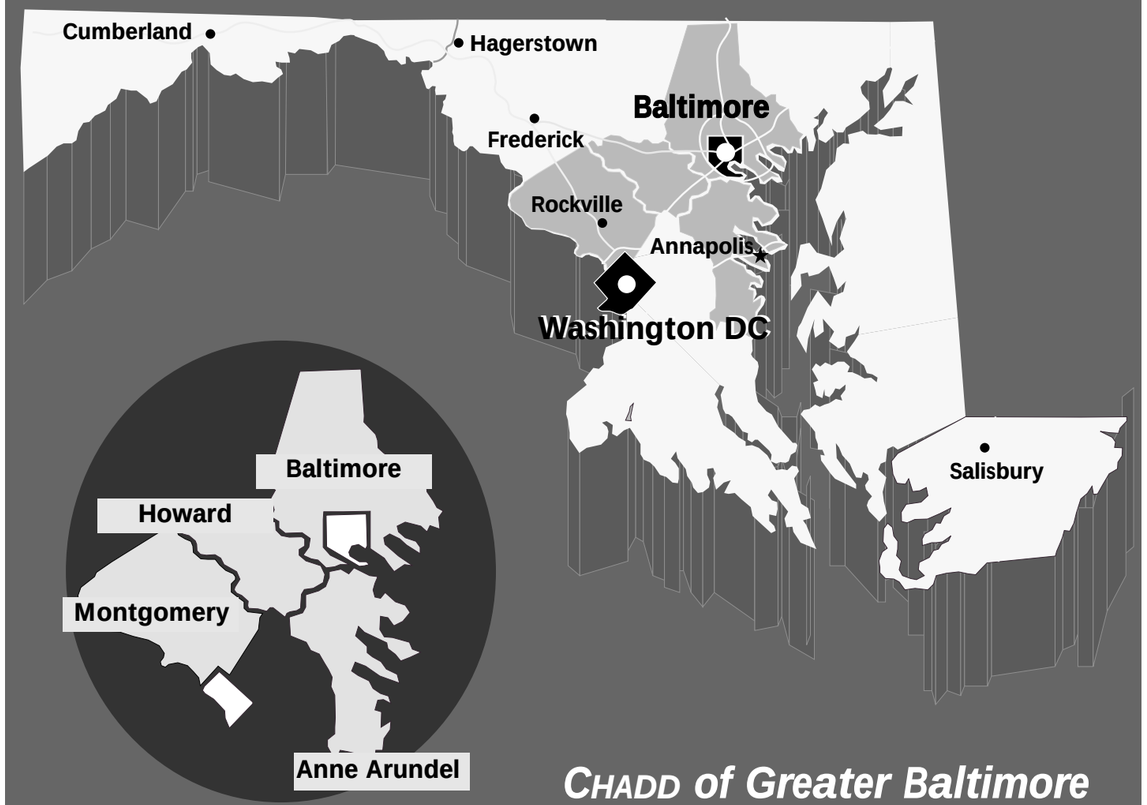
CHADD of Greater Baltimore

Serving Children and Adults with Attention Disorders

Hyper~talk

Fall 2002 · Volume 6 Issue 2

Hyper~talk Expands!



CHADD of Greater Baltimore joins Howard, Anne Arundel, and Montgomery Counties in publishing this issue.

Research Subjects Needed

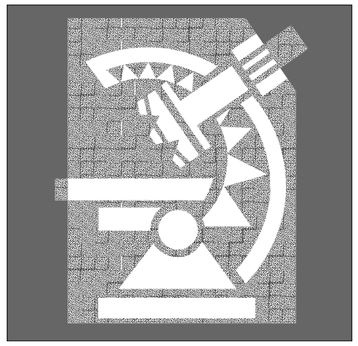
Memory and the Brain
Participants are needed for two brain studies on AD/HD and memory underway at the University of Maryland, Department of Psychiatry, School of Medicine. The Maryland Psychiatric Research Center is looking for adults between the ages of 18 -40 and children between the ages of 8-12 diagnosed with AD/HD, combined type who have no other currently severe psychiatric problems including depression, bi-polar, or schizophrenia. For further information, please call Patrick O'Donnell at 410 402-6886.

Preschoolers with AD/HD
Johns Hopkins is conducting a study, sponsored by the National Institutes of Mental Health, to test medications for preschool children ages 3-5 with AD/HD. We are looking for children with symptoms that include: always "on the go", fidgeting, squirming, excessive talking, easily distracted, not waiting his/her turn, and interrupting. If you child has shown these symptoms for the past nine months, he/she may be suffering from AD/HD. Our research study team may be able to help. If eligible for the study, your child could receive doctor visits and medical evaluations free of charge. For more information, call Erin Garth at (410) 614-4460.

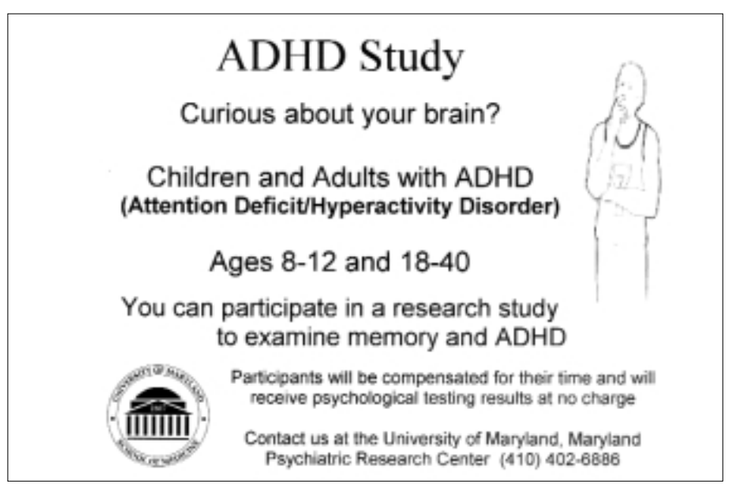
AD/HD and Memory: Behavior and Brain Imaging Studies
The University of Maryland, School of Medicine
Dr. Julie Schwietzer, Principal Investigator, is recruiting children and adults with AD/HD for a study of memory and AD/HD. Study I involves the testing of memory functioning and how it relates to symptoms of AD/HD. Study II evaluates the relationship between deficits in memory and brain functioning and involves behavioral testing and brain imaging. Participants may wish to volunteer for Study 1, then determine their interest in the second study. Participants should have symptoms of AD/HD, be an adult between the ages of 18 and 40 or a child between the ages of eight and twelve. Contact Carlos Cortes, M.D., at 410-6886 for further information.

National Institute of Health Research Study
Children with or without AD/HD with proximity to NIH (Bethesda) between the ages of six and 13 are needed a study to determine how the brain controls finger movements. The study is non-invasive and involves a neurological exam. If interested please contact Chris Barker, 310-496-5323.

Adult AD/HD Study Looking for Participants
The Brain Imaging Center at NIDA, located on Johns Hopkins Bayiew Campus at 5500 Nathan Shock Drive, is currently seeking ment and women between 21 and 45 with AD/HD for a neuro-imaging study examining cognitive and brain functions. Dr. Monique Ernst M.D., Ph.D., is the principal investigator. All participants will receive free medical and psychological evaluations and will be financially compensated for their participation. All participants should be physically healthy, should not be active substance abusers, and should not have any other Axis I diagnoses.
Any appropriate candidate should call Dr. Satya Tata at 1-887-600-5774.



Child Study Looking for Participants
The Brain Imaging Center at NIDA, located on Johns Hopkins' Bayiew Campus is currently seeking adolescents between the ages of twelve and fourteen with AD/HD, conduct disorder, or both to be participants in a longitudinal study examining cognitive, neurological, and psychosocial variables. Dr. Monique Ernst M.D., Ph.D., is the principal investigator. All participants will receive free medical and psychological evaluations and will be financially compensated for their participation. All participants should have no history of substance abuse and will receive free medical and psychological screenings. Please contact Dr. Frank Wolkenberg at 410-550-1568 for more information.



CHADD of Greater Baltimore

Inside:

CHADD of Greater Baltimore is delighted to announce a new direction of publishing that will include the meetings of the chapters in Anne Arundel County and Montgomery County and list the support groups meeting in Silver Spring, Linthicum, and Columbia.

On August 10th, 2002, chadd-mc.org–formerly CHADD of Montgomery County's online link–will become the link for CHADD of Maryland, with links to Baltimore, Anne Arundel, and Montgomery Counties' speaker schedules, meetings, and additional links to our newsletters and news updates.

Join CHADD in Maryland as we advocate statewide To improve the lives of people with AD/HD.

Hyper~talk is a publication of CHADD of Greater Baltimore in conjunction with CHADD of Montgomery County and CHADD of Anne Arundel County. CHADD does not endorse products, services, publications, medications, or treatment, including those advertised in *Hyper~talk* . Placement of an advertisement in *Hyper~talk* does not represent an endorsement by CHADD, nor does it represent any testimony by CHADD as to the quality of the products advertised and the validity of claims made by the advertisement. CHADD programs are not intended as therapy nor are they intended to substitute for medical advice. *Hyper~talk* is published bi-annually by CHADD of Greater Baltimore. For subscription information or advertising rates, please contact CHADD168@aol.com.

Editor, Barbara Hawkins Associate Editors, Linda Spencer, Suzanne Strutt
Editorial Advisor, Carol Watkins, M.D. Design and Layout, Suzanne Strutt

CHADD of Greater Baltimore

Dear Members: July, 2002

I am truly overwhelmed by the past year's accomplishments of the Baltimore Chapter and very excited to open a new agenda of co-operation with other Maryland Chapters for the coming year.

The Mid-Atlantic Conference on AD/HD in March was inspiring, overwhelming, and such an incredible success that I'm not sure we've recovered yet! Over 650 attended the confer ence; my "Hat's Off Award" goes to the steering committee and conference chair, Dr. Linda Spencer. Obviously, the community felt a great need for what the Conference provided—updated, accurate information for many parents and for professionals in the field. I wish a warm welcome to the more than 60 new members who joined **CHADD** the day of the Conference. Do join us for our monthly meetings and get involved in meeting the challenges facing our Chapter.

