently less able to organize their behavior for longer-term success. They will always be more dependent on external forms of assistance when trying to meet expectations.   When told about their disability, the expectation is that the “afflicted” will have a grief response. It is then necessary for them to go through a mourning process. But in the end, they will know why their life has been in shambles, and eventually, their new understanding will comfort them. They will know that ADHD is not their fault, and they can seek the necessary assistance from medicine and other forms of compensation without feeling guilty. They will accept “the fact” that they are “unable”, and welcome efforts to offset their disability (Murphy & Gordon, 1998).     **Point of Performance Treatment**  The traditional (i.e., psychosocial) way to offset ADHD is to get an individual to submit to contingency management. "Point of performance” treatments are necessary. Since those with ADHD are unable to recognize the future “in their mind’s eye”; natural consequences are insufficient. Loved ones must bring the future to the present so that the impaired individual can be aware of longer-term consequences (Barkley, 2006).  Achievement is possible, but only in small increments. As soon as the support system goes away, people diagnosed with ADHD will likely fall back into the short sightedness of their disability. They will operate only for immediate gratifications and jeopardize their longer-term safety and adjustment. So let’s examine this view and identify some of its problems.  **Critique**: First, we expect that people subjected to “contingency management” will fall back to old behaviors when the system stops. When people learn to do behavior under conditions of coercion, they are not as likely to do the behavior when the control is withdrawn. Whether the manager doles out rewards or punishments, the system induces pressure, and the expected behavior is unlikely when those efforts stop. There is nothing unique about the failures of the ADHD population when “point of performance” intervention ceases; we find the same recidivism when people are “institutionalized” and subjected to unilateral force and control.  Second, what is the basis for asserting that individuals diagnosed with ADHD cannot see the future? Perhaps we are simply confusing their pattern of being less attentive (and conforming) to what others want with this supposed disability. Frequently we observe people diagnosed with ADHD showing behaviors that eventuate into impressive longer-term achievements without “point of performance” intervention (e.g., learning guitar, amassing card collections, mastering auto mechanics, etc.), and often we find them showing punctuality and time management when the agenda is something they instigate (e.g., planning and coordinating with friends). They might not be doing their homework or chores, but their behavior is very different for activities that they initiate and enjoy.  **Alternative:** People diagnosed with ADHD might be able to see the future just fine. But they might not be reinforced to do the behaviors and achievements that other value. People often avoid activities that are associated with negativity (e.g., exercising, schoolwork, listening to authority, etc.); and frequently they continue to do behaviors (even if they lead to future problems) when the activities are pleasurable (e.g., eating sweets, unprotected sex, etc.). It seems incongruous that a child with ADHD can scheme and sneak to reduce the probability of reprimand, but not see the future enough to recognize problems associated with failure to do homework or close the cabinet drawer.  It is not that people diagnosed with ADHD require “point of performance” intervention; it is that once we start that kind of treatment, we must continue to use it. This is true for most people, and it says nothing about whether people diagnosed with ADHD are unique in this regard. Moreover, when we assume that people diagnosed with ADHD need “point of performance” intervention because they cannot see the future, we are essentially dooming them to that limitation. When we do not socialize them to do actions and achievements valued by others without contingency management, we cannot expect them to behave in that way when left to their own devises.  **Disciplining with Rewards and Punishments**  As noted, most ADHD therapies recommend that you change the behavior of a child diagnosed with ADHD by imposing a strict system of controls. The thought is that only this kind of stringent socializing will keep the “afflicted” individual from the chaos that ADHD generates. No doubt, disciplining in that fashion works quickly. It’s easy to do, and all parents know that stringency is sometimes necessary to protect a child. Yes, coercion—disciplining with rewards and punishments—has a significant role in child rearing, but it has some downsides worth considering.  **Critique:** First, when you manage a child’s behavior, using special incentives and penalties, things will seem fine as long as there is no controversy and the child keeps earning the rewards you control. He may even be happy that he is getting something extra for showing the behaviors that you expect. But this kind of coercion can be problematic when it’s the primary way to socialize within a family.  As reported by Lepper, Greene, & Nisbett (1973), connecting a bribe to an activity will reduce interest in doing the activity when the bribe stops. This means that once you introduce a reward system, you must keep doing it, to avoid a significant drop in performance. Your discipline increases the child’s desire to obtain the reward and makes the activity seem less enjoyable.  Second, any reward system that you control limits the extent of your personal involvement. You want success to occur without you, but the invented system of rewards and punishments trains compliance only under supervision. You will not be able to monitor every action that a child takes, and so you will not have influence over him sometimes. Sadly, this will increasingly be the case as the child grows older and spends more time away from the adults in his world.  But that’s not all. What happens when your consequence is not strong enough to outweigh the hassle of meeting the expectation? For example, it’s just not worth it to lug the trash outside when it’s snowing just to get another star on the chart. Many children recognize this problem, and it’s common for them to resist until the bribe or threat is increased. Your relationship spirals into a power struggle.  There are other problems as well. Some children may stop liking a reward so that you cannot pressure them. Some may become overly concerned about unwanted consequences and develop anxiety. Some may stop telling you what they like so that you cannot use it to “pull their strings”. Some may lie or sneak to beat the system.  And sometimes failure to obtain a privilege makes little difference to a child as long as the child can remain in the center of your concerns.  As you can see, when your purpose is to create discomfort or give something extra to get a child to obey, **you are teaching the child to overpower rather than to cooperate.** He sees you trying to force submission, and he duplicates the same behavior to gain authority over you. You take away what he wants, so he takes away what you want.  Even if it means putting himself in jeopardy, he may find a way to gain the upper hand. You pressure him to be more productive, and he learns ways to get you to reduce your expectations. He tries to outmaneuver you, and you work to close the loopholes. You end up struggling for dominance, and the child is not learning to self-manage. Empathy, attending to each other’s perspective, scratching each other’s back, and finding a middle ground are often set aside when you get into this arrangement.  So ask yourself, does a child really need extra payment or the threat of a “time out” to achieve or to be kind and honest? Do you want him to agree to cooperate and help out only if he gets something extra in the deal, or do you want him to derive pleasure from building a caring relationship with you? Even if the reward is spending time together, do you really want to turn time together into a business deal or make it an obligation? Of course not.  **Alternative:** With all of these potential side effects, let’s take a different approach. You can focus a child on a very important reason to cooperate and develop proficiency; he will be happier if he is kind and skillful. Lack of connection with others and lack of competence are the most potent negative consequences, and inclusion and knowledge are the most wanted treasures. Think of the immediate and profound influence that a mother’s smile has on her infant. And think of a child’s celebration the moment he solves a jigsaw puzzle.  **Medications**  In addition to “point of performance” intervention, the other primary way to treat “biologically caused” ADHD is to alter brain activity by giving medication. This approach is part of our culture, and it is now very common for Pediatricians and Primary Care Providers to write prescriptions as soon as an ADHD diagnosis occurs. New medications for ADHD come out frequently, and there are hundreds of studies demonstrating the immediate benefits of medicinal interventions (Barkley, 2006).  **Critique**: According to a recent Johns Hopkins study (2013) however, ADHD medications do not help to reduce ADHD behaviors when used over longer periods of time (i.e., six years). The authors conclude, "we clearly need better interventions." These findings are consistent with the longer-term data of the massive MTA (2004) study and with the evaluation carried out by Consumer Reports (2012) which states: “While the medications help up to 80% of children become less hyperactive/impulsive and distracted, there is no good evidence that the benefits last more than two years.”  There are other problems as well. While prescribers assure the public that ADHD medicines are powerful yet harmless, how much of any medication is entirely safe? Side effects could worsen over time and biological and psychological changes can become difficult to reverse, the longer any drug remains in the body. Already there are reports that ADHD drugs can take a toll on the brain (Higgins, 2009), and longer-term effects on very young children are still unknown (Rappley, 2006).  Medicinal treatment can also take away the urgency of a problem. Urgency is what drives people to work hard and change, and lack of urgency can lessen a person’s desire to seek assistance. Individuals may end up relying solely on a medication because it works so well at the beginning. But what if it stops working after several years? When that happens, the decision to postpone other treatments such as psychotherapy can make things significantly more difficult. When children are older, it may not be as easy for them to change their habits and routines.  Keeping a child on long-term medicinal treatment can also mean higher dosages and multiple drugs as time passes. A child may need more medication as he grows, and there is a possibility that the body will build up a tolerance to the drug as well. Sadly, the potential for side effects increases with the amount and number of drugs needed to achieve the desired effects.  Medicinal therapy can also create the belief that medication is necessary for success. Once a person starts a medication regime, positive change is often attributed to the drug (even if the person could have attained success without the drug). The individual unwittingly learns to seek psychiatric drugs as a primary way to make improvements and is less likely to explore the possibility of resolving problems in other ways.  Finally, it is often difficult to stop medicinal treatment once it starts (even when supervised by a physician). Stopping medication often requires a person to adjust psychologically and biologically to not having a chemical boost in the body. Unwanted behaviors are likely to occur as soon as the medication is withdrawn, and this can persuade many people to keep taking drug. Many will conclude that the drug is a necessity (even when the benefits are not that great) and they will not want to endure the hardships associated with weaning off the drug.  **A Learning Model for ADHD**  In the learning perspective, ADHD responses have psychological meaning (even if the enactor does not recognize the meaning). The responses are functional; they are not “defective” or “lacking in control.” Similar to what Freud (1935) proposed in regards to slips of the tongue, forgetfulness, lack of follow through, etc., the intrusiveness and non-participatory behavior included in the ADHD diagnosis inform us about the psychological status of the individual. The behaviors occur in particular contexts, situations, and circumstances and increase in frequency in relation to what happens. While the responses can lead to many unwanted problems, they also yield advantages that are difficult to ignore.  Since biological determinism is replete with contradictions and shortcomings, it is reasonable to understand ADHD data within a learning paradigm. Yes, certain kinds of atypical biology (or functional difficulty) may increase the probability of learning ADHD, but those problems do not cause ADHD, nor are they signs of incipient ADHD. A behavior is not necessarily defective just because it is socially unacceptable. The learning model uses the same historical analysis to make sense of ADHD behavior and it does for more easily tolerated behaviors.  **Nurturing Self-Reliance and Cooperation: A Non-Medicinal Psychosocial Intervention**  In this intervention, participants learn that ADHD behaviors are frequent due to reinforcement; the label does not affix a defect, disruption, or delay onto the individual. There is great power in this understanding. When a person recognizes that he is doing ADHD, he understands that he can to do something else. ADHD responding is framed as a way to cope with not having what is wanted and not liking what is had. Individuals learn to do socially acceptable responding in situations that had previously triggered ADHD reactions. New learning becomes the antidote for ADHD.  There is a presumption of competency; those diagnosed with ADHD learn to alter their ways of coping. Instead of mourning the presence of a disability, psychological sense can be made of the socially unacceptable responses. Rather than infer incapacity, treatment changes the ways in which a person responds to adversity.  