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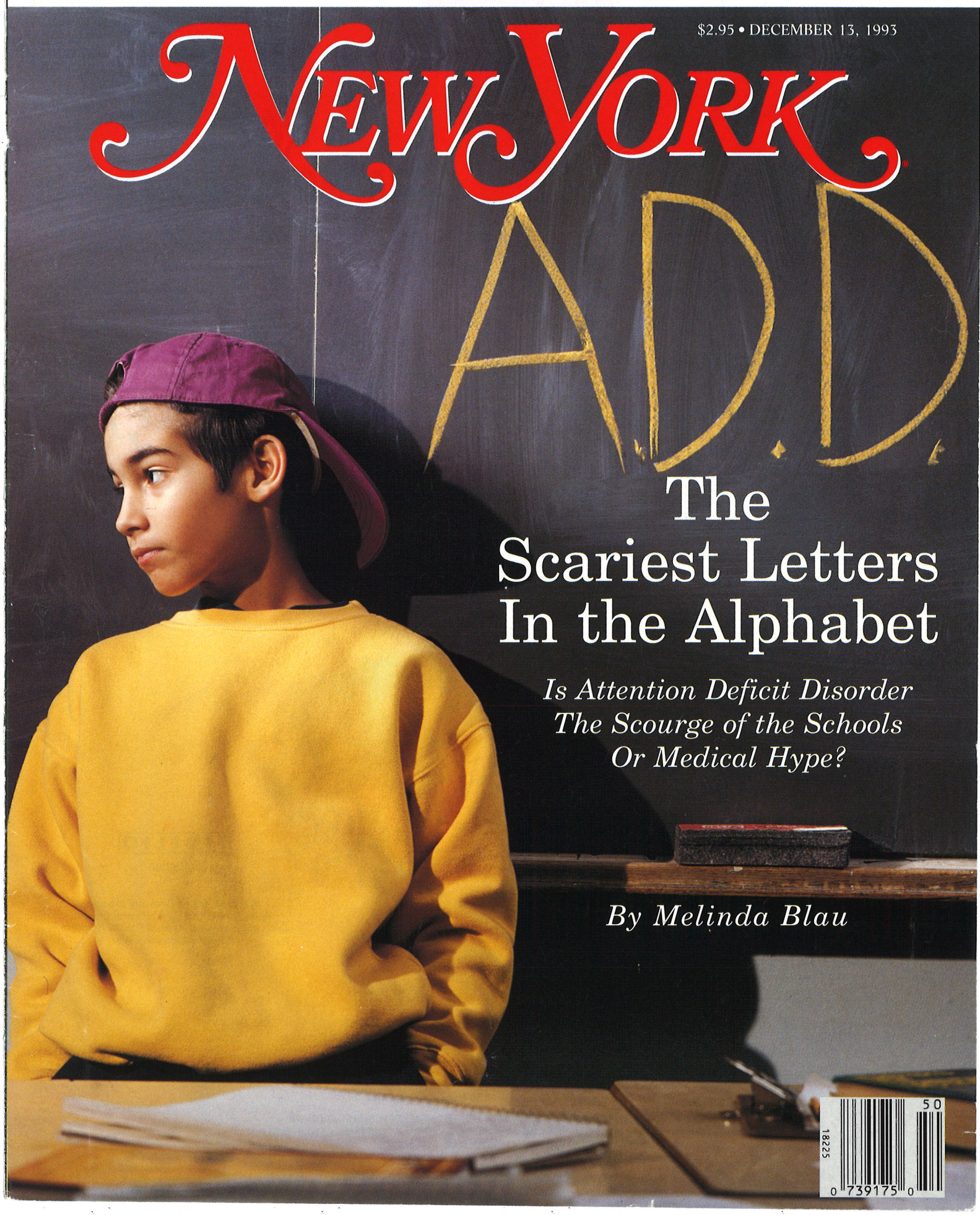

The Scariest Letters In the Alphabet

Is Attention Deficit Disorder The Scourge of the Schools Or Medical Hype?

By Melinda Blau

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The Scariest Letters In the Alphabet