We are also thrilled to announce a series of parent support group meetings co-sponsored by **CHADD** of Greater Baltimore and **CHADD** of Anne Arundel County. A special thank you and welcome to Dr. Karen Cruise, Bonnie Compton, and Dr. Carol Robbins, Co-Coordinator of **CHADD** of Anne Arundel County, for agreeing to lead the meetings at the Loyola College Graduate Center in Columbia. Please see the schedule on page 13 and let your Howard County friends know about this opportunity.

Our Chapter is also please to announce a series of adult support group meetings scheduled for this year at St. Christopher Church in Linthicum. A special thank you to Kerch McConlogue, who will lead them. Thank you, also, to board member Trish Peiper and her husband, the Reverend Christopher Peiper, for inviting us to use the Church as a meeting place. Schedule details are on page 9.

We cordially invite you to join us as a volunteer and to offer your support for our new efforts. Our first Chapter Board meeting is scheduled for 7 PM Wednesday, September 28, at the Loyola College Graduate Center in Timonium. Please consider attending the board meeting.

One last thank you is in order: Dr. Sharyn Rhodes, Loyola College Graduate Division faculty member and **CHADD** of Greater Baltimore Professional Advisory Board member, arranged our conference site at the Loyola College Graduate Center and has arranged for us to hold our regular monthly meetings at that wonderful facility. She also has arranged for our new Howard County Parent Support group meetings to be held at the Loyola College Graduate Center in Columbia. Thank you, Sharyn, and all of our wonderful board members for your support of **CHADD** in Maryland!

Sincerely,

Barbara Hawkins

Coordinator, CHADD of Greater Baltimore

CHADD of Greater Baltimore Board of Directors

Professional Advisors

Harold Cohen, Ph.D.
Baltimore County Fire Department

Debi Gartland, Ph.D.
Faculty, Towson University

Linda Jacobs, Ed.D.
Director, Harbour School

Leslie Seid Margolis, J. D.,
Maryland Disability Law Center

Tish Michel, M.B.A., C.P.A.
CHADD National Board of Directors,
Immediate Past Coordinator

Sharyn Rhodes, Ph.D.
Faculty, Loyola College,
Department of Special Education

Michael Sherlock, M.D.
Pediatrician

Kenneth Tellerman, M.D.
Behavioral Pediatrician

Carol Watkins, M.D.
Psychiatrist

Hilary Wohl, Ph.D.
Speech-Language Pathologist

Board Members

Barbara Hawkins, Coordinator

Linda Spencer, Ph.D., Co-Coordinator

Karen Sayler, Secretary

Diane Borenstein, Treasurer

Kerch McConlogue, Adult Support Group Leader

Barbara Prince, M.S.W., L.C.S.W.,

Suzanne Strutt, Chapter Publisher

Bill Waring, Data Processing Director

Marcy Hershhorn

Claudette Brown, J.D.

Marilyn Halle-Webster

Nancy Nicholson

Patricia Peiper, M.S.W.

CHADD of Greater Baltimore Meeting Schedule

Support group and speaker meetings are held the first Wednesday of every month at 7 PM at the Loyola College Graduate Center in Timonium, Maryland.

Meetings are open to members at no charge, and to non-members with the request of a $5 donation per meeting.

Please call the Chapter phone line at 410-377-0249 for more information on meetings or with any additional questions.

6:30–7 Registration & Library
7–8 Guest Speaker
8–9 Small Group Support

Wednesday, September 4, 2002
Ask the Experts: A Panel Discussion with Members of the Professional Advisory Board
Kenneth Tellerman, M.D., Pediatrician
Debi Gartland, Ph.D., Educator
Karen Cruise, Ph.D.Psychologist

Wednesday, September 25
Professional Advisory Board Meeting

Wednesday, October 6
AD/HD and Work
Harold Cohen, Ph.D.
Support Group meetings for parents and adults follow the presentation.

October 16–19 • Miami, FL
CHADD National Conference

Wednesday, November 6
AD/HD Treatmen: Family, Caregiver, and Educator Concerns
Bruno Anthony, Ph.D.

Tuesday, November 19
Professional Advisory Board Meeting

Wednesday, December 4
Biofeedback Research: Are There Promising Results?
Marvin Berman, Ph.D.

Wednesday, January 9,2003
Review of PBS Special Misunderstood Minds, *followed by discussions and support group meetings*

Wednesday, February 5
Behavior Management and Educational Concerns
Sharyn Rhodes, Ph.D.
followed by adultsupport group meeting

Wednesday, February 19
Professional Advisory Board Meeting

Wednesday, April 2
Rearing a Competent Child: Enhancing Executive Functioning
Joyce Cooper-Kahn, Ph.D.

Wednesday, April 16
Professional Advisory Board Meeting

Wednesday, May1
Panel Discussion on Physical and Spiritual Issues
Carol Watkins, M.D.
The Reverend Christopher Peiper, Ph.D.

Directions The Loyola College Graduate Center in Timonium is one block west of the State fairgrounds. Take I-695 to I-83 North. Take the first exit, Exit 16, Timonium Road East; stay in the right hand lane and turn right at the light onto Greenspring Drive. The Graduate Center is directly behind the Red Roof Inn on the corner, with a large, well-lighted parking lot in front.

About Our Speakers

Kenneth Tellerman, M.D.
A behavioral pediatrician in private practice in Baltimore City who specializes in children with AD/HD, Dr. Tellerman is a member of the Professional Advisory Board of CHADD of Greater Baltimore and the Governor's Task Force on AD/HD.

Debi Gartland, Ph.D.
Associate Professsor, Department of Special Education, Towson University.
Dr. Gartland, who received her Ph.D. from Pennsylvania State University in Special Education, is Professor of Special Education at Towson University. She is also an Executive Board Member of the International Council for Learning Disabilities and the Maryland Federation of Council of Exceptional Children.

Karen Cruise, Ph.D.
Psychologist, Ellicott City, MD
Dr. Cruise maintains a private practice specializing in children and adolescents. Dr. Cruise serves on the Steering Committee of CHADD of Howard County.

Harold Cohen, Ph.D.,
Battallion Chief, Baltimore County Fire Department
As well as a Baltimore County Fire Department Division Chief, Dr. Cohen is an advocate for adults with AD/HD. A licensed paramedic, he holds a doctorate in Health Services from Walden University, and is a Diplomate of the American College of Healthcare Executives. Actively involved in Adult AD/HD research, he has published research on AD/HD in the work environment and serves on the Governor's Task Force on AD/HD.

Marvin Berman, Ph.D.
Director, Quiet Mind Neurofeedback Services, Lafayette Hill, PA
Dr. Berman recently completed a study on the effectiveness of brainwave biofeedback on children with AD/HD.

Bruno Anthony, Ph.D.
Director, ADD Clinic, University of Maryland
Dr. Anthony is Associate Professor of Psychiatry at the University of Maryland School of Medicine, and Director of the Maryland Center for Attention and Developmental Disorders, a multidisciplinary program which provides assessment, treatment, and outreach services, as well as conducting research in a variety of areas. Dr. Anthony received his Ph.D. in Psychology at Columbia University and clinical training at the University of Wisconsin-Madison and Yale University. A former Senior Staff Fellow at the NIMH Intramural Research Program, Dr. Anthony has been working in the area of attention dysfunction for more than 20 years. He recently received a 5-year Career Development Award from the National Institute of Mental Health.

CHADD of Montgomery County

Greetings!

My name is Michael Winick, and I am me new coordinator of Montgomery County CHADD. I started volunteering for CHADD a few years ago when I realized the impact that AD/HD had on me and my family. Back then, I was so eager to learn about AD/HD that I attended CHADD's annual conference in Washington, DC.

We have a very exciting speaker schedule (third Wednesday of each month) this year and will continue our successful support group (first Monday of each month). The latest and most current meeting information will always be posted on our web site at www.chadd-mc.org.

In addition to our meetings, we plan to:

- Increase the number of our volunteers. This is a prerequisite for accomplishing anything else.
- Increase the number of our members. Montgomery County has 330 active members and another 350 former members who have not renewed. To those of you that have let your membership lapse, we want each and every one of you back!
- Solicit grants from foundations to fund chapter operations and our future growth. Our local chapter keeps 90% of grants (less than $10,000) that we receive.
- Start a satellite support or speaker group in an underserved area like Frederick County.
- Lobby state and local governments to support legislation that benefits CHADD-MC members.
- Hold special meetings to foster increased dialogue with MCPS Special Education and CHADD members.
- Start an e-mail group list so members can stay connected and share information

Since we are a volunteer organization, the support of our membership and volunteers is vital to achieving our goals. If you can help us with chapter activities, please contact me, Michael Winick at michael/@chaddmc.org. I look forward to working with you. Thank you.

Regards,

Michael Winick

Coordinator CHADD of Montgomery County Michael@chadd-mc.org

CHADD of Montgomery County Board of Directors

Advisory Board Members

Sherry Askwith, L.C.S.W.-C., PAB Chair,
Maureen Donnelly, M.D.
Deborah Fisher, Ph.D.
Robert Hedaya, M.D.
Barbara Ingersoll, Ph.D
Peter Latham, J.D.
Patricia Latham, J.D.
Kathleen Nadeau, Ph.D.
Patricia Quinn, M.D.
Britt Rathbone, L.C.S.W.-C.
Ruth Spodak, Ph.D.
Judith Stern, M.A.
Dr. Susan Van 0st

Executive Board Members

Michael Winick,
Chapter Coordinator
Sara Brown, Support Group Chair
Susan Cecil,
Parent Prograrn Chair
Beverly Jones, Treasurer
Holiday Jones,
Membership Chair
David Lotts,
Database Administrator

The following board positions are available for volunteers:

Coordinator Elect
Adult Program Chair
Secretary
Fundraising
Information Resources Chair
Telephone Support Chair

Not Just Another Exercise Story

Growing up, I hated any kind of exercise. We've all heard a thousand times that exercise improves health and reduces the risk of disease. But what is less commonly known is how exercise can help AD/HD children and adults. I've heard John Ratey (one of the authors of *Driven To Distraction*) speak about "training up the attention system" through rnovement. Combining movement with paying attenffon helps AD/HD children and adults. For children, martial arts is one good choice. And for adults, aerobics and step classes are helpful. The inattentive AD/HD person receives constant reminders to focus—and to move—in instructors' cues. Naturally, these activities can increase one's coordination, sense of rhythm, and balance, and help eliminate boredom. In the end, it is important to find an actvity one enjoys in order to sustain an active lifestyle. I encourage you and your children to find your activity; get our there and move!

