



Family Matters

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Advising Families on AD/HD: A Multimodal Approach

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Nurses who interact with families having children with attention deficit hyperactivity disorder (AD/HD) are perfectly poised to help them understand optimal AD/HD management. While medication can be important in managing AD/HD symptoms, many times it is not a sufficient treatment. A medical examination and a comprehensive neuropsychological or psycho-educational evaluation are important to establish the diagnosis and identify or rule out competing diagnoses and potential co-morbid conditions. A comprehensive evaluation will also lay the groundwork for planning accommodations in school and supports at home that will best facilitate an individual child's learning and development. Nurses can encourage comprehensive evaluations, educate parents about school advocacy, and assist families in understanding ways in which changes in parenting style and the home environment can benefit a child with AD/HD. Nurses can also educate families about the varied professionals and range of resources helpful in managing AD/HD and improving outcomes.

"I don't think my son's Adderall® is working. He can play his Gameboy for hours (as can his dad). However, he can't even sit for five minutes to do his homework. He's always moving, dropping his pencil, and talking. He sometimes cries. Could he be depressed?"

"My child is always calling me from soccer practice because some part of the uniform has been forgotten or lost. I'm always running in so many directions after school that we often start homework and dinner late in the evening. Can our doctor increase the AD/HD medication to help my child focus better?"

These examples illustrate that attention deficit hyperactivity disorder (AD/HD) in children often presents as complex complaints. It is not uncommon for parents of children with AD/HD to report that their child's medication is "not helping," or that it helps a little but their child is still struggling with school, peers, and/or managing behavior and emotions. All too often, the solution is not simply an issue of altering the child's medication. Rather, the solution often involves making changes in both the school and home settings as well.

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Authors' Note: The terms AD/HD and ADD are used interchangeably in this article. AD/HD is the official term used by the DSM-IV TR (2002) and includes individuals who were referred to as ADD in the past, with or without hyperactivity.

The *Family Matters* section focuses on issues, information, and strategies relevant to working with families of pediatric patients. To suggest topics, obtain author guidelines, or to submit queries or manuscripts, contact Elizabeth Ahmann, ScD, RN; Section Editor; *Pediatric Nursing*; East Holly Avenue Box 56; Pitman, NJ 08071-0056; (856) 256-2300 or FAX (856) 256-2345.

Nurses can best advise families having a child with AD/HD by discussing a multimodal approach to the management of AD/HD symptoms. This approach should involve 1) plans to obtain a comprehensive, effective evaluation; 2) strategies for improvement in the learning environment; and 3) approaches to both parenting and the home environment to help the child better manage AD/HD.

The Need for a Comprehensive Evaluation

"My teenage daughter always stays up late to check her email, IM her friends, and update her Facebook while doing her homework. She spends hours doing her homework and then forgets to turn it in. Do you think she has a memory problem? Can she be tested?"

Parents often report their own or teachers' concerns regarding their child's possible AD/HD. As the scenario above illustrates, complaints may focus on memory difficulties, such as forgetting to hand in assignments, remembering daily routines, or recalling information while reading or taking tests. While there is no single test to check for AD/HD, nurses can advise parents on the advantages of completing a comprehensive psycho-educational or neuropsychological evaluation in addition to obtaining a medical consultation with their child's pediatrician.

Difficulty remembering things is not the only concern parents may present. Children who have AD/HD often have difficulty learning in school (Stevens, 1997). In fact, some researchers estimate that up to 50% of children with AD/HD have a co-existing learning disorder (Pliszka, 1998). Families may report that their child is emotional, angry, forgetful, hyperactive, or inattentive while doing school-related tasks. These behaviors may be signs of a learning disability in addition to AD/HD. Again, a thorough evaluation can help distinguish causes of school and learning issues.

Psychologists with advanced training in the influence of attentional and learning factors on a child's academic functioning can provide the most thorough psycho-educational or neuropsychological testing. These specialists work in a number of settings, including private clinics that specialize in attentional and learning issues; pediatric psychology, or neuropsychology departments in medical centers; and within school systems. Referring families to psychologists who

have specialized in the area of AD/HD and learning issues will best assure an appropriate and complete evaluation.