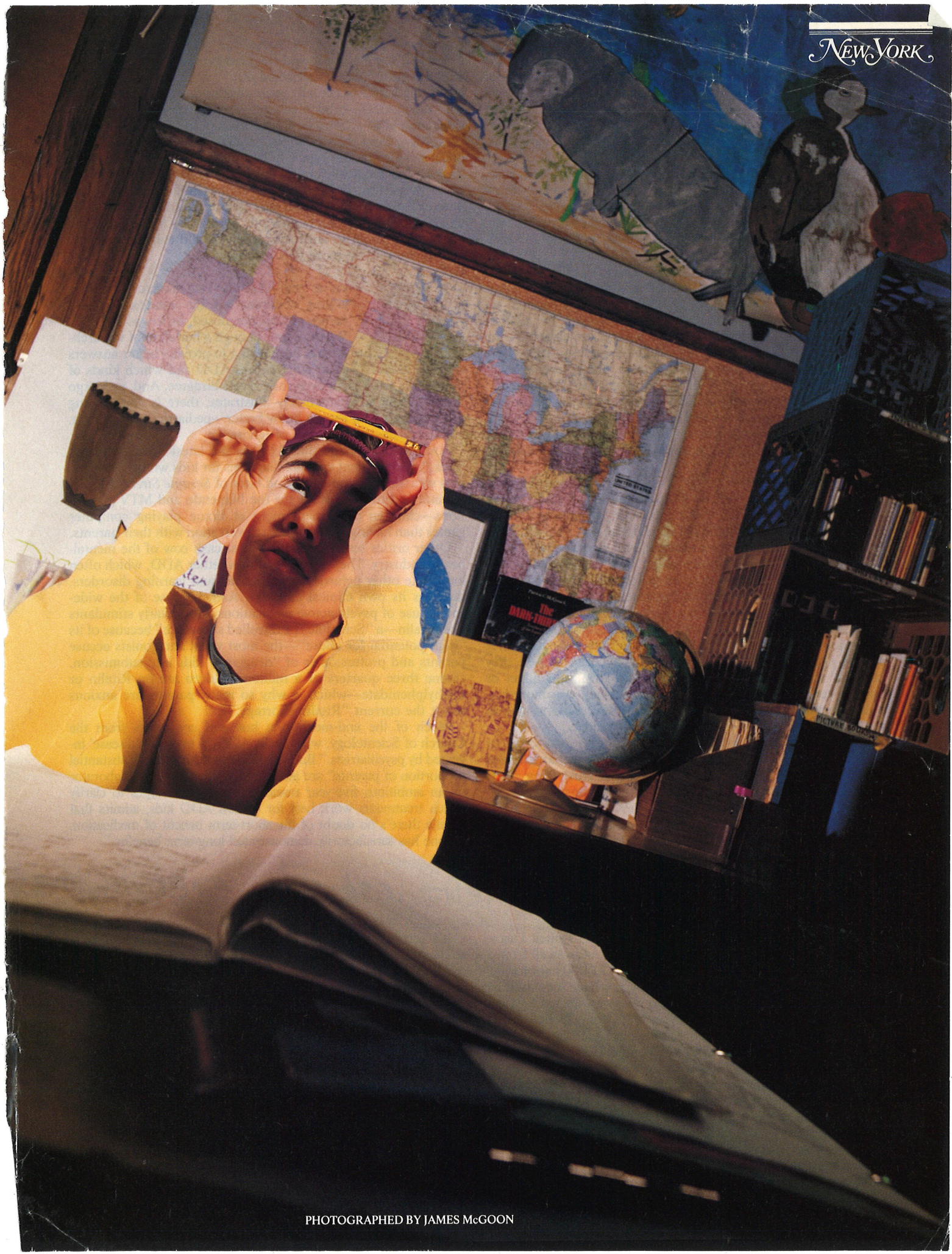
MARGO WIRTH* REMEMBERS WEEPING when she read *The Difficult Child.* "David* was around 5. He had always had very irregular sleep patterns, and there were never any grays for him, no compromise or negotiation—he saw things only in black or white. The simplest things, like getting dressed in the morning, were a battle. By 8:30 A.M., we were exhausted."

When David was in third grade, Wirth recalls, "the tantrums started. At first, they would last 20 or 30 minutes and happen

**Name and other identifying details have been changed.*

By Melinda Blau

Stylist: Jill E. Bloomer; Model: Joshua Kaplan/Bookers, Inc.


NEW YORK
PHOTOGRAPHED BY JAMES McGOON

maybe once a week. He would explode over anything and everything—if the tuna salad had celery in it, if he couldn't find the wrench to his Erector Set, if I said 'Hang up your coat' or told him to do his homework."

Immersed in what she describes as "the worst nightmare of my life," Wirth became desperate. "As time went on, the tantrums were daily and lasted for hours. Neighbors thought I was abusing my child.

"By last December, it had really escalated to physical abuse. His fists were up in front of my face all the time. He'd throw furniture around the room. I was being worn down to a frazzle. I felt suicidal. There were times I shook him, screamed at him, even smacked him. I had tremendous guilt, but I couldn't handle it."