—Michael Winick

CHADD of Montgomery County Meetings

Parent and adult support group meetings are held the first Monday of every month at 7:30 PM at the Silver Spring Center in Silver Spring.

Speaker Meetings are held the third Wednesday of every month at 7:30 PM at the St. Elizabeth's School in Rockville, Maryland.

For more information on meetings or with any additional questions: www.chadd-mc.org

Wednesday, September 18

Evidence-based, Comprehensive Treatment for AD/HD
Andrea Chronis, Ph.D.

Monday, October 7

Support Group Meeting

Wednesday, October 16

Non-pharmacological Treatments for AD/HD
Robert J. Hedaya, M.D.

Monday, November 4

Support Group Meeting

Wednesday, November 20

Winter Blues: Seasonal Affective Disorder (SAD) and AD/HD, What It Is, and How To Overcome It
Norman E. Rosenthal, M.D.

Monday, December 2

Support Group Meeting

Wednesday, December 18

Classroom Management Techniques That Work, for Parents and Teachers
Rosie Greenberg

Monday, January 6

Support Group Meeting

Wednesday, January 15

What Can You Get Out of Teaching?
Ruth B. Spodak, Ph.D.

Monday, February 3

Support Group Meeting

Wednesday, February 19

How To Talk to Your Kids About AD/HD
Judith Stern, M.A.
How To Talk to Your Spouse About AD/HD

Monday, April 7

Support Group Meeting

April 2 amd May 21, TBA

Wednesday, June 18

ADD-Friendly Ways to Organize Your Life
Kathleen Nadeau, Ph.D.

Directions to Speaker Meetings • **St. Elizabeth's School** on 917 Montrose Road in Rockville: Take I-270 to Exit 4-A, Montrose Road East, toward Rockville Pike, Route 355. After the second traffic light, turn left into the parking lot of the school.

Directions to Support Group Meetings • **Silver Spring Support Group** meets at the Silver Spring Center, 8818 Georgia Avenue, Silver Spring, 20910: From I-495 take exit 31 to Georgia Avenue South. Turn right on Ballard Street; the entrance to the center is on the left.

About Our Speakers

Andrea Chronis, Ph.D.

Dr. Chronis received her degree from the State University of New York at Buffalo, a student of William Pelham, Ph.D., one of the world's leading AD/HD researchers. After interning at University of Chicago Hospitals, she joined the faculty of the University of Maryland-College Park. Dr. Chronis' research focuses on comprehensive behavioral and combined behavioral/pharmacological treatments for AD/HD, particularly the impact of maternal stress/depression and family functioning on parenting behavior and child treatment outcome. She is presently developing an AD/HD clinical research program at the University of Maryland that will offer behavioral parent training, school consultation, social skills training, and parent stress management programs to the community.

Robert J. Hedaya, M.D.

Dr. Hedaya, certified by the American Board of Adolescent Psychiatry and the American Board of Psychiatry and Neurology, is a clinical psychopharmacologist and Professor of Psychiatry at Georgetown University Hospital. The author of *Understanding Biological Psychiatry* (Norton, 1996) and *The Antidepressant Survival Program* (Random House, 2000), Dr. Hedaya founded the "Whole Psychiatry" concept, integrating standard psychiatry (bio-psychosocial-spiritual) with assessment and treatment of immune, gastrointestinal, nutritional, and hormonal systems.

Norman E. Rosenthal, M.D.

Dr. Rosenthal, a psychiatrist, first described seasonal affective disorder (SAD) or winter depression and pioneered the use of light in its treatment. As a National Institute of Mental Health (NIH) researcher, he won an international prize for the study of depression. He has conducted extensive research into disorders of mood, sleep, and biological rhythms. Dr. Rosenthal has written *Winter Blues: Seasonal Affective Disorder: What it is and how to overcome it* (Guilford, 1998); *St. John's Wort: The Herbal Way to Feeling Good* (HarperCollins, 1998); and most recently, *The Emotional Revolution: How the New Science of Feeling Can Transform Your Life* (Kensington, 2002). A popular television and radio guest on many national shows, he has appeared on *Good Morning America, CBS Morning News, CNN, All Things Considered* and *The Diane Rehm Show*. Dr. Rosenthal has an active private practice in suburban Maryland.

Rosie Greenberg, M.Ed.

Ms. Greenberg received her M.Ed. degree from Florida Atlantic University in Exceptional Child Education and her Certificate of Advanced Study in Administration and Supervision in early childhood education. With thirty years teaching experience, she has held positions as resource teacher, teacher trainer, and assistant principal. Ms. Greenberg is presently an educational consultant and director of The Learning Link in Montgomery County.

CHADD of Howard County

Howard County Forms Support Group

The Greater Baltimore and Anne Arundel County chapters are cooperating to form the Howard County Parent Support Group. The support group will provide a vehicle for parents to share their experiences, joys and frustrations of rearing a child with AD/HD. It has been recognized that AD/HD affects the child directly, and can compromise their ability to interact socially, in school, and at home. Often parents feel alone as they guide their child.

The rotating group facilitators will include Bonnie Compton, C.S., C.P.N.P.; Karen Cruise, Ph.D.; and Carol Robbins, Ph.D. In addition to being a parent of AD/HD children, Bonnie Compton has a private AD/HD nursing practice in Howard County. Dr. Cruise is a psychologist practicing in Howard Count,a and Dr. Robbins, a psychologist in Anne Arundel County. The group will meet the second Wednesday of each month at the Loyola College Graduate Center in Columbia, 7135 Minstrel Way, Columbia, 21045. The first meeting will be September 11, 2002, at 7 p.m. CHADD membership while not required, is encouraged. Membership information will be available at the meeting.

Linda Spencer, Ph.D.
Co-Coordinator, CHADD of Greater Baltimore

CHADD of Howard County Steering Committee

Bonnie Compton, R.N., M.S.N.
Board of Directors, CHADD of Greater Baltimore

Barbara Hawkins,
Coordinator, CHADD of Greater Baltimore

Linda Spencer, Ph.D.
Co-Coordinator CHADD of Greater Baltimore

Joyce Cooper-Kahn, Ph.D.
Board of Director, CHADD of Anne Arundel County

Carol Robbins, Ph.D.
Co-Coordinator, CHADD of Anne Arundel County

Mick Terrone,
Director of Membership and Chapter Services, CHADD National

Kirk Hadsell,
Coordinator, CHADD of Anne Arundel County

Howard County Meetings

Support group and speaker meetings are held the second Wednesday of every month at 7 PM at the Loyola College Graduate Center in Columbia.

Meetings are open to members at no charge, and to non-members with the request of a $5 donation per meeting.

For more information on meetings or with any additional questions: www.mdpa.com

Wednesday, September 11
Facilitator:
Bonnie Compton, R.N.

Wednesday, October 9
Facilitator:
Carol Robbins, Ph.D.

Wednesday, November 13
Facilitator:
Bonnie Compton, R.N.

Wednesday, December 11
Facilitator:
Carol Robbins, Ph.D.

Wednesday, February 12
Facilitator:
Bonnie Compton, R.N.

Wednesday, March 12
Facilitator:
Karen Cruise, Ph.D.

Wednesday, April 9
Facilitator:
Carol Robbins, Ph.D.

Wednesday, May 14
Facilitator:
Karen Cruise, Ph.D.

Directions **Loyola College Graduate Center in Columbia:** From Rte. 29, take the exit onto Rte. 32 east. Take the Broken Land Parkway exit north toward Columbia. From the right lane of Broken Lane Parkway, almost immediately make a right turn onto Snowdon River Parkway. Then turn left at the first street, Minstrel Way. Loyola will be on the left just before the end of the street.

About Our Facilitators

Carol Robbins, Ph.D.

Carol Ann Robbins, Ph.D., is a licensed clinical psychologist in Annapolis who specializes in treating children, adolecents, and adults with AD/HD. She also works with Kathleen Nadeau, Ph.D., in Silver Spring at Chesapeake Psychologial Services of Maryland. She earned her doctorate at the University of Miami and trained at National Children's Medical Center in Washington, DC. In private practice for nine years, she is currently the co-coordinator of the Anne Arundel County chapter of CHADD.

Bonnie Compton, R.N., C.S., C.P.N.P.

Bonnie Compton is a child and adolescent therapist and a Certified Pediatric Nurse Practitioner with a private practice, Parenting Partners, in Ellicott City. A graduate of the University of Maryland, Ms. Compton specializes in the evaluation and rnanagement of AD/HD, the behavioral and emotional problems of children, and parenting skills and family relations.

Karen Cruise, Ph.D.

Dr. Cruise, who has a Ph.D. in child and family psychology from Michigan State University, was formerly with the Kingsbury Center and the Children's National Medical Center. A former adjunct faculty member at Loyola College, Baltimore, and the George Washington University Medical School, she is currently in private practice in Columbia. Dr. Cruise specializes in evaluations, therapy, school consultations with a particular emphasis on Learning disabilities and AD/HD.

CHADD of Anne Arundel County

At CHADD of Anne Arundel County we're looking forward to another exciting year. We've spent the summer planning and working on chapter leadership.

We're particularly enthusiastic about our productive partnership with the Greater Baltimore CHADD chapter, which allows each of our chapters to provide more value for your membership. This year, we will co-sponsor with Baltimore CHADD a monthly support meeting for adults which will meet in Linthicum. Kerch McConologue, an ADD Coach, will provide primary leadership for that meeting. Our own Anne Arundel County Chapter Co-Coordinator, Dr. Carol Robbins, will be providing leadership to the the newly-forming Howard County adult support group.

Last year we began building new working relationships with key people at the County Board of Education and we look forward to more opportunities to work together to spread the word about the services we offer.

Below is our Fall schedule of speaker meetings. We hope to see you there! Consider joining our leadership team. For more information send an e-mail to Mick Terrone at 'Mick_Terrone@chadd.org.