The goal of psycho-educational or neuropsychological evaluations is to better understand the child's strengths and weaknesses in cognitive and academic functioning, to identify learning disorders and executive functioning difficulties (a discussion of executive functioning disorders follows), and to advise on appropriate educational and treatment planning. This information can be critical to the family and the school. Additionally, in a medical context, the evaluation provides suggestions about the need for medication or for a change in medication for an attentional disorder. It can also highlight other concerns that may require further attention by a treating physician. A thorough medical evaluation should also be conducted to rule out potential physical causes for AD/HD-like symptoms.

Table 1.
Other Disorders That May Present with AD/HD-Like Symptoms

Physical Conditions	Psychological Conditions
<ul style="list-style-type: none"> • Impaired vision or hearing • Seizures • Traumatic brain injury • Acute or chronic illness • Poor nutrition • Sleep disorders • Developmental delays 	<ul style="list-style-type: none"> • Anxiety • Depression • Sequelae of abuse or neglect • Tourette's disorder • Bipolar disorder • Conduct disorder • Oppositional defiant disorder

When assessing a child with characteristics of AD/HD, it is important to remember that several disorders show manifestations similar to AD/HD (Neul, Applegate, & Drabman, 2003). Table 1 outlines several physical and psychological disorders that may mimic AD/HD-like symptoms. For example, teachers may mislabel children with mental retardation, borderline intellectual functioning, and/or learning disabilities as having AD/HD (Landman & McCrindle, 1986). At the same time, it is important to note that AD/HD can occur comorbidly with these conditions. Given these issues, ruling out alternative explanations of AD/HD-like behavior is a crucial component of any assessment of AD/HD. Evaluation is also important to better understand the child's strengths and weaknesses in cognitive and academic functioning, to identify learning disorders and executive functioning difficulties, and to plan for appropriate educational and treatment interventions.

Special concerns for girls. Accumulating evidence suggests that girls with AD/HD often go unrecognized (Nadeau, Littman, & Quinn, 1999). In part, male AD/HD patterns may be overemphasized because they typically involve hyperactivity, and therefore, are easier to observe. Girls, through biology and socialization, tend to be less active, more compliant, and less aggressive (Gaub & Carlson, 1997). In general, children who exhibit attention problems but not hyperactivity are more difficult to identify, and thus, may escape evaluation. They are the quiet, distracted daydreamers who are not disruptive. However, the impact of their inattention may be manifested in more subtle ways, such as "not reaching their potential," difficulty completing exams in a timely manner, and being forgetful and disorganized in managing their schoolwork, relationships, and lives. These kinds of concerns, espe-

Table 2.
Common Behavioral Complaints that May Be Due to Executive Function Deficits

Complaints to Nurse: "My child..."	Executive Function	Definition of Executive Function
Has trouble remembering things, even for a few minutes; when sent to get something, forgets what he or she is supposed to get; frequently needs to re-read things just read.	Initiating	Beginning a task or activity.
Has trouble "putting the brakes" on behavior; acts without thinking.	Inhibiting	Not acting on an impulse or appropriately stopping one's own activity at the proper time.
Gets stuck on a topic or tends to perseverate; my child cannot think of alternative solutions without my help.	Set shifting	Freely moving from one situation, activity, or aspect of a problem to another as the situation demands.
Starts assignments at the last minute; does not think ahead about possible problems.	Planning	Anticipating future events, setting goals, and developing appropriate steps ahead of time to carry out an associated task or action.
Has a scattered, disorganized approach to solving a problem; is easily overwhelmed by large tasks or assignments; does work but doesn't turn it in; often forgets his or her belongings.	Organizing	Establishing or maintaining order in an activity or place; carrying out a task in a systematic manner.
Does not check work for mistakes; is unaware of own behavior and its impact on others.	Self-monitoring	Checking one's own actions during or shortly after finishing the task or activity to assure appropriate attainment of goal.
Is too easily upset, explosive; small events trigger a big emotional response.	Emotional control	Modulating/controlling one's own emotional response as appropriate to the situation or stressor.
Has trouble getting started on homework or chores.	Working memory	Holding information in mind for the purpose of completing a specific and related task.

Source: Adapted from Gioia et al., 2000.