The professionals Wirth consulted—David's pediatrician, his teachers, the school guidance counselor, a social worker, a psychologist, and two psychiatrists—focused on the parents' divorce, blaming Wirth's bad parenting and labeling her a "hysterical mother." She recalls, "The second psychiatrist—the head of child psychiatry at a major hospital, no less—told someone, 'This is a case of *parentis incompetus.* These parents created a monster, and now they don't know what to do with him.' He finally suggested that I put David into residential treatment.

"Mind you, I spent close to $10,000 in two and a half years, and no one gave me a diagnosis. At one point, David was on the floor, screaming, 'Help me, Mommy, help me. I can't help it.' He was the best diagnostician."

Most experts who deal with the millions of children like David—children who suffer from attention-deficit disorder, or ADD—would agree. Until they are correctly diagnosed and unless they are properly treated, ADD children *can't* help it. They are not the product of bad parenting, and they are not "bad" kids. Many are extraordinarily gifted and creative, their IQs above average. Still, they are often called willful, self-centered, and uncooperative. They baffle, frustrate, and infuriate parents and teachers, who typically say these kids can't concentrate, won't listen, refuse to pay attention, and don't follow rules. Their peers tend to see them as too rough or bossy, because they can be aggressive and overly physical; "hyper," because they can't sit still, talk excessively and out of turn, and fidget or squirm constantly; and "weird," because they are unpredictable, constantly throw non sequiturs into conversations, and often act like they're on—or from—another planet.

Attention-deficit disorder is an umbrella term for a category of complex, idiosyncratic, and chronic conditions characterized by impulsiveness, short attention span, low frustration tolerance, distractibility, aggressiveness, and, in varying degrees, hyperactivity; it affects anywhere from 3 to 9 percent of all school-age children. In the past five years, the disorder has catapulted into public consciousness, thanks in large part to support groups like Children and Adults with Attention Deficit Disorders (CH.A.D.D.), which has seen its membership swell from a few hundred members in 1988 to more than 21,000 nationwide.

Ironically, the incidence of ADD may not have increased all that much since a nineteenth-century German doctor first described certain young boys as "fidgety Phils," says Gene Arnold, special expert in the Child and Adolescent Disorders Research Branch of the National Institute of Mental Health (NIMH) in Bethesda, Maryland. Arnold acknowledges, however, that ADD has probably become somewhat more prevalent in the past 50 to 70 years, owing to factors that would make *anyone* more vulnerable, including improper diet and "noxious insults" from the environment, such as lead poisoning, and possibly pesticides. A confluence of cultural factors also makes ADD noticeable: more stress, less family support, and schools that are overcrowded and demand conformity. "The old one-room classroom was ideal," says Arnold, "with small classes, individualized attention, and frequent breaks in the routine, so children with ADD didn't stand out."

It's impossible to actually count the number of schoolchildren who have ADD—private schools won't release that information, and public schools lump the disorder in with other disabilities. More boys than girls have ADD, although many experts believe that girls are typically less disruptive and tend to slip through the diagnostic cracks. In either case, there is no "cure"; up to 80 percent of those diagnosed in childhood continue to have at least minor problems throughout their lives. Untreated, children with ADD, particularly those who are hyperactive, are often more prone to antisocial behavior and substance abuse, and to committing more serious crimes.

ADD IS THE LEADING PSYCHIATRIC DIAGNOSIS among children, but the condition is also commonly misdiagnosed, as it was in David Wirth's case. Though a battalion of researchers has been trying to provide better answers as to what causes ADD and which kinds of treatments work best, even the experts disagree. And, as Margo Wirth's story so dramatically illustrates, there is also, among professionals who should know better—pediatricians, teachers, psychologists—a great deal of ignorance.

Some critics charge that ADD is the latest "disease of the week," a convenient catchall diagnosis for kids whose busy parents weaned them on the sound bites of *Sesame Street.* ADD is certainly a fitting disorder for the Nintendo and MTV generations—children who seem more at home playing computer games than having quiet dinner conversation with their parents.

Other critics see ADD as the latest cash cow of the mental-health industry. They even question whether ADD, which often looks like other behavioral, emotional, and learning disorders, deserves its own clinical category. And, because of the widespread use of psychoactive medications, particularly stimulants like Ritalin—a "Schedule II controlled substance" because of its "high potential for abuse"—the most vocal antagonists accuse parents and professionals of "drugging" kids into submission. (Some three quarters of a million children are on Ritalin or methylphenidate—which is why so many parents are anxious about the current "Ritalin shortage.")

Much of the anti-medication hue and cry comes from the Church of Scientology, which calls ADD "a mythical 'disease' invented by psychiatrists." But, acknowledges Arnold, a "substantial proportion of parents" are also skeptical. Arnold, co-collaborator on an ambitious five-year research project that hopes to clarify which treatments work best for certain ADD kids, admits that "while there's no doubt of the short-term benefit of medication, no one has satisfactorily demonstrated long-term benefits."