CHADD of Anne Arundel County Steering Committee

Joyce Cooper-Kahn, Ph.D.
Board of Directors, CHADD of Anne Arundel County

Kirk Hadsell
Coordinator, CHADD of Anne Arundel County

Carol Robbins, Ph.D.
Co-Coordinator, CHADD of Anne Arundel County

Scott Smith
Psychologist

Mick Terrone
Director of Membership and Chapter Services, CHADD National Member-at-large/Consultant

Stanley Weimer, M.D.
Pediatrician

Richard Wago
Chapter Treasurer

Colleen Wright
Chapter Communications

Anne Arundel County Meetings

Meetings are held the second Tuesday of every month at 7 PM at the Severna Park United Methodist Church. .

For more information on meetings or with any additional questions: 410-721-2468 or e-mail Mick Terrone, m_terrone @chadd.org

Website: www.chaddonline.org/chapters/chadd541.html

Tuesday, September 10
Language Issues and AD/HD
Liinda Spencer, Ph.D.

Tuesday, October 8
Educational Issues in AD/HD
Jane Snider, Ph.D.,
Founder and Director of The Summit School

Tuesday, November 12
The Care and Feeding of the AD/HD Child: Building Self Esteem
John Walkup, M.D.

Tuesday, December 10
Transition to College: Making the College Experience Successful
Carol Robbins, Ph.D.

Tuesday, February 11
TBA

Tuesday, March 11
TBA

Tuesday, April 8
TBA

Tuesday, May 13
TBA

Directions **Severna Park United Methodist Church:** Take Rte. I-97 to Exit 10, Benfield Boulevard, toward Severna Park. Turn left on General's Highway and immediately turn right onto Governor Stone Parkway. The church is approximately one mile farther on the right.

About Our Speakers

Carol Robbins, Ph.D.

Carol Ann Robbins, Ph.D., is a licensed clinical psychologist in Annapolis who specializes in treating children, adolecents, and adults with AD/HD. She also works with Kathleen Nadeau, Ph.D., in Silver Spring at Chesapeake Psychologial Services of Maryland. She earned her doctorate at the University of Miami and trained at Naional Children's Medical Center in Washington, DC. In private practice for nine years, she is currently the co-coordinator of the Anne Arundel County chapter of CHADD.

John T. Walkup, M.D.

Dr. Walkup is a child and adolescent psychiatrist and a faculty member in the Dlvision of Chlld and Adolescent Psychiatry at Johns Hopkins School of Medicine. Dr. Walkup has presented a number of times at CHADD meetings locally and state-wide. An expert in the evaluation and treatment of children with all psychiatric disorders, he has focused his career on treatment interventions, both pharmacologlcal and behavioral, for Tourette syndrome, AD/HD and OCD. He is the Principal Investigator of the Research Unit of Pediatric Psychopharmacology and Psychosocial Interventions at Johns Hopkins, which is currently studying a number of interventions for children with AD/HD, mood, and anxiety disorders.

Jane Snider, Ed.D.

Dr. Snider is the founding Director of the Summit School, a small private school for children who have language learrung difficulties in Edgewater, MD. Dr. Sruder's career includes university teaching at the George Washington University, work as an educational diagnostician and placement specialist, and the conceptualization and development ofthe Sumnit School. Now in its 14th year, with over 100 students, The Summit School represents a model program for the Greater Washington, D.C. area and the Baltunore corridor. Dr. Snider has trained and inspired her professional staffto help her implement innovative programming for children and youth who have dyslexia and learning disabilities, as well as provded information, training and support to families.

Linda Spencer, Ph.D.

A Speech-Language Pathologist, Dr. Spencer is certified by American Speech-Language-Hearing Association and licensed to practice in Maryland. With thirty years' experience as a clinican and college teacher, she holds degrees from Southern Illinois University, Northwestern University, and the University of Oklahoma Health Sciences Center. In private practice in Arme Arundel and Howard counties, her practice is lirnited to assessment and advocacy for children with language-based learning disabilities, as well as AD/HD and other co-existing problems.

Linthicum Adult Support Group

Cosponsored by Chadd of Greater Baltimore and Chadd of Anne Arundel County

Adults with Attention Deficit/Hyperactivity Disorder face many challenges. Support group meetings enable those with attention issues to discuss problems and share solutions in a friendly and confidential atmosphere. Kerch McConlogue, an AD/HD coach and member of the board of directors of CHADD of Greater Baltimore, will lead the discussions. Support group meetings are not intended to provide medical information or take the place of therapy. Meetings are held the third Wednesday of each month. The discussions will address issues in life planning, business and personal goals, organization/time management, task analysis, problem solving strategies, and clutter control, each focusing on a specific topic of interest to attendees. All meetings are free and open to the public.

The meetings will be held at St. Christopher Episcopal Church, 1 16 Marydell, Linthicum Heights, MD 21090; take Baltimore Beltway to Camp Meade Road e~t south. Turn right at the light on Maple Road, right again on Switzer. Go through the development, turn right on Marydell into the parking lot.

For more information: Phone 410-377-0249
Email:chadd168@aol.

Meetings are scheduled on these Wednesday evenings from 7–8:30 PM :

Wednesday, September 18	**(None in January)**
Wednesday, October 16	**Wednesday, February 19**
Wednesday, November 20	**Wednesday, March 19**
Wednesday, December 18	**Wednesday, April 16**

Kerch McConlogue, CPCC, is a personal coach for adults with AD/HD who know they are capable of more and want to prove it. With more than twenty years as small business owner, Kerch is a member of the CHADD of Greater Baltimore board of directors, Attention Deficit Disorder Association (ADDA), the Guild of American Papercutters, and is President Elect of the Baltimore Regional Chapter National Association of Women Business Owners (NAWBO). She is a volunteer program screener for Women Entrepreneurs of Baltimore (WEB) and workshop leader on time management for entrepreneurs.

Why Join CHADD?

There is strength in numbers. CHADD national membership numbers over 20,000, to which the Maryland Chapters contribute more than 600 active members. We hope to continue increasing that strength throughout 2002. Please join us in our our efforts.

Our members receive the most up-to-date, reliable information available about AD/HD. Any new research breakthrough reaches our members through *Inside CHADD* or *ATTENTION!* If an important issue faces the U.S. Congress, our members are hear about it.

National Member benefits

- *Attention!*, a national bi-monthly magazine on AD/HD
- *Inside CH.A.D.D.*, the quarterly national newsletter
- The complete CHADD Fact Sheet Series on AD/HD and related issues, such as parenting, AD/HD in adults, education rights, classroom interventions, and more.
- Reduced registration rates for the annual national CHADD conference

Benefits of belonging to CHADD Chapters in Maryland

- *Hyper~talk*, the semi-annual CHADD of Greater Baltimore Chapter magazine
- Monthly meetings give members access to eminent authorities in related fields
- Parent Support and Meetings
- Adult Support and Meetings
- Resources for referrals, networking, and links with other nearby CHADD Chapters
- Library privileges

CHADD Membership Application
Greater Baltimore Chapter #168
Anne Arundel Chapter #541
Montgomery Chapter #100

CHADD is a non-profit, tax exempt organization working to improve the lives of people with AD/HD through education, advocacy, and support.

Name _____
Occupation _____
Organization _____
Address _____
City _____
State _____ Zip _____
E-mail _____

☐ $45 family or educator membership
☐ $75 Health care professional membership
☐ $35 Student membership
☐ $250 Organizational membership
☐ ----- Hardship/scholarship, call CHADD

☐ New Member
☐ Renewal
☐ Greater Baltimore
☐ Montgomery
☐ Anne Arundel

Method of Payment: ☐ Check

☐ Visa ☐ MC ☐ Amex ☐ Exp. date ☐☐ / ☐☐

☐ Name on card _____

☐ Card number _____

☐ Signature _____

To Decide or Not To Decide . . .
Is That a Question? Did You Mean, Now?

—Kerch McConlogue, Certified Coach

Make up your mind. Choose. Judge whether this option is better than another. Are your palms sweating, your heart racing? Just plain deciding is often a difficult task for a person with a million ideas, all with seemingly endless possibilities. Saying yes to one means saying no to another. If you do decide quickly, you might be wrong. Your parents have been telling you for years that you don't think things through. So this decision must be wrong; it was too easy. What if the one you decided against was really the better one? Or perhaps it really doesn't matter what the choice is; you can go along with any decision as long as you don't actually have to make it yourself.

I often hear clients say that not deciding leaves room for flexibility. But that flexibility comes at a price. Consider this example: Your grass is long over due for mowing, so you decide to appease your wife and do yard work on Saturday afternoon. You even remember to check the gas in the lawn mower on Thursday so that you know you'll be ready on the weekend. You are prepared for the task, but on Friday afternoon you get a call from a friend who wants help at his place on the weekend.

You have to decide. But you have options. You get to judge if his need is greater or his invitation more fun. If you decide to help him, you'll have a reason to explain the delay to your wife. But in all cases, you get to choose what you will do.

On the other hand, if you did not make a plan to work on your lawn this weekend. You also didn't check the gas. Now when your friend calls, you have to consider, all at the same time, not only *his* needs but also your own, as well as the threats from your wife. Oh, and by the way, do you have gas in the mower?

So many variables. You might feel pressured to help him. He is, after all, your friend. While you are helping him, you feel guilty that you didn't do your own yard and you worry about what your wife will say. Or if you choose work in your own jungle, you feel guilty for not helping him. Either way, you don't enjoy what you are doing.

Actually, decisions don't eliminate flexibility. Rather, they make enjoying flexibility possible. You can always change your mind. Almost no decision is irreversible. A foreman in a steel mill once told me, "You can change iobs every year until you are 35 and *still* work 30 years for the same company."

Many people just have to *learn* to decide. And as with any new skil1, it takes practice. You probably don't have to decide the earth-shattering stuff first. The primary objective is to get your mind used to a new comfort zone.

"Just do(ing) it" is not easy. But since you have to start somewhere, study how you decide on the easy stuff. One such pedestrian decision is what to order for dinner in a restaurant. What would happen if, knowing you dislike sea food, you don't bother look at the fish page? And knowing that you like chicken, you only considered chicken items on the menu? The number of items for consideration is diminished. What if you realize that no babies will die no matter what you eat? So you just pick, close the menu, and promise yourself that, just this once, you will not change your mind, no matter what.