Table 3.
Differences Between an IEP and a 504 Plan

Individual Education Plan (IEP)	Section 504 Plan
Falls under Individuals with Disabilities Education Act (IDEA).	Section of the Rehabilitation Act of 1973.
Federal law that governs special education and provides funding to school districts to support special education.	A civil rights law that prohibits discrimination on the basis of disabling conditions by programs and activities receiving or benefiting from federal financial assistance.
Provides special education services for those who meet the criteria for eligibility in a number of distinct categories of disability.	Covers individuals who have or have had a physical or mental impairment that substantially limits a major life activity (such as learning).
ADD/ADHD can be covered by IDEA under the category "Other Health Impaired" if the child's symptoms are affecting his or her educational performance.	Covers children who require related services, even if they do not require special education.
Children are eligible for IDEA only if they require special education in order to respond to the difficulties caused by their disability.	Children covered under Section 504 either have less severe disabilities or have disabilities that do not neatly fit within the categories of eligibility under IDEA.

Source: Adapted from Cohen, 2007.

cially from the parents of girls, are an important indicator of the need for further follow up through comprehensive evaluation. Otherwise, these children may suffer from low self-esteem and chronic academic underachievement due to their undiagnosed yet very real difficulties.

Executive function disorders. Recently, developments in understanding the nature of attentional disorders include discussion of the role of executive function deficits in those who have been diagnosed with AD/HD. The executive functions are a collection of mental processes that are responsible for guiding, directing, and managing cognitive, emotional, and behavioral functions (Gioia, Isquith, Guy, & Kenworthy, 2000). Executive functions guide purposeful, goal-directed, problem-solving behavior and include components of attention, reasoning, planning, organization, inhibition, shifting, interference control, and working memory (Pennington & Ozonoff, 1996). Children with AD/HD often exhibit executive functioning deficits, although these deficits are not unique to AD/HD. Executive function difficulties are also evident in individuals with other conditions, including obsessive/compulsive disorder (OCD), Tourette's disorder, and depression. Whatever the etiology of children's executive function deficits, nurses can advise parents to pursue further evaluation and follow up. Table 2 provides examples of typical problems that are often reported by parents and may be the result of executive function deficits.

Support for School-Related Issues

Once a thorough evaluation has been conducted, a plan to support the child's optimal learning should be developed. Most children diagnosed with AD/HD need and benefit from behavioral and educational accommodations at school. Two laws govern the provision of accommodations: the Individuals with Disabilities Act (IDEA), which has provisions for developing an individual education plan (IEP) for a qualifying child, and Section 504 of the Rehabilitation Act of 1973 (see Table 3). School districts have greater administrative latitude and less accountability under a 504 Plan than with an IEP under IDEA. Thus, many school districts may be unwilling to consider eligibility for children with AD/HD under IDEA's "Other Health Impaired" category despite their qualification to receive such services (Cohen, 2007). Consequently, most children with AD/HD who receive services at school do so

under a 504 Plan. Unfortunately, qualifications for a 504 Plan vary considerably from school district to school district. If a child's academic performance is at grade-level, he or she may or may not receive services even if an evaluation has demonstrated a much higher potential. So, a diagnosis of AD/HD does not guarantee accommodations in the classroom.

Whether via an IEP or a 504 Plan, a child diagnosed with AD/HD will often need and benefit from school-based supports. Each child with AD/HD is different and is likely to need individualized accommodations based on his or her attentional, learning, and developmental needs. Effective and specific identification of strengths and weaknesses facilitates the development of individualized educational accommodations and treatment. None-the-less, nurses can share with parents the following list outlining common accommodations for children with AD/HD:

- Provide preferential classroom seating. Children with AD/HD are likely to benefit from sitting close to their teacher in the classroom, decreasing the likelihood of being distracted by objects and events in the environment. They also benefit from surrounding themselves with model students who will not distract them and who are likely to respond to attempts at socializing only at appropriate times.
- Use repetition and also concise directions, along with presentation in more than one sensory modality. Directions should be short and simple, and should be presented both orally and visually.
- Assure that oral directions are kept short and uncomplicated. Important information should be emphasized with advanced cues, such as stating, "This information is important to know." In addition, advance warning may help children with AD/HD prepare for a new task (for example, "In a moment, we will...").
- Write homework assignments on the board and on a handout for these children to take home. They should be expected to write down their assignments, but it is essential to ensure that they have transcribed the assignments correctly (this can be done by having the teacher sign the child's agenda book).
- When giving directions, check the child's comprehension of the directions before allowing him or her to begin

the task. One way to do this is to have him or her paraphrase the instructions out loud.