Parents should trust their instincts, even in the

It's certainly not for lack of trying. ADD is "the most well-studied childhood psychiatric disorder in existence," says Russell Barkley, director of psychology and professor of psychiatry and neurology at the University of Massachusetts Medical Center. In the U.S., ADD's early history is often linked to the influenza epidemic of 1918, which left large numbers of children with postencephalitic behavior disorder—inability to concentrate, regulate their behavior, or control their impulses. More or less the same condition has been called brain-damage syndrome, attention-deficit disorder (with or without hyperactivity), and, in the 1987 revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders III*—or *DSM-III*—attention-deficit hyperactivity disorder (ADHD).

When *DSM-IV* comes out, in May, the name ADHD will stick, but the guidelines will change again, reflecting ADD's diverse forms. Arnold calls it the "Chinese restaurant" ap-

proach—one column for inattention and one for hyperactivity/impulsivity. Depending on the number of symptoms a child (or adult) displays in each column, he or she might be classified as predominantly inattentive, predominantly hyperactive-impulsive, combined (which represents an estimated 50 percent of ADD children), or not otherwise specified, a catchall category.

As to why certain children have attention-deficit disorders, the consensus is that there is probably a combination of psychosocial and biological factors. A slew of environmental causes have been hypothesized, among them lead poisoning, negative mother/child interactions, a sensitivity to food additives or to refined sugar, cigarette smoking during pregnancy, and the various problems associated with poverty.

present in *all* children, but when these signs appear to a more serious degree than in other children of the same age," this "cluster" of serious and debilitating symptoms can indicate ADD.

"It's much easier to diagnose when hyperactivity is attached to it," claims Arlene Portman*, a mother who didn't realize that her daughter, Sue Ellen*, had ADD until last year, when she seemed to be having trouble "fitting in" with the other first-graders. "I thought maybe she acted different because she felt different," says Portman, whose adopted daughter is of mixed racial background.

Sue Ellen was very bright and was an early reader, but she had trouble concentrating and following directions. "Approaching a group of children or working her way into a conversation was hard for her, too," says Portman. "She was always a step behind—last in line, last to get her coat."

face of expert opinion—or a dissenting spouse.

EARLY BIOLOGICAL THEORIES ATTRIBUTED THE condition to high fevers, birth trauma, infections, epilepsy, and head injury. A current, more popular hypothesis is that ADD children have different brains. Research strongly suggests that these kids are somehow "wired" differently from other children and may be slower to metabolize certain chemicals that are instrumental in carrying messages from one neuron to the next.

There is little disagreement that ADD runs in families. Between 25 and 35 percent of siblings, 25 to 40 percent of parents, and 20 to 25 percent of other relatives have the disorder. "The contribution of genes over environment is ten to one," Barkley says.

Of course, who among us isn't at times inattentive, impulsive, or hyperactive? "It's a perplexing and puzzling disorder for professionals and families alike," agrees Barkley. "The symptoms can be

In the vernacular of the new *DSM-IV,* Sue Ellen will be classified as a predominantly inattentive type (whereas a child like David Wirth will be a predominantly hyperactive-impulsive type). Of the nine symptoms listed under "inattention," including "often does not seem to listen to what is being said to him or her" and "often loses things necessary for tasks or activities," Sue Ellen has the requisite six. However, with any type of ADD, a good diagnosis is more than a matter of ticking off a list of symptoms.

A host of other conditions can mimic ADD, be a by-product of the disorder, or co-exist with it. A depressed child may be hyperactive; a child who has a conduct disorder maybe impulsive; a child with a hearing or vision problem may be inattentive; and, certainly, a child who has a learning disorder may tune out or act out in school. Therefore, the only way to determine if a child has a "pure ADD" is to first rule out everything else, determining what the child *doesn't* have.

Model right, Evan "Ham" Hoffman/Bookers, Inc.

"A comprehensive evaluation," explains Wade Horn, a clinical child psychologist and the executive director of CH.A.D.D., "begins with a thorough developmental history establishing that the symptoms were present before age 6 or 7. Then you need an assessment of the child's current behavior." Using the Conners rating scale, a widely used behavioral checklist, the evaluator responds "not at all," "just a little," "pretty much," or "very much" to items such as "demands must be met immediately," "fails to finish things he starts," and "denies mistakes or blames others." The results are then measured against published norms.

Sometimes a Continuous Performance Test (CPT) is also used. Random letters are flashed on a computer screen, and every time a particular letter pattern appears—say, "A" followed by "X"—the child is told to press the space bar. CPTs have proved to be about 70 percent accurate. Arnold Cohen, a child psychiatrist at Mount Sinai, explains, "Inattentive kids tend to miss the pattern altogether, and impulsive kids push the 'A' before they even see the next letter."