Increased familiarity with the situations that trigger the ADHD reactions and alternative ways to handle the problematic circumstances become the focus of treatment. The inadvertent reinforcement of ADHD behavior ends through systematic training of children, parents, and other significant adults. Treatment fosters self-reliance and cooperation instead of dependency on compensations.  **Stopping the Reinforcement of ADHD**  Very young children are naturally self-centered. They are vulnerable and they depend on others for security and support. Being able to command the attention of their caregivers is crucial for their survival. Thus they often find reinforcement for many hyperactive or impulsive behaviors; these behaviors typically draw people in and get things to happen quickly.  As children get older, we expect them to defer and conform to a larger number of rules and expectations. However, many tend to chafe at these restrictions on their behavior. That is when inattentiveness may be reinforced as a way to avoid “big kid” responsibilities and as a way to defend against failure.  In other words, ADHD behavior (hyperactivity, impulsivity, inattentiveness) can result in outcomes that relieve discomfort. They can also get you and others to give more attention and assistance. When we understand what reinforces ADHD behavior, we can alter the consequences for these behaviors to reduce their frequency. We can help a child learn different behaviors; ones that produce better outcomes with fewer negative side effects.  **The Five “A”s**  ADHD behavior may have any of the following beneficial effects: it may garner attention, it may get others to make accommodations, it may help a person avoid certain situations, it may help him acquire something he wants, and it may antagonize others for doing things he does not like. Any one of the five “A’s” can increase the frequency of an ADHD behavior. Sometimes these reinforcements even work in combination to drive particular behaviors, strengthening them that much more.  Table 1: Examples of ADHD Reinforcements   |  |  | | --- | --- | | ADHD behavior and response | Reinforcement | | 1. A child is dancing in front of a stranger in a waiting room while a parent is reading a magazine. The parent asks the child to look at pictures in the magazine the parent is reading. | Attention | | 2. A child is groaning, daydreaming, and covering her face while doing her homework. The parent goes over to her desk and asks her whether she needs help. | Accommodation | | 3. A child sticks out her leg and trips her younger brother. The parent yells at the child. She runs to her room and the parent rushes in to talk. | Antagonism | | 4. A child reaches quickly to get food before others and knocks over her milk. The parent cleans up the spill while she continues to eat. | Acquisition | | 5. A parent asks a child to help put away groceries, but she keeps watching TV without responding. The parent keeps calling her and continues to put groceries away. | Avoidance |   **Ten Principles to Develop Self-Reliance and Cooperation**  If children are going to succeed in life, they must ultimately learn to function autonomously and get along with others. They must learn skills to complete necessary tasks, understand the point of view of the people they interact with, and balance their wants with the wants of others without sacrificing their integrity. Nurturing self-reliance and cooperation and stopping the reinforcement of ADHD behavior are not simple tasks.  Here are ten principles that can help. These principles are evidence-based interventions that facilitate goal achievement for diverse groups of people (Latham, Erez, & Locke, 1988; Locke & Latham, 2002). They help to reduce avoidance behaviors (Ehrenreich et al., 2007), they develop postive interacting (Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000; Henry, Schacht, & Strupp, 1990), and they can increase resilience in children (Brooks & Goldstein, 2001). |  |
| **1. Use coercion as a last resort.**  When you manage a child’s behavior using special incentives and penalties, things will seem fine as long as there is no controversy, and the child keeps earning the rewards you control. But this kind of coercion can be problematic when it’s the primary way to socialize a child. Side effects such as evasion, submission, anxiety, minimal conformity, retaliation, selfishness, rigidity, materialism, domination, maneuvering, procrastination, withholding, and reliance on others are likely to increase. So instead, minimize coercion and increase socially valued behavior by helping the child recognize that she will be happier when she acquires new skills and cares for others. Focus on those outcomes. |  |