- Provide frequent breaks during difficult academic tasks. Children with AD/HD may benefit from frequent short breaks from academic work to minimize their distractibility. In addition, it is often helpful to divide long tasks into sub-units or chunks to decrease demands on sustained attention and to help them see an end to their work.
- Reduce distractions while completing work. Children may benefit from decreased distractions, such as taking tests alone and in a quiet area.
- Require that children with AD/HD keep unnecessary objects off their desks.

Since school-based supports are often needed but not automatically provided for children with AD/HD, parents often must learn to advocate for their children. Nurses can educate parents about the differences between an IEP and a 504 Plan (see Table 3). Nurses can also link parents with educational, support, and advocacy groups, such as Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD); local groups can be identified through the CHADD Web site (<http://www.chadd.org>). Parents may need to help school personnel understand how specific symptoms of AD/HD are impacting their child's academic potential. If parents are not successful in gaining needed accommodations, they can be encouraged to seek consultation from outside clinical professionals and lawyers in assessing the viability and desirability of their child's options.

The home environment impacts the child's learning potential and school success as well. Nurses can also advise families to consult with either a therapist specializing in the treatment of AD/HD or an AD/HD coach to help the family set up a home environment conducive to their child's learning and attentional needs. In addition to implementing similar accommodations to the school setting, the following suggestions may be helpful to families:

- Increasing structure in the home environment, including provision of a quiet space to do homework, a specific time to do it, as well as consistency regarding mealtimes, chores, and effective morning and evening routines will all be useful in reducing problems with organization.
- Share at least one meal a day to improve structure at home, model organization, and improve interactions within the family.
- Improve the child's workspace by setting up a proper desk/study area with all the materials he or she needs at hand (this can be the kitchen table, but a container with important school supplies should be readily available so he or she does not spend time looking for materials).
- Supervise and provide assistance to help the child stay focused and organized during homework time. Parents can arrange to do some of their work (such as bill paying, office work) at the same time so positive work-time behavior is modeled and they can feel they are also getting something accomplished.
- Encouraging short (approximately 5 minutes) movement breaks at regular intervals during homework time can help the child with AD/HD.
- Use hands-on manipulatives and/or visual images so the child learns different concepts.
- Help organize homework by providing a folder where the child consistently places homework to be done and the completed assignments. A clinician, ADD-coach, or professional organizer may be able to help find a system that is most appropriate.

Helping parents find the professional resources and support they may need is also an important nursing role. Mental

Table 4.
AD/HD Services Offered by Different Professionals

Specialist	Services Offered for AD/HD
Psychiatrist	Obtain detailed mental health history Diagnose mental health disorders Prescribe psychotropic medications (May provide psychotherapy) Occurs in an office setting
Psychologist	Obtain detailed mental health history Diagnose mental health disorders Provide counseling and psychotherapy Provide psycho-educational and neuropsychological testing Develop behavior management plans for children Offer parent training Occurs in an office setting
Tutor	Teach a specific educational subject or skill May focus on building executive functions and/or improving organizational skills Often occurs within the child's home
AD/HD Coach*	Help client manage time, organize, and set goals Help client start and complete projects Help client develop systems for school, work, home Provide education about how AD/HD affects the client Sessions often are conducted by telephone and email

*See the article on AD/HD coaching, published in the September/October 2008 issue of *Pediatric Nursing* (Sleeper-Triplett, "The Effectiveness of Coaching for Children and Teens with AD/HD," pp. 433-435) for more information on coaching.

health practitioners specializing in AD/HD can be located through CHADD, the nation's leading non-profit organization serving individuals with AD/HD and their families. Table 4 provides a quick reference of various specialists to whom nurses can refer families for further assessment or follow-up treatment for AD/HD. These professionals can provide assistance with school-related issues and other aspects of living with AD/HD.

Advising Parents on Home Environment and Parenting Issues

Managing AD/HD requires active involvement of a child's parents. Supporting parental efforts to make changes in the home setting, whether it is the way parents learn to parent the child with AD/HD or efforts they undertake to make their home more "ADD Friendly" (Kolberg & Nadeau, 2002), is a very beneficial nursing intervention. A thorough parental education in AD/HD sets a foundation for understanding parenting strategies and home organizational practices that can be helpful. The "ADD-Friendly Household," a concept developed by Judith Kolberg and Kathleen Nadeau (2002), focuses on improved communication and relationships, and strives to achieve organization through established routines and schedules for the family managing AD/HD. A case study (see Figure 1) will illustrate many of the main concepts of an ADD-Friendly Household.