"At one point," says Margo Wirth, "David was on

Because ADD often mimics a learning disability, yet requires different treatment, a competent evaluator must try to tease apart the two conditions. "ADD makes students *unavailable* for learning, because they are either too hyperactive or inattentive. But an LD makes them *unable* to learn, because they have problems with their basic processing," says Larry Silver, a child and adolescent psychiatrist and professor of psychiatry at Georgetown University School of Medicine. "They are related but different disorders." Depending on whose statistics you accept, of children who have ADD, 20 to 50 percent also have LDs, and of those who have LDs, up to 80 percent have what would be considered "secondary attention deficits."

ALTHOUGH THE SIGNS ARE THERE EARLIER, ADD behavior usually crops up when a child is first challenged academically and forced to sit at a desk and pay attention to a single activity. Calvin Lerner*—who was "smart but couldn't sit still"—did well in a low-key preschool, but when he entered "a top-notch private school," his mother, Karen Lerner*, says, "he started flunking out of first grade. He couldn't learn to read, and he knew he wasn't making the grade. He was a basket case. Either he'd be lashing out at other kids or he'd turn off, go to the corner, and cry and sulk."

By January, the Lerners had had Calvin tested, but the first psychologist who evaluated him saw no evidence of ADD; Calvin was very attentive in his office. Skeptical, the Lerners wisely sought a second opinion from a psychologist who observed their son at school. She determined that Calvin was "classically hyperactive." This is apparently a routine diagnostic phenomenon: ADD children often do quite well in novel, one-on-one situations, and they can linger for hours in front of a TV set. But when they're in a classroom or other group setting, all hell breaks loose.

Parents should trust their instincts, even in the face of so-called expert opinion—or a dissenting spouse. Fred Parsons*, whose two children, Billy*, 11, and Adria*, 10, both have ADD, can now admit, "It was Linda's* determination and quest for an answer that kept us on the trail. But at one point, I thought my wife was looking for a problem that didn't exist. I thought maybe motherhood didn't come as easily to her as to other people."

Pamela Sicher, a child psychiatrist in private practice and on the faculty of Cornell University Medical Center, says this sce-

nario is not uncommon. "The typical profile is that one parent knows that something is wrong—often the mother, who spends more everyday time with the kid. She says, 'I don't think he can control himself,' and the father says, 'You need to be tougher.' "

Norma Doft, a psychologist and author of *When Your Child Needs Help,* adds, "Parents feel tremendous shame. Their child has a tantrum, kicks them, and other people say, 'What a spoiled brat.' Or they get calls from school: 'Your child just scratched another child's face.' Then, when they find out what's causing this, they wonder, 'What kind of life is my child going to have?' "

Parents are also eternally frustrated. "The child appears not to hear, doesn't follow instruction. And some of these kids are even tough to hug," says New York psychiatrist Alan Wachtel. Parents often shower the ADD child with attention or overlook infractions that other children get punished for. Wachtel recalls one teenager complaining about the focus always being on his older brother. "He summed it up quite poignantly by saying, 'He ate my childhood.' "

ADD need not be a life sentence of failure and instability for the whole family—*these children can be helped.* However, if a child's ADD is not recognized early, says Ron Taffel, a Manhattan family therapist and author of *Parenting by Heart,* "he has to overcome ten years of parents and teachers yelling at him." Because children with ADD can't stick with boring, repetitive work—work that needs to be done to develop a skill—Taffel explains, "They don't get good at anything, and they don't develop an identity, so they end up glomming on to marginal kids. They become graffiti writers or hang out with the drug crowd or get into criminal behavior. But at least they get noticed."

PETER BENNETT* CONFIRMS TAFFEL'S THEORY. "They'd give me a test in school, and I'd say, 'I'm not taking it,' because I'd rather be bad than stupid," he explains. "Because I wasn't passing, the popular kids didn't accept me. So I got in with the bad crowd, where I was accepted." Peter has been in trouble ever since he handcuffed a kid to the flagpole in grade school; he has been in and out of a mental hospital; and recently, he was arrested for breaking and entering. "I could end up in jail," he says wistfully. "It gets harder and harder to ask for help as you get older." Peter is 17.

Why aren't children like Peter identified and helped earlier? Taffel maintains that many schools are unaware and, parents interviewed for this story would add, "unsympathetic." Patricia Moss*, whose 4½-year-old son, Sam*, has "a mild ADD," is understandably bitter about his first preschool. "The teacher used him as a negative object lesson, saying to the other kids, 'You'd better behave or you'll have to sit out like Sam.' " Hal Meyer, of New York City CH.A.D.D., recalls one horror story of a school that "punished" an ADD child by taking away his medication.

ing?), and relational (does he need to learn social skills?).