**2. Stay calm.**

When you model calm behavior, you simply act in the way you want a child to; he learns by observation. When a child is overreacting, do not escalate the problem. Keep your tone of voice calm and reasonable even as you repeat yourself. As a last resort, stop responding until the child settles. If necessary, create physical space between you and the child to facilitate “quieting down.”

**3. Actively address and resolve problems.**

Some may think that reducing coercion means letting a child do whatever she wants. This is not so. A child can learn to conform to expectations with a less forceful management style. You might allow some failures to occur that would end more quickly with coercion (i.e., much like what happens when you ignore a tantrum), but you are not idle; you are methodically developing mature behavior. You are reducing pressure tactics to persuade in more subtle ways. So instead of solving problems for the child, try asking, “How do you want to handle that problem?” or “What are your options (choices, priorities)?”

**4. Be patient.**

You may have to revisit a problem many times before progress becomes evident. Most people need more than one trial to change a behavior; relapse is expected. You can have a productive discussion with a child, and she may still behave in the same old way. Instead of giving up or resorting to coercion, stay on the path of finding a mutually agreeable solution. Maintain the view that, over time, new learning will eventually take hold.

**5. Suspend judgments.**

Under some circumstances, evaluation can stimulate achievement and be helpful. But a child may relate to you more honestly and show more attentiveness if you suspend judgment and hear him out. You want the child to open up to you, and that will feel easier for him when he feels safe from criticism. You can put him at ease and make it comfortable for him to speak his mind by talking with him in a frank and respectful manner. Impartial statements about observations and facts will make it easier to build a relationship that both of you value and enjoy.

**6. Say it positively.**

If you are using a lot of negative language, switching to positive will help a child learn the advantages of acceptable behavior. She will also learn to think positively when the language that she learns and uses is affirming. While it’s important that your child be aware of negative consequences and comply immediately when you tell her not to do something, too much emphasis on the negative can be counterproductive.

**7. Treat the child as competent.**

A child will improve more quickly when you treat her as competent. Before assuming she is inept, assess competency when she is doing tasks that she has practiced or enjoys. Use those activities to gauge what she can do under positive circumstances. Let her know that she is impressive, and allow her to inform you. This will put her in the driver’s seat, and it will reassure her that she can do well on her own. Value her achievements and contributions, and take notice of her ambition even if it shows only with her hobbies. Your positive responses will help her repeat similar behaviors with other activities.

**8. Establish "buy in."**

When a child is comfortable with what is happening, he is more likely to follow through and do his part. For this important reason, it’s good practice to obtain “buy in” when you are trying to get him to accommodate. Look at whether he nods his head, smiles, or says a sincere “okay.” When you act with concern about your child’s perspective, you model responses that will benefit him throughout his life. Research shows that when infants and caretakers resolve problematic interactions by adjusting to each other in positive ways, their relationships become stronger. The child develops trust with the caretaker, self-regulation improves, and psychological problems in the future are less likely (Sroufe, 2005).

**9. Assert yourself.**

You may tell a child what you want her to do, but if she resists or disregards you, her lack of cooperation may keep you stuck. Don’t confuse less coercion with weakness or inactivity. Instead of remaining frustrated, take the reins. Assert yourself, and your child must then deal with the changes you have made. If your child ignores you, rather than repeating the same instruction, you can physically stop her from what she is doing without saying a word. You can also talk with a child about problems more often, beginning with a focus on you and what you are willing and not willing to accept. Let her know that you value her input, but don’t stand still and let her control what happens.

**10. Foster independence.**

You can enhance a child’s welfare when you help him learn self-reliance. This can be difficult when you are anxious about harmful consequences. Of course it is necessary to come to a child’s rescue and protect him whenever you sense significant danger. However, you might find that he learns many valuable lessons when you allow “natural consequences” to run their course. Let him experience the natural results of his actions (if there can be no significant harm). Give him an opportunity to solve problems on his own before offering assistance. For instance, let him order his own meal at a resturant instead of speaking for him. Or allow him to spend his money the way he chooses. You help him to learn self-management by not giving extra money when he complains that he is “broke.”

**Concluding Remarks**

A very important question remains unanswered. Are the generally poor outcomes of the ADHD population due to the incurability of a putative biogenetic delay, or are they due to the use of treatment methods that rarely produce longer-term benefits for any population? Stringency and supervision force a child to comply, but these practices are unlikely to help a child develop independence. And if no one is helping the child learn self-management, how can we expect that competency to occur? Because a child is generally more difficult to monitor, as she grows older, this concern increases as adolescence approaches.

The recommendation to nurture self-reliance and cooperation is not about controlling a child more often. Nor is it about catering and excessively accommodating to a child. It’s about developing a child’s self-care and concern for others. The goal is to establish a mutually respectful relationship in which obtaining the child’s endorsement is more valuable than ordering the child around. Those who socialize the child focus on staying calm, they learn to enjoy the child’s company, and learn to use a reasonable tone of voice when resolving problems. They communicate, “We’re in this together, so let’s solve it together.”

Many children with ADHD may not like having this kind of increased responsibility at first, but they are likely to enjoy having more say over what happens in the end. They may also like the fact that they are achieving and that others appreciate what they have to offer. While the methods emphasize understanding the child’s perspective, they also emphasize helping the child learn to be considerate of others and to contribute to their well-being. The treatment helps the child strike that key balance, because it presents the best opportunity for the child’s future happiness and the diminishment of ADHD behavior.

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