Figure 1. Case Study

A 38-year-old mother (Mrs. Smith), who has a diagnosis of ADD, also has an 11-year old daughter with ADD (Jennifer); her husband, while not yet diagnosed, also has symptoms of AD/HD. Both parents work full-time while the daughter attends a public middle school. The mother is responsible for managing the household as well as scheduling all of Jennifer's activities. Both parents have difficulty with time management and organization – the same struggles faced by their daughter. Arguments about homework, bedtime, and chores occur on a daily basis.

Components of the ADD-Friendly Household model are implemented as follows to assist the Smith family.

Improved Communication

Using the ADD-Friendly Household model, family members can improve communication with one another by discussing important matters during neutral times and by learning to be patient. In the case example, Jennifer's father often "exploded" at his daughter's non-compliance with schoolwork or chores. Jennifer would respond by crying and yelling; within seconds, the entire family was in turmoil. To avoid these incidents, the family learned about AD/HD and how it impacts each family member, specifically, how Mr. Smith's temper was a characteristic of his own impulsive AD/HD. With this new understanding, family members became more tolerant of one another.

Organization

Organization is another cornerstone of an ADD-friendly household. Mrs. Smith's own disorganization resulted in unhealthy or poorly planned meals. She learned to manage her disorganization by compiling a list of quick and simple recipes, as well as the accompanying grocery list. The grocery list was entered into both parents' Palm-Pilots so trips to the grocery store didn't result in impulsive purchases.

Another way that the Smith family became more organized was by creating a chore list. Enlisting involvement from other family members decreased Mrs. Smith's stress. Although the Smiths were concerned that Jennifer needed to spend her time on homework and did not have time for chores, they found that daily tasks, when tackled as a family, took less time than imagined and were opportunities for Jennifer to learn important life skills. The family developed a simple chore list and posted it on the refrigerator, and each family member became responsible for cleaning a different area of the house.

Routines and Schedules

Developing routines and schedules is the final component of creating an ADD-friendly household. Developing daily routines, especially a "morning routine" and an "evening routine," can help a family be more organized. Since individuals with AD/HD may suffer from sleep/arousal disturbance (Brown & McMullen, 2001), it is often beneficial for affected patients to take their medication when the alarm clock rings in the morning. Jennifer had a very difficult time awaking to her alarm in the morning. By setting her alarm clock 20 minutes earlier, she learned that she could take her medication, set the alarm for "snooze," and then wake on her own.

The Smith family also developed a plan for a breakfast routine. Like many children, Jennifer did not usually eat breakfast in the morning. Once she understood how the lack of a nutritious, protein-enriched breakfast affected her energy level and focus, she agreed to take "grab-and-go" snacks, such as mozzarella cheese sticks or a peanut butter sandwich. Over time, she developed the routine of eating breakfast, and her attention and mood improved.

Jennifer's after-school routine began with checking her schedule, which included a break, homework, piano practice, dinner, and then getting ready for bed. Following the schedule enabled her to achieve gold stars each day. At the end of the week, the gold stars from her reward chart were converted into privileges, such as 30 minutes of television or computer time.

Jennifer's parents became more disciplined themselves by developing the routine of reminding her to go up to bed at least 45 minutes before "lights out" to allow time for her to relax and unwind. By eliminating computer time before bed and getting to bed at a reasonable hour each evening, Jennifer's next morning generally went much more smoothly.

Visual supports, including a schedule, a reward chart, and auditory reminders (such as an alarm), all contributed to Jennifer's ability to learn new routines. Mr. and Mrs. Smith worked hard at creating an ADD-friendly household by "practicing what they preached." By turning off their own television earlier in the evening and creating a calming sleep environment, they also had better sleep, and consequently, a better morning and subsequent day.

Two additional issues are important in home management – addressing sleep problems and the possibility, since AD/HD has a genetic component, that a parent might have AD/HD as well.