Then pay attention to yourself. What does it feel like to have decided? To have decided quickly . . . or slowly? What is your anxiety level like? How do you feel sitting with your companions enjoying the conversation instead of worrying over what entrée to have?

Make sure you don't try to make more than one decision at a time. Don't decide on dessert and dinner together. Neither one is difficult, but together they seem to be greater than the sum of their parts. Decide first, do I actually *want* an appetizer?

When the decision is bigger, more important, consider breaking it into smaller parts. Planning a family vacation has lots of bits. Do you hate riding in the car with small children? Is flying too expensive? Spend some time asking the questions before deciding on the answers.

Life isn't like *Jeopardy*. But even on *Jeopardy*, they pose only one question at a time; you don't get to the final round before you have played through the first ones. And that's really the only number you have to deal with, in any decision.

Kerch McConlogue, CPCC, is a personal coach who works with adults with AD/HD. You can reach her by email at Kerch@mapthefuture.com For further reading on getting comfortable with a new skill, consider reading In the Yikes! Zone, *by Mermer Blakeslee (2002).*

Getting a Diagnosis:
Questions to Ask When Selecting a Professional to Assess or Treat AD/HD

While the Schwab Foundation is pleased to present information and referral sources, it is our policy not to recommend or endorse any one specific referral source. These questions are designed to aid in the referral selection process.

Family questions:

Why do I think my child may have AD/HD?

Will my insurance cover the cost of an AD/HD assessment? treatment?

Are there other unusual events or circumstances happening in our family that may be affecting my child?

Questions for the professional who may do the assessment:

How do you diagnose for AD/HD?

Which types of tests or measurements do you use?

Do you use the DSM-IV or other references?

How do you determine those symptoms exist in at least two settings?

How long will the assessment take?

Do other professionals assist in the assessment process?

What age range do you assess?

Are you knowledgeable about special services provided at public schools for children and youth with AD/HD?

How long have you been doing assessment for AD/HD?

If you confirm an AD/HD diagnosis, would you be willing to write a letter to the school or speak to a school official?

What type of written feedback will I receive when the assessment is completed?

If medication is involved, do you work with a specific physician?

Questions for the professional who may do treatment (You may choose a different person to do treatment.)

How is medication used in your practice?

If medication is prescribed, what might be some of the side effects?

What other therapy in addition to medication do you suggest?

Is counseling part of the treatment plan?

If I do not want to put my child on medication would you attempt to find other possible solutions?

What are some typical results you have had with your clients?

Could you arrange for me to speak with some of them?

What are your fees? Do you have a sliding scale?

What can I do at home to help my child?

Review questions:

Was this professional easy to talk to? Were all of my questions answered satisfactorily?

Reprinted from the Schwab Foundation for Learning Website http://www.perc-schabidn.org

It Takes a Community . . .

• of caring to provide a network of assistance.

• of professionals who share their knowledge to educate parents and adults.

• of individuals to make changes in attitudes and perceptions.

• of persistence and passion to meet the needs of students with AD/HD and make success attainable.

• of volunteers to continue the many activities initiated by others.

• of educators with compassion and understanding to provide struggling students with strategies that allow them to compete with their peers.

• of educational administrators to change how schools deal with students who cannot attain success.

• of collaborative efforts to make a difference in the lives of those who must contend with the associative eiements of AD/HD.

• of caring individuals to advocate for laws that will benefit those with AD/ HD in the areas of education, healthcare, and the workplace.

• of passion to see us through the roller coaster of constant ups and downs.

• of people to give of their precious time regardless of how small the amount.

• of compassion to keep our CHADD Chapter operating and bring together both those in need and those willing to share what they know.

We need you. We need your help. We need your support. Together we can help one another. There are so many who depend on the efforts of our Chapter and your kindnesses. Please share your many talents and knowledge.

Two from Dr. Nadeau

Dr. Kathleen G. Nadeau, Ph.D., is a clinical psychologist who has specialized in ADHD issues for many years. She is the author of many books on ADHD and lectures frequently around the country. She serves on the professional advisory board of CHADD National. Her current focus is on issues of girls and women with ADHD. She will be the speaker at the Montgomery County meeting on June 18, 2003.

Helping Your Teenage Daughter with AD/HD To Develop Skills for Independent Living

The move toward autonomy as girls with ADHD progress through the high school years can create much anxiety in parents. Often, this results in predictable, but non-productive battles as daughters insist on freedom that parents aren't sure they're ready to handle responsibly. A much more positive approach is to actively work to help your daughter gain skills for autonomy and independence. It is important to remain patient and to recognize that the process may take her longer than the average adolescent. Advance practice can be helpful.

• For example, if she hopes to go away from home to college, she may benefit greatly by attending a school that offers an extended orientation period in the summer before freshman year for students who have special needs.

• It may be very helpful to open a checking account during high school, where she can deposit any cash gifts or money earned from summer jobs. In this fashion, she has a ionger period of time to learn the habit of recording checks and keeping an accurate account balance.

• Learning to handle charge cards responsibly is crucial to adult life, but can be very difficult for any teen. Obtaining a card with a very low limit—$200-$300—can provide experience without opening the door to disaster.

• Providing her with a clothing allowance during high school also can give her experience in managing money, setting priorities, and making decisions within defined limits.

• Learning to use a day planner is one of the most critical skills your daughter needs to master as she leaves home for college or the working world. A day planner is not only for recording appointments, but for recording all crucial infommation—phone numbers, addresses, shopping lists, directions, and so on. By developing the habit of writing all important information in one place, she will have a skill that is very valuable in managing AD/HD tendencies toward forgetfulness and disorganization.

• The simple act of setting an alarm clock and depending upon oneself to get up on time in the morning is often very challenging for girls with AD/HD. This is a skill best practiced at home, where parents can remain a back-up system, rather than waiting until she is away at college or in her first apartment.

• All students face increasing, multiple demands as they enter their high schooi years—multiple teachers and assignments, extra-curricular activities, part-time jobs, increased responsibilities to help at home, learning to drive, beginning to date—the list is long and daunting. Girls with AD/HD will need help in organizing and managing these multiple demands, and in making AD/HD-friendly choices so that they are not juggling more than they can manage. Working with a coach who specializes in AD/HD can often be very helpful for girls as they learn to organize and prioritize. The more you support your daughter in gaining skills for successful independence the better you and she will feel as she spreads her wings and leaves the nest.

Mid-life Transitions for Women with AD/HD

In midlife, a woman with AD/HD makes several major transitions. Biologically, she goes through perimenopause and enters menopause. Interpersonally, her family responsibilities are probably waning. In her fifties, a woman with AD/HD has new choices before her. Perhaps this is a time to pursue a long-neglected dream—to return to school, to develop a dormant talent, to establish a different lifestyle that is more compatible with her needs as a woman with AD/HD.

The Hormone Connection

It is critical for women with AD/HD as well as their treating physician to be aware of the powerful interaction of AD/HD symptoms and estrogen levels. Many women whose AD/HD symptoms have been successfully treated with psychostimulants report that their stimulants are less effective during perimenopause and menopause. The interactions of AD/HD symptoms with estrogen levels are not yet widely known and appreciated.

Shifting Focus from Family Needs to One's Own Needs

As children leave home for college or work, many women with AD/HD experience contradictory reactions—on one hand the complexity and daily demands often decrease, but on the other hand the structuring function of the familiar role of mother is lost and some women feel lost without it. For women whose children's needs and schedules have driven the course of her life for two or more decades, the sudden loss of role may feel daunting, even depressing. For other women, who also have a job or career, the empty nest may be welcome relief from a punishing daily schedule that involved sports practice, dental and medical appointments, homework supervision and meal preparation on top of a demanding work schedule.

Jumpstarting or re-starting a career in mid-life

Like other women, many women with AD/HD have put hopes or ambitions on hold while raising a family, planning to put more energy into their own projects when they have more time. The extra challenge when a woman has AD/HD, however, is that the kinds of skills needed to follow through on such plans are often those very skills that are most difficult for her. While she may have felt hampered and frustrated for years, when the time and opportunity open up she often feels overwhelmed and directionless. How do I get started? Where should I begin? A woman with AD/HD facing a structureless void—"free" time—may feel paralyzed, unable to move forward.

As for all other projects or undertakings, women with AD/HD need structure introduced externally in order to function well. Her first task is to draw parameters of some sort around her dream—to create or find structure—within which she can then begin to take steps toward accomplishment. Structure may come in the form of an ADD coach who can help her break down a dream into "things to do this week." Structure can also come in the form of a partner—someone to be accountable to, someone to plan with, someone off whom to bounce ideas. Structure can also come in the form of a formal job. For example, if a woman's ultimate dream is to start her own enterprise, she may begin by taking a job working for someone else initially. Of course, she should take care to work for an employer who is well-organized or she has limited her options without adding structure! Other ways to add structure are to join groups groups of women who are engaged in similar activities. There are many such groups—of women artists, professional women, business women—who provide structure, support, encouragement, and contacts. Enrolling in classes can also provide structure while helping a woman to build or enhance skills related to her developing career path.

Renegotiating Relationships in Midlife

In mid-life, opportunity to re-design her lifestyle beckons, if a woman with AD/HD will heed its call. One of the most AD/HD-friendly decisions that a woman can make in midlife is to consider her entire lifestyle up for re-design. Whether she is a single parent, renegotiating expectations with newly adult offspring or a married parent, renegotiating with children and spouse alike—she finally has the option to radically lower her daily stress level by changing the expectations that she has of herself and that others have of her.

Building New Habits To Create Balance

The primary mid-life goal to create a new sense of balance in her life—balance within herself, and balance between herself and significant others. The challenge is to slow down the merry-go-round she's been on for so long—slow it down so that she can hop off and go for a walk in the woods, for a soak in the hot tub, for a calm moment of meditation or yoga. And then to ask herself whether she wants to ride that merry-gor-ound at all. With fewer family responsibilities, she may decide to reduce her work hours, or to change career directions altogether.

Getting There

When a woman with AD/HD struggles to find a meaningful direction for herself at this phase of her life, psychotherapy may be very useful—to help her to take stock in her life, rekindling old dreams or developing new ones better suited to the self that she has become. If she's married, she also needs to work toward creating a different balance in relationship to her husband. "The way it's always been" no longer needs to be. Yet habit and expectations can have strong powerful pulls. It may be most helpful to work with a therapist to understand ways to create a more AD/HD-friendly life, to give herself permission to take better care of herself, and to find the strength and focus to renegotiate long-standing patterns with her spouse.