"Parents need to decide whether the whole program makes sense for *their child,*" stresses Lynne Hacker, a speech and language pathologist. Parents are the only constant in a child's life, which is why Russell Barkley suggests that they assume three roles: *advocate* (standing up for the child), *scientist* (challenging, questioning, and seeking solutions), and *executive* (retaining the ultimate decision-making authority).

A number of "alternative" treatments may be suggested, among them sugar- or additive-free diets, vitamin therapies, the use of motion-sickness medication, deep pressure/massage, and biofeedback training. But parents ought to be suspicious of any one method that boasts "miraculous" recovery over a more comprehensive approach. Even biofeedback researcher Joel F. Lubar, a psychologist at the University of Tennessee, says that biofeedback "has proved most effective when integrated with other forms of treatment, including medication."

Psychostimulant drugs—methylphenidate (Ritalin), dextroamphetamine (Dexedrine), and pemoline (Cylert)—have proved 80 percent effective in the treatment of ADD, according to Judith L. Rapoport, chief of child psychiatry at NIMH/Bethesda. When a child can't tolerate a stimulant, antidepressants as well as the antihypertension drug clonadine (Catapress) are occasionally used, but Ritalin is the drug of choice. Often described as "safer than aspirin," Ritalin nevertheless has side effects, including nervousness, insomnia, stomachaches, headaches, nausea, rashes, loss of appetite, and feelings of agitation. If a child looks "glazed" or "glassy-eyed," the dosage probably needs to be lowered, or perhaps the medication should be changed. At the same time, because most doctors start with an extremely small amount—usually 2.5 or 5 milligrams twice a day—and because the effects of Ritalin dissipate within four to six hours, most potential problems are short-lived. However, some children also experience a "rebound" effect as the drug wears off, causing extreme irritability and sadness. A few develop a neurological "tic," or experience stalled growth, so some professionals recommend drug "vacations" on the weekends and in the summer.

What makes a parent want to even risk a few hours' worth of side effects? "Desperation" is a common answer. For Calvin Lerner, the results of using medication were dramatic—typical of about a third of the children who take stimulants, says Rapoport.

"At first," admits Karen Lerner, "the thought of putting my kid on a drug. . . .I felt guilty and horrible. I just knew that this was the kind of thing that was going to appear in *New York* Magazine in the year 2000, about how all these terrible parents put their kids on drugs because they couldn't handle them. But within two days of being on the medication, he was a different student—much less frustrated, much less angry. It was like a miracle."

The key to proper medication is constant monitoring by an experienced doctor, says neuropsychologist Antoinette Lynn. "The

the floor, screaming, 'Help me, Mommy, help me.' "

To be fair, some schools are also quite diligent, and parents dismiss their recommendations. One teacher, who has worked in several private schools, says, "It goes both ways. I've seen cases in which the school tells the parents in first grade, 'Your child has problems and we think you should look into it.' Then the kid will hit fourth or fifth grade, suddenly he won't be able to cope, and the parents say, 'Why didn't you tell us?' Some parents are reluctant to spend a lot of money to get the child checked out fully, and some don't want to acknowledge that anything's wrong." (In New York, a thorough academic and psychological evaluation costs anywhere from $600 to $1,800.)

Because ADD pervades every aspect of a child's life, treatment requires a "multimodal" approach, involving an assortment of professionals, who minister to all the child's needs: physiological (is he a candidate for medication?), emotional (does he need counseling?), educational (does he require tutor-

doctor must titrate dosage to behavior." Hence, a prescribing doctor—ideally, a child psychiatrist trained in psychopharmacology—will observe the child in school after he is given the medication, as Calvin's did, or, at the very least, ask the parents and teachers to fill out a Conners scale before and after the drug is prescribed.

Because psychiatrists have different opinions on the role medication should play in the total scheme of treatment, it's vital to find out where a doctor stands. Some, like Wachtel, are bullish on Ritalin. "You treat them with medication and the other stuff is add-on—the behavioral work, the individual support, the educational help. You don't treat diabetes with therapy or parent education." More conservative practitioners, like William Chambers, prefer to phase in medication slowly. "Ritalin will give anyone a greater attention span," he says. "But when I give medication to someone who doesn't want it or isn't ready to change habits, it doesn't work as well."

However, children with severe ADD may need medication in order to sit still long enough to undergo therapy. David Wirth, for example. Or the 10-year-old boy who was drinking up to thirteen cups of coffee a day, explaining, "It's the only way I can watch my cartoons." Chambers says, "That child had been unknowingly 'self-medicating' with caffeine."