Sleep issues. Sleep disturbances are frequently reported in individuals with AD/HD (Brown & McMullen, 2001; Owens, Maxim, Nobile, McGuinn, & Msall, 2000; Ring et al., 1998), and Jennifer, as explained in the case study, was no exception (see Figure 1). Children, especially teens, often watch television or are on the Internet communicating with their friends before bedtime. A number of studies address screen usage before sleep and its impact on an individual's functioning. For example, "screen time" before bed is suggested to disturb sleep and cause physical symptoms, such as muscle stiffness (Tazawa & Okada, 2001). Another study indicated that those who played more computer games went to bed later on both week and weekend days, and awoke later on weekend days. According to these researchers,

"Television viewing, computer game playing, and Internet use all lead to getting to bed later and to spending less time in bed" (Van den Bulck, 2004, p. 101).

Parents with AD/HD. Parenting a child with AD/HD can indeed be challenging, but it is even more difficult when struggling with one's own attention problems. Households with more than one member having a diagnosis of AD/HD are not uncommon. As parents recount their child's symptoms of AD/HD during developmental interviews, memories of themselves as children are often elicited; parents sometimes have experienced very similar learning and attentional struggles when they were young. However, it may be difficult for a parent to acknowledge those same characteristics in him or herself. Recognizing how a parent's own disorganization, inconsistent responses to inappropriate behavior, and/or impulsive behavior or reactions impacts the family is an important step in effectively raising a child with AD/HD. Accurate identification of AD/HD in the parent can be a key

part of the treatment process. Without awareness of their own difficulties, parents are ill-equipped to provide the structure necessary for their child.

Given the strong genetics of AD/HD (Levy, Hay, McStephen, Wood, & Waldman, 1997), it is often necessary to educate the entire family about AD/HD and ways to manage its symptoms. Organizing their child's schoolwork or bedroom, helping find lost objects, and developing daily routines are just some of the tasks that parents of children with AD/HD face everyday. These obstacles are exaggerated when one or both of the parents need to manage their own AD/HD symptoms. By creating an "ADD-Friendly" household, one designed to avoid or minimize the chronic problems caused by AD/HD (Kolberg & Nadeau, 2002), parents can improve both their child's odds of achieving school success and their own parenting practices, as was seen in the case study presented in Figure 1.

Many families greatly benefit from further consultation with a mental health professional who specializes in AD/HD to tailor a routine that is unique for their own family's needs and daily life. Such a professional is also often knowledgeable about helping with issues related to school and learning and home routines, and can act as both an educator and advocate for the family.

Conclusion

Nurses may be in the role of advising families about the complexities of the AD/HD diagnosis and various methods of treatment and intervention that are helpful in addition to medication management. Providing appropriate referrals for psycho-educational evaluations, therapy, tutoring, coaching, and other therapies that may help address the needs of children and parents with a diagnosis of AD/HD will provide a multimodal approach to the treatment of this disorder. Table 4 describes the services of several specialists who can provide assistance and support to the child and family managing AD/HD. Nurses can refer parents to CHADD for lists of professionals and should urge them to interview any specialist about the extent of their experience with AD/HD before making a decision to work together. The resource list in Table 5 may also be useful to families as they work toward understanding and managing AD/HD.

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Table 5.
Resources for Families

- *Executive Skills in Children and Adolescents: A Practical Guide to Assessment and Intervention* (Peg Dawson and Richard Guare, 2004)
- *Homework without Tears* (Lee Canter and Lee Hausner, 1987)
- *Taking Charge of AD/HD* (Russell A. Barkley, 2000)
- *Your Defiant Child: Eight Steps to Better Behavior* (Russell A. Barkley, 1998)
- *SOS Help for Parents* (John Robb and Lynn Clark, 2005)
- *How to Talk so Kids will Listen and Listen so Kids will Talk* (Adele Faber and Elaine Mazlish, 1999)
- *Straight Talk about Psychological Testing for Kids* (Ellen Braaten and Gretchen Felopulos, 2004)
- *Help4ADD@HIGH SCHOOL* (Kathleen Nadeau, 1998)
- *From Chaos to Calm* (Janet Heining and Sharon K. Weiss, 2001)
- *ADHD and Teens* (Colleen Alexander-Roberts, 2001)
- *Adolescents and ADD: Gaining the Advantage* (useful for teens to read) (Patricia O. Quinn, 1995)
- *ADD-Friendly Ways to Organize Your Life* (Judith Kolberg and Kathleen Nadeau, 2002)

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Additional Reading

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