For a woman who knows what she wants to do, but can't seem to mobilize herself to do it, coaching may prove very helpful—to set realistic goals, to break those goals down into do-able steps, and to remain focused and motivated as she works toward reaching her goal.

With structure, strategies and supports in place, midlife can become a golden opportunity for a woman with ADHD—an opportunity to reduce stress, become more centered, and to accomplish things she only dreamed in earlier years.

Landmark full-page ad

AD/HD and Substance Abuse

—Carol E. Watkins, M.D.

Individuals with AD/HD have several characteristics that make them more vulnerable to substance abuse: These may include self-medication, impulsivity, social skills problems and a tendency to associate with others who are not doing well in school.

Adult attention deficit disorder seems to be related to earlier onset of substance abuse, a longer period of active abuse, and a lower rate of recovery. (Wilens, Biederman and Mick, *Am J Addict* 1998) A study by Biederman et al *Am J Psychiatry* 1995 suggested found that 52% of adults with AD/HD (versus 27% of controls) had had a problem with substance abuse. Other studies have found slightly lower rates but have still found that the rates are significantly higher than those of individuals without AD/HD.

Appropriately prescribed stimulant medication does not seem to increase the chance of later substance abuse. A recent study published in Pediatrics Vol. 104, No.2 1999 suggested that adolescents with AD/HD who were treated with stimulant medication, were less likely to develop drug problems than those who were not treated. It is possible that newly diagnosed adults have the higher rate of substance abuse because their AD/HD was not treated when they were children.

Prevention: Parents of a child with AD/HD should start talking about drug abuse and risky behavior early and maintain an open dialogue. Children and adolescents who are aggressive or who habitually break rules are at increased risk. If your child fits this profile, consider more intensive individual or family therapy. Teach your child the difference between legitimately prescribed drugs and illegal drugs. Look at your own pattern of drug or alcohol use. Try to model a conscientious approach to alcohol. If you the parent is in recovery from drug or alcohol abuse, consider taking your adolescent with you to a few Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings. If a child or adolescent has AD/HD along with a strong family history of substance abuse, he or she should probably never drink. It is important to be honest with him about the family history so that he can understand the risks.

Treatment: If an individual seems to have both AD/HD and a substance abuse problem, how do we treat him or her? First, it is important to do an accurate diagnostic evaluation. Drug use can sometimes shorten attention span and thus mimic AD/HD. We get an in-depth history and often get information from family members. At some point, we like to see the individual when he or she is sober and is not in acute drug withdrawal. If this is not possible, we may need to make a tentative diagnosis and defer the definitive diagnosis until later.

It can be more difficult to treat substance abuse in an individual with AD/HD than in a non-AD/HD individual. We prefer not to treat an individual who has both AD/HD and substance abuse with medications alone.

We often encourage group therapy in a setting that encourages abstinence from drugs. Family therapy is also a good idea. The individual may benefit from 12-step groups. Family members may benefit from Alanon or Naranon. If impulsivity is part of the individual's AD/HD, recovery may be more difficult. It might be good to have a Narcotics Anonymous (or NA) sponsor who also has AD/HD. Such an individual may sometimes need more intensive treatment during the early and also the later phases of recovery. The substance abuse recovery program may become boring after a while. The individual and the treatment team need to watch out for this factor.

Should we prescribe Schedule II medications (e.g. stimulants) to individuals who are actively abusing drugs? We prefer not to do so, especially if the individual refuses to participate in other forms of treatment. We may consider using a Schedule II stimulant if the individual is a minor, and the parents can tightly monitor the medication, and get regular drug screens. In other cases, we may start with non-Schedule II medications such as Wellbutrin. If active drug abuse is severe, or if close monitoring is not possible, it may not be safe to prescribe any medication at all. Once an individual is involved in treatment, actively working on sobriety, we can be more confident about prescribing medication. However regular drug screens, and close communication with other members of the person's support system, are useful.

The individual who has AD/HD accompanied by persistent substance abuse may need intensive outpatient or even residential treatment to break through denial and start treatment in a safe environment. If the individual refuses treatment, we may start by bringing the family into treatment so that they can learn to understand the situation and set limits.

Carol Watkins, MD., is a psychiatrist in private practice. She serves on the Professional Advisory Board of CHADD of Greater Baltimore, and was the CHADD Volunteer of the Year in 2001.

Adult AD/HD Advocacy

Harold C. Cohen,
Ph.D., Che, EMT-P

35 Anderson Ridge Road
Catonsville, MD 21228

Phone 410-747-8637
Cell Phone 443-829-8113
Fax 410-747-7643
E-mail EMSHC@aol.com

Updates from Our Professional Advisory Board

In the Law

—Leslie Seid Margolis

This has continued to be a busy time for education advocates.The 2002 legislative term proved to be a successful one. After a tremendous amount of work, education advocates celebrated passage of the "Thornton Commission" legislation, which will increase education funding substantially over the next several years. Additionally, the legislature allocated funding for the infants and toddlers early intervention program for the first time in many years and gave the program a budget for the first time ever.

The legislature also passed a bill requiring the development of a task force to develop regulations regarding the use of restraint, seclusion, and time out in schools and requiring consultation between the superintendent of schools and higher education institutions to ensure that teacher preparation programs include sufficient training for teachers in positive behavior supports, interventions, and strategies.

The restraint/seclusion/time out task force met for the first time on July 9 and will meet monthly through November. The regulations must be submitted to the State Board in time for consideration at the Board's December meeting. For more information, contact Leslie Seid Margolis at (410) 727~352, ext. 227 or lesliem@mdlcbalto.org

On the federal front, Senate and House committees have been holding hearings regarding the reauthorization of the Individuals with Disabilities Education Act (IDEA). The President's Commission on Excellence in Special Education issued its long-awaited report on July 9, and recommended sweeping changes to the IDEA. Included in the Commission's recommendations are the recommendations that the No Child Left Behind Act become the driving force behind IDEA reauthorization, that parental empowerment and school choice be increased, that local school systems be held accountable for results, that mediation be available whenever requested, that funding be increased, and that teacher preparation programs be improved.

It is likely that a number of competing IDEA bills will be introduced over the coming months. For ongoing updates about the status of the IDEA reauthorization, contact Preserve lDEA@dredf.org, an e-mail service being provided by the Disability Rights Education and Defense Fund, a national disability rights organization based in Berkeley, California.

Leslie Seid Margolis is an attorney with the Maryland Disability Law Center. She serves on the Governor's Task Force on AD/HD and is a member of the board of CHADD of Greater Baltimore.

AD/HD—Inattentive Subtype

—Ken Tellerman M.D.

Researchers have documented significant differences between people with AD/HD inattentive subtype versus those with AD/HD combined subtype suggesting that the two are distinct in their presentations and clinical pathways.What follows is a summary of some of these findings:

1) Current diagnostic criteria for AD/HD require an onset by age seven years. Whereas 82% of children with the combined type meet this criteria, only 57% of children with the inattentive subtype meet symptom criteria prior to age seven years. Children with inattentive subtype may not display full symptomatic behavior until they are age nine to eleven years.

2) Whereas difficulty with behavioral inhibition is a hallmark of people with combined type, inhibition is not a significant problem for the inattentive group. The combined group is characterized by distractability and impulsivity whereas the inattentive group is characterized by "slow cognitive tempo".

3) Comorbid conditions such as conduct disorder and oppositional defiant disorder are more frequently noted with combined than inattentive subtypes.

4) People with inattentive subtype have a higher rate of math related difficulties.

5) Children with inattentive subtype may be socially withdrawn but tend to have fewer fights than children with combined subtype.

6) In both types, males predominate, but the male:female ratio is more matched in the inattentive subtype.

7) Children with inattentive subtype are more likely to have relatives with anxiety disorder or learning disabilities. Children with combined subtype are more likely to have relatives with attention deficits and hyperactivity.

8) Children with inattentive subtype appear to respond to lower doses of stimulants than their combined subtype counterparts.

Ongoing research should help to further define and track outcome for these two populations and delineate whether inattentive subtype is truly a subtype of the AD/HD spectrum.

(*AD/HD Report:* "The Predominantly Inattentive Subtype" Richard Milch, Ph.D, VoL 10, Number 1, Feb 2002)

Assessment Approaches

—Robert J. Hedaya, M.D.

While the standard treatment of AD/HD can be very effective, much research indicates that other approaches may enhance the response to the standard treatments. Much data, for example, suggests that the immune system—60% of which surrounds the gastrointestinal tract—when activated can release chemical messengers called cytokines. These cytokines are known to affect emotional, cognitive and hommonal function.

In a similar manner, the brain is known to require adequate amounts of essential nutrients—from amino acids and vitamins to minerals and essential fatty acids—for optional functioning. Stress, nutritional or gastrointestinal deficiencies can create weak points in the functional metabolism of brain systems, leading to some degree of impairment which can manifest as AD/HD. In general it is advisable to ensure that those systems known to affect cognitive function be assessed in the treatment of AD/HD, in addition to the standard assessment approaches.

Correct Information About AD/HD

—Sherry Askwith

Although information on AD/HD appears frequently in newspapers, magazines, and on television, it is often incorrect information presented in an emotional and biased fashion by "experts" who have inadequate knowledge of AD/HD. It is difficult if not impossible for AD/HD adults and parents of AD/HD children to know which of several contradictory pieces of information is correct. For that reason, parents who are first bringing their children for diagnosis and/or treatment often make comments such as the following: "I don't mind if he takes medication but I want him to try to do it on his own first. Too many parents and teachers just want kids on medication to make their jobs easier with medicine."

"He is not living up to his potential. He is a very bright child and could do excellent work if he would just try harder."

"How do I know that you are giving her an accurate diagnosis? You professionals are getting kickbacks from the pharmaceutical companies—of course you are going to diagnose her with AD/HD."

"I know it is all my fault. I should have spent more time with her and been more helpful and loving. Then she would not be having these problems."