RESEARCH INDICATES THAT UNDER THE RIGHT conditions—a structured, orderly classroom and a home with a steady routine—and with the right kind of academic and psychological counseling, the need for stimulants can be reduced or eliminated. "If you combine medication with psychosocial intervention, including parent education and training," says Wade Horn, who conducted one such study, "you can use half the dosage of Ritalin and get the same effect."

Arnold Cohen says parents should ask themselves whether medication will improve the quality of their child's life. Of the seventeen parents interviewed for this article, all but one thought this was a compelling reason to try Ritalin; fifteen have seen positive enough effects to keep their children on it.

However, Cohen cautions, "Ritalin alone doesn't change a kid's life. Medication should be thought of as part of an integrated-treatment package. It depends on the child and on the context—how much the kid is acting out, how much the school is tolerating it, how disturbing it is to the family. Parents should make sure everything else has been attempted."

Which is why Arlene Portman decided against medication for Sue Ellen, now in second grade. "She's bright; she understands her difficulty. And with the cooperation of her teachers and with therapy, there's been tremendous improvement. I think no medication is the harder way. And I don't know how I'd feel if she had that wound-up kind of craziness that you see in some kids. But I feel positive that for now we're doing the right thing."

It's important to note that medication does not lead to drug addiction. "It's an unfounded fear," insists Horn. "In fact, some studies suggest that ADD kids who are treated medically are *less* likely to abuse drugs than they would have been had they not been treated."

Medication is definitely not The Answer. Anyone with ADD needs to understand the disorder and learn new habits and new ways of relating, which is where therapy plays an important role. But you can't "therapize ADD away," Doft stresses. "What I do is more about how children function, not about how they feel."

Especially with older kids and adults, says Chambers, "you have to break down their abysmal, gruesome habits, because they perceive the world as intrusive, overstimulating, and rejecting. They have been criticized endlessly. It takes a good deal of time to help them learn to start to trust again, to start being nice to people."

Greg Mishkin, now 22, began seeing Chambers at 13 because his parents were perplexed by his impulsive and constant lying. "I couldn't understand how talking could make everything better. I now realize that Bill was helping me sort things out and develop social skills."

Behavioral and relationship problems notwithstanding, school is often the biggest stumbling block; most children with ADD need far more than academic tutoring. "I pick up what I see they can't do and start there—whether it's social, learning, or organizational," says Hacker, who sees adults, as well as children. Regardless of age, "one of the key symptoms is disorganization." Another is a lack of "active working memory"—the ability to hold something in your immediate memory while working on other things. This would affect your ability to do a two-step math problem, to retain information when someone gives you three directions, even to remember why you're going from one room to another. Hacker helps clients organize their minds by organizing their environments—book bags, datebooks, desktops. "I train them to do things that most of us do normally."

The older you get, the harder it is to change, which is why it's crucial to catch children now. Ask M. J. Vineburgh, 48, a caterer who first consulted Hacker after reading "Learning the Hard Way" (*New York,* September 26, 1988) and realizing that her difficulties in life had a name: learning disabilities. "Lynne mentioned ADD, too," says Vineburgh, "but I wasn't ready to hear it—until recently, when my life got so disorganized that I got incredibly depressed." Asked to respond to a list of adult symptoms of ADD—restlessness, distraction, mood swings, disorganization, hot temper, impulsiveness, low tolerance for stress—Vineburgh says, "I couldn't fall into those categories more clearly." Therapy has made her more aware and less critical of herself, but she

WHERE TO TURN FOR HELP

Support Groups And Resource Networks

Children and Adults With Attention Deficit Disorders (CH.A.D.D.) of New York City. *Call the Manhattan chapter (721-0007) or the national office (305-587-3700).*

Attention Deficit Information Network, Inc. (AD-IN), *475 Hillside Avenue, Needham, Massachusetts 02194. Call 617-455-9895 or write.*

Learning Disabilities Association of New York City. *Provides reading lists and referrals. Call 645-6730.*

National Center for Learning Disabilities. *Call 545-7510. Advocacy group serving parents, adults with LDs or ADD, and professionals; provides referrals and information.*

Orton Dyslexia Society. *Call 691-1930. Has an extensive resource file and will recommend tutors and evaluators.*

Connecticut Association for Children and Adults With Learning Disabilities. *Call 203-838-5010.*

The Churchill School and Center, *22 East 95th Street, New York, New York 10128. Advisory service and programs including social-skills training for children (nine one-hour sessions, $450); a behavior-management program for parents (six 90-minute sessions, $450); and monthly speakers. Call 722-0610.*

Windward School, *Windward Avenue, White Plains, New York 10605. Community-outreach program sponsors talks and other community events, workshop series for parents and professionals; $5 per session. Call 914-949-6968 to be put on the mailing list.*