It is often difficult for professionals who keep up with current AD/HD research to answer such questions without discrediting reporters and television stations, even though we know we are not getting kickbacks and that most AD/HD-diagnosed children cannot "do it on their own" or "try harder" successfully. And we know that parents' guilt frequently gets in the way of their ability to learn new techniques for dealing with their children's AD/HD.

One helpful way to promote accurate information is to keep a variety of accurate literature at hand. Information from appropriate medical websites, the National Institute of Health, and the International Physicians' Position Paper on AD/HD can be comforting to parents and not as suspect as information from AD/HD organizations. It behooves every CHADD chapter to have a "researcher" who checks accredited websites frequently for information of interest to chapter members. This information would be useful to parents going to school meetings, to faculties of schools and to employers. Although a great deal of excellent AD/HD information is readily available, most members of the community are not aware of this and do not have the time or the inclination to take advantage of it.

Wouldn't it be nice if CHADD members who saw television. shows or read articles with inaccuracies could say, "That is not true and I know why because I read . . . ?"

Working together, members and advisory board members can help counteract the "AD/HD hysteria" which often occurs in the media and provide accurate and useful information to members of every community.

Worth a Look

AD/HD: Attention-Deficit Hyperactivity Disorder in Children, Adolescents, and Adults

by Paul Wender

Paul Wender began his career treating people with AD/HD over thirty years ago. His exhaustive research and insight gained from clinical practice has led to the publication of several prominent books on the disorder. Now, with the publication of this revised and updated edition, he presents the definitive resource on AD/HD.

In his discussion of treatments, Wender stresses that drug therapy remains the most effective. He adds, however, that psychological techniques combined with medication can produce further improvement. Most important, Wender offers extensive practical instructions on how parents can best help their AD/HD child. Throughout, Wender supplies case histories of children and adolescents with AD/HD, as well as accounts of the experience of AD/HD in adults as perceived by both patients and their families. In addition, the book contains valuable information on where to seek help as well as on the kinds of diagnostic tests currently available.

$10.95, ISBN 0-19-511349-7, Call 1-800-451-7556 or ViSit www.oup-usa.org to find out more.

The Childhood Roots of Adult Happiness: Five Steps to Help Kids Create and Sustain Lifelong Joy

by Edward M. Hallowell, M.D.

Connection, play, practice, mastery, and recognition: these five concepts hold the key to rearing children with healthy self-esteem, moral awareness, and spiritual values according to Edward M. Hallowell, M.D., well know as coauthor of *Driven to Distraction* (with John J. Ratey, M.D.) and many other books.

In his newest book, due out in October, Dr. Hallowell argues that we don't need statistical studies or complicated expert opinions to rear children. What we do need is love, wonder, and the confidence to trust our instincts. This book outlines a five-step plan that all parents can use to give their children the gift of happiness that will last a lifetime. Dr. Hallowell explores each step in depth and shows how they work together to foster trust, respect, and joy. He even talks about how household chores can foster a child's sense of mastery.

Dr. Hallowell welcomes correspondence from readers, and can be reached through his web site: www.DrHallowell.com. Ballantine Books, available October, 2002

From Chaos to Calm; Effective Parenting of Challenging Children with AD/HD and Other Behavioral Problems

by Janet E. Heininger, Ph.D., and Sharon K. Weiss, M.Ed.; Forward by Sam Goldstein, Ph.D.

An account of a family's real life situation, this book gives practical suggestions to help parents: establish daily routines; set realistic goals; dealing with stalling, forgetting, overreacting, and other everyday behavioral problems. This very practical book gives advice on how to work with your child's teachers and find professional help when needed. It explains how to engage in proactive—not reactive—parenting and how to avoid common traps when dealing with a challenging child. Information is available at amazon.com review and at www.sharkweiss.com.

Journeys Through ADDulthood: *Discover a New Sense of Identity and Meaning with Attention Deficit Disorder*

by Sari Solden, M.S., L.M.F.T.

Often, even long after diagnosis, many adults struggle with trying to overcome the symptoms of AD/HD rather than learning to integrate certain building blocks of "ADDult" development. They continue to judge themselves by the external markers of success—a clean desk, timely actions, promptness—and often miss out on the valuable connection between their core self and others.

Sari Solden's new book is a step by step quide to the long term process of understanding your brain and primary symptoms, finding your true self—separate from your AD/HD—and then learning to share who you are with others without sacrificing your true self. Each chapter of the book includes useful self-help exercises called "explorations" designed to help the reader look carefully at the progress of his journey. Sari Solden is the author of women with Attention Deficit Disorder. Her web site is www.sarisolden.com.

Tricyclic Antidepressants (TCAs) in AD/HD

—Thomas Spencer. M.D.

TCAs modulate various brain neurotransmitters, especially norepinephrine and serotonin, by blocking re-uptake presynaptically. The secondary amines (desipramine and nortriptyline) are more selective for noradrenergic function and are associated with fewer side effects in sensitive populations. Advantages of this class of drugs include their relatively long half-life (approximately 12 hours), absence of abuse potential, and putative positive effects on mood, anxiety, sleep, and tics. There is a large body of literature supporting the efficacy of TCAs in the treatment of patients with AD/HD. Out of 33 studies evaluating TCAs, 91% reported positive effects on AD/HD symptoms.[12] Imipramine and desipramine are the most frequently studied TCAs; a handful of studies have been conducted on other TCAs. Although most TCA studies had a relatively brief duration, lasting a few weeks to several months, 4 studies reported enduring effects for up to 2 years.l67-70] Outcomes in both short- and long-term studies were equally positive. Longer-term studies reported sustained improvement for up to 1 year with robust dosing, including desipramine ~ 4 mg/kg l71,72] and nortriptyline 2 mg/kg.[70] Although response was equally positive for all dose ranges, it was more sustained in those studies that used higher doses. A high interindividual variability in TCA serum levels has been consistently reported for imipramine and desipramine with little relationship between serum levels and daily dose, response, or side effects. By contrast, nortriptyline appears to have a positive association between dose and serum level.[70]

The largest juvenile controlled trial of a TCA reported favorable results with desipramine in 62 clinically referred AD/HD children.[67] Many of these children had previously failed to respond to psychostimulant treatment. Sixty-eight percent of desipramine-treated patients were considered very much or much improved, compared with only 10% of placebo patients (P ~ .001), at an average daily dose of 5 mg/kg. In a further analysis, neither comorbidity with conduct disorder, depression, or anxiety nor a family history of AD/HD yielded differential responses to desipramine treatment.l73] In addition, desipramine-treated AD/HD patients showed a substantial reduction in depressive symptoms compared with placebo-treated patients.

Similarly, in a prospective placebo-controlled discontinuation trial, we recently demonstrated the efficacy of nortriptyline in doses of up to 2 mg/kg daily in 35 school-aged youth with AD/HD.[74] Of note, there was a lag in response to medication administration. While the full dose was achieved by week 2, the full effect evolved slowly over the ensuing 4 weeks. AD/HD youth receiving nortriptyline also were found to have more modest but statistically significant reductions in oppositionality and anxiety. Nortriptyline was well tolerated, with moderate weight gain being considered a desirable effect.

Studies of TCAs have uniformly reported considerable improvement in AD/HD symptoms in AD/HD subjects with comorbid depression or anxiety.[70,73,75,76] In addition, a robust rate of response has been consistently reported in studies of TCAs and AD/HD subjects with comorbid tic disorders.[77-82] For example, in a recent controlled study, Spencer and colleagues[83] replicated data from a retrospective chart review indicating that desipramine had a robust beneficial effect on AD/HD and tic symptoms. Several case reports in the 1980s of sudden death in children being treated with desipramine raised concern about the potential cardiotoxic risk associated with TCAs in the pediatric population.[84] Despite uncertainty and imprecise data, an epidemiologic evaluation of this issue[85] suggested that the risk of desipramine-associated sudden death may be slightly elevated but not much greater than the baseline risk of sudden death in children not on medication. Nevertheless, treatment with a TCA should be preceded by a baseline ECG, with serial ECGs being conducted at regular intervals throughout treatment. Because of the potential lethality of TCA overdose, parents should be advised to carefully store the medication in a place inaccessible to the children and their siblings.

Reprinted with permission from *The Medical Education Collaborative: Pharmacologic Treatment of Attention Deficit/Hyperactivity Disorder in Children.* CME author Thomas Spencer M.D., June 28, 2002.

Organize Your Mail and Bills

Glenn Brynes, Ph.D., M.D.

1. Mail Bin:
When the mail comes in, most people get a mixture of bills, junk mail, letters and miscellaneous items. A system for dealing with mail cannot depend on your having time to sort the mail when it arrives. One way to deal with it is to have a bin or box where all the mail can be dumped when it is brought inside, so it will not get lost.

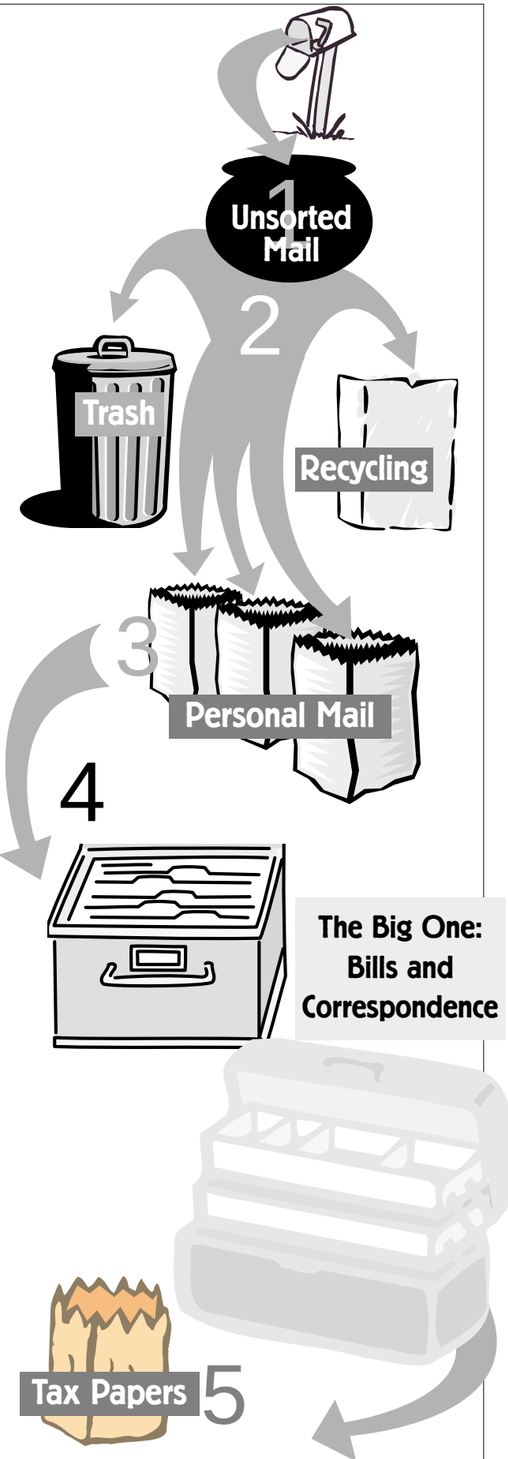
2. Trash and Recycle:
Once or twice a week, go through the mail and sort it: Trash and recyclables can be tossed in their bins. Catalogs that are saved can either go in their own bin or into the personal bins (below).

3. Personal Mail:
Each family member should have their own bin, for which they are responsible. Make sure that the other members of the household know that they must review their mail regularly, so their containers don't overflow. Also that they must not use them for long term storage.

4. Bills:
This is the most important part of all! All bills go in this box, including recurring bills (like mortgage or car payments). It helps to write the due date on the outside of the envelope, and to stack the bills with the most urgent ones on top. Set aside a time each week for paying bill. On that day, go through the stack in the Bill container, and set aside any that are due in the next ten days (if you are going through the bills weekly and it takes a couple days for the payment to get to the creditor, the ten days ensures that you will not be late with the payment).

Fishing tackle boxes—available at Wal-Mart, K-Mart, or sports stores—make great bill-paying centers. Put small items—rolls of peel-off stamps and addres labels, paper clips, pencils or pens, and rubber bands can go in the little compartments of the top tray. Larger items—which might include a stapler, staple-puller, scissors, letter openier, deposit slips and envelopes and your checkbook—go underneath. No need to go searching for supplies—just grab the box.

5. Tax bin:
Receipts, paid bills, and other papers you will need at tax time can be tossed in here for April 15th.



Executive Functioning: What Is It and How Does It Affect Learning?

—Ruth Spodak, Ph.D.

Executive Functioning is a new term being used by some professionals to describe problems associated with Learning Disabilities and/or Attention Deficit Hyperactivity Disorder (ADHD), yet it represents a confusing picture. It often refers to problems with memory, organization and planning, but it does not fit neatly into the aptitude/achievement discrepancy model used to diagnose learning disabilities in many school systems. It appears to be an important syndrome which can often explain the reasons for a child's difficulties in school and beyond, yet it is only just beginning to be understood and assessed.

What is Executive Functioning?

Typically diagnosed by neurologists, psychologists and educators, Executive Functioning difficulties relate to behaviors which deal with planning, organizing and strategizing. Different definitions have emerged: Dr. Martha Denckla, Director of the Kennedy Institute, Baltimore, MD presents the acronym ISIS to stand for "Initiate, Shift, Inhibit, and Sustain, to plan, organize and develop strategies or rules." Children with these problems therefore have problems planning, organizing and managing time and space.

Researcher Dr. F. Xavier Castellanos describes Executive Functioning as "the ability to delay responses and sustain or shift attention so that an individual can set priorities in responding to various environmental stimuli" (and) "as attention with regard to the future."

Dr. Russell Barkley, author of *Taking Charge of ADHD*, states that "executive functions (are) critical to playing, organizing, and carrying out complex human behavior over long periods of time."

One specific component of Executive Functioning is "working memory," the ability to hold information in one's mind while one is processing and manipulating the information. This kind of ability is necessary for something as straightforward as performing mental math computations or as complex as listening to a college lecture, organizing the information and relating it to previously acquired knowledge. Younger children rely on these abilities when following a sequence of instructions - "brush your teeth, get dressed and come downstairs for breakfast."

Professionals see a strong relationship between Executive Function and ADHD, and in fact, there is a high degree of overlap, in that rnany students with ADHD demonstrate symptoms of Executive Functioning difficulties. However, these symptoms are often not evident with the initial diagnosis of attentional problems since one of the defining characteristics of ADHD is that the onset is in early childhood, before the age of seven. Although some aspects of Executive Functioning are expected to be developed at an early age, such as the ability to transition from one activity to another easily, the more notable difficulties such as organizational problems emerge as children move into middle school and enter adolescence.

How are Problems in Executive Functioning Identified?

A survey of six major journals undertaken in the preparation of a major book, Attention, Memory, and Executive Function, found that there were over 20 different measures used to assess Executive Functioning with school-aged children. There was also much overlap between these measures and those used to assess attention and memory. The confusing situation is that there is no agreed upon single test or series of tests which measures Executive Functioning; yet recognized professionals do agree on its existence and its critical effect on academic performance.

Executive Functioning problems are evident across academic areas. In other words, if the student has difficulty planning and managing his time, this will affect his performance in all subjects - English, math, history and art. Therefore, to assess this factor, evaluations must include instruments which assess the child's executive abilities, independent of the particular academic subject. An assessment must focus on abilities such as memory factors, planning and organizational strategies, and the ability to shiD from one strategy to another. These abilities are separate from the student's academic skills in a particular discipline although they can dramatically impact the student's performance in school.

Executive Functioning, therefore, can impact a student's grades independent of his skill level in the subject area. For example, a student may know his math facts, but fail to complete his homework on time; or he may be unable to organize the information to solve math word problems effectively; or he may have studied for a test but be unable to answer the questions due to a novel format. These issues could signal deficits in Executive Functioning which would affect that student's grades despite adequate skills on a math calculation test. These abilities are often assessed in evaluations for Learning Disabilities and Attention Deficit Disorder. Separate tests must be included; furthermore, the examiners must be sufficiently knowledgeable to recognize the symptoms when they occur. Parents must be explicit about the problems they are seeing so they can determine if the particular evaluation will address those issues.

How Can Executive Functioning Problems be Remedied?

Once deficits in Executive Functioning have been identified, there are several approaches to address them. Although classroom teachers typically work on some of these issues within their programs, students who have these problems usually require additional individual work outside the classroom setting. Tutors specially trained in this area are often called "Coaches" and they stress the organizational skills needed to overcome these weaknesses.

To address organizational difficulties, students need to be taught explicit strategies to deal with these problems. These will vary with the age of the student and his particular learning style. Planning tools like master calendars, electronic organizers, watches with alarms and timers are often very helpful. The computer has become a valuable asset for many of these students; not only the word processing features, but the calendars, the outlining programs, the ability to use graphics and color coding can all be important assets. In addition, students need to be explicitly trained in the skills they are lacking: mnemonic devices, visual imagery for memory enhancement; self-talk and self-monitoring techniques to help sustain attention; organizational strategies to address various reading and writing requirements. Most importantly, these skills cannot be addressed in the abstract; the student must be taught how to apply these strategies to his daily assignments.

Moreover, Executive Functioning problems will also likely affect activities outside the school arena. For example, these students often have problems with the concept of time. They cannot estimate how long a task will take, they do not plan for contingencies. As a result they procrastinate and are typically behind schedule, whether that refers to a homework assignment or being ready to leave on time for a family outing. Needless to say, this can then lead to social difficulties and considerable stress in day to day situations.

Hence, besides academic consequences, students with Executive Functioning problems may also experience problems in the social arena which may extend beyond the school years. Their difficulty with timing may alienate friends and family. Since they do not self-monitor readily, these individuals may also have a difficult time reading others' responses and changing their behavior accordingly. They may have a hard time empathizing with others. In the same way that "coaches" can address the academic consequences of these problems, Social Skills groups exist to help individuals develop a repertoire of skills appropriate to their age and social situation. As with the academic application, only those skills can be taught which are developmentally appropriate so that often instruction must be reintroduced at different phases. In other words, a ten-year-old is only able to grasp certain concepts and abstractions; by the tirne he is sixteen, he is ready for another round of strategies aimed at a higher level. Therefore, often students need intervention at different times in their lives to address the problems specific to that particular age level.

Where Do We Go From Here?

Although the concept of Executive Functioning is still being defined and understood, it is clear that students with learning disabilities and ADHD are more vulnerable to the problems identified by this term; namely, problems in formulating long-term goals, attending to the issues needed to attain those goals and organizing themselves and their activities to accomplish these goals. An inability to accomplish these activities can be a serious impediment to someone's ability to achieve success - in the academic world, in the personal arena, and in one's social relationships. It is exciting to know that these problems are beginning to be identified and addressed, but there is still much confusion and disagreement in the field.

Some of these children and individuals are often considered "lazy" or "unmotivated." However, with the appropriate intervention, their situation can change and many new doors can be opened. It is vitally important that, when present, Executive Functioning problems are identified so individuals with these difficulties are recognized and helped to develop the chance to prove themselves as bright, capable and productive.

Ruth Spodak, Ph.D. is a psychologist specializing in learning disabilities. She directs Ruth Spodak & Associates, an organization offering a multidisciplinary team approach to the diagnosis and treatment of learning disabilities, AD/HD and secondary emotional problems often accompanying these problems.

References

Barkley, Russell. *Taking Charge of AD/HD*. New York: The Guilford Press, 1995.

Lyon, G.Reid and Krasnegor, N. (Eds). *Attention, Memory and Executive Function.* Baltimore, MD: Paul H. Brookes, 1996.

The Parent Coach:
Strategies To Bolster Self-Esteem

—Dr. Steven Richfield

A parent writes, “Our eight year old son has recently expressed many negative thoughts about himself. In addition to sometimes telling my husband and I that he hates himself he becomes very moody and fixates upon what's wrong with him. We're worried that he may become depressed. What can we do to help him develop a stronger self-esteem?

One of the most troubling dilemmas for parents is when children show signs of low self-esteem. Despite our best efforts to help them feel good about themselves we watch with dismay as they resist social opportunities, narrow choices to “ego safe” activities, verbally punish themselves, or display a variety of other self-deprecating behaviors. Unfortunately, these signs serve to confirm their negative self-view, setting in motion a self-defeating cycle that can lead to even more disturbing