Books for Adults

Attention Deficit Hyperactivity Disorder *(professional text), by Russell A. Barkley (Guilford Press, New York).*

Dr. Larry Silver's Advice to Parents on Attention Deficit Hyperactivity Disorder, *by Larry B. Silver, M.D. (American Psychiatric Press, Washington, D.C.).*

Attention Deficit Hyperactivity Disorder: Questions and Answers for Parents, *by Gregory S. Greenberg and Wade F. Horn (Research Press, Champaign, Illinois).*

The Complete Directory for People With Learning Disabilities, *edited by Leslie Mackenzie (Grey House Publishing, Lakeville, Connecticut).*

Developmental Variation and Learning Disorders, *by Melvin Levine, M.D. (Educators Publishing Service, Cambridge, Massachusetts).*

Maybe You Know My Kid, *by Mary Cahill Fowler. (This and many other resources are available through the* **A.D.D. Warehouse,** *800-ADD-WARE or 305-792-8944).*

Books for Children

All Kinds of Minds *(for young students) and* **Keeping a Head in School** *(for adolescents), by Dr. Mel Levine (Educators Publishing Service, Cambridge, Massachusetts).*

Many children's books are available through the A.D.D. Warehouse (see above); call for a catalogue. **M.B.**

still struggles. "It's physically painful to do things consistently. The problem is, whatever is in front of me is most important."

SUE ELLEN PORTMAN, A MUCH YOUNGER VERSION OF Vineburgh, is ahead of the game: At 7½, she already understands her ADD and is learning how to compensate for her scattered thoughts. This fall, she told her new second-grade teacher, "I have ADD, and it would be very helpful if I could sit close to you. And when you're speaking to the class, every now and then, could you tap me on the shoulder?"

Sue Ellen also has a very supportive mother. Every day, Arlene prints a note on the computer, REMEMBER TO TAKE———, and helps Sue Ellen fill in whatever she needs. "We just keep working on things over and over, and we're making progress. I now see her writing notes to herself."

Many other parents of ADD kids devise similar "systems." With two ADD kids in the house, Linda Parsons uses "the chip system," a common behavior-modification technique. "Three chips for staying on your chair, two for hanging up your towel. I also wrote reminders on Popsicle sticks for a while—TURN OFF THE LIGHT, FLUSH THE TOILET—until Billy broke all the sticks. So I had to figure out a new system—nothing keeps working."

Patricia Moss, one of Norma Doft's clients, says, "I've learned the importance of The Voice—keeping calm, ignoring instead of overreacting." And instead of getting into power struggles, Moss now repeats one sentence over and over: " 'Can you get back in control or should I help you?' Sometimes that's all we have to say. Being 'out of control' is not the same as being 'bad' or 'naughty.' "

Moss constantly reinforces her son. "I'll say, 'It used to take you ten minutes, now it takes you two. That must mean you're working very hard.' Or, to build his self-esteem, I'll say, 'That was really wonderful how you helped your brother with his coat.' You have to get on his side. "It's frustrating," she admits. And some suggestions that seem to work well for other kids don't necessarily work for your child. For example, "time-outs" don't work with Sam, says Moss. "Being in a room with a closed door makes him even more hysterical."

Nothing can be taken for granted with these children; everything has to be taught and retaught. "ADD is a hidden disorder," says Ray Levy, a clinical psychologist in Dallas who holds parent workshops. "These children are not in wheelchairs. They appear spoiled, they have temper tantrums, and they're not as sensitive to rewards and punishments."

Being supportive and accepting that your child has a disorder may mean changing, but not necessarily lowering, expectations. "I like the metaphor of going on a trip to Italy and landing in Holland instead," says Doft. "You stop looking for gondolas and you look for tulips." Parents need to help their child find an "island of competency"—a sport, a hobby, a talent—that will counterbalance his difficulties in school and give him a sense of achievement.

While long-term studies often emphasize the risk factors, there's a bright side, too: Half of ADD children triumph over their disabilities. Chambers contends that some of the most gifted people in Hollywood and the most prosperous entrepreneurs have ADD. "The critical message for parents is that there's a growing number of children who seem to be doing well on follow-up," says NIMH's Judith Rapoport. "The successful kids remember that their parents hung in there for them and weren't judgmental."

Greg Mishkin, now applying to graduate school, where he plans to earn a doctorate in clinical psychology, is a young man whose achievements highlight key elements that predict positive results: supportive parents, correct diagnosis, competent professional support, and effective and well-monitored medication.

"I still tap my feet; I have feelings of restlessness here and there, but not enough to keep me from listening. When things get disorganized, I take a deep breath." Mishkin asked that his real name be used. "I'm not ashamed of anything, and I don't want to hide. My story should give people hope. I've learned to deal with my difficulties. They don't get to me now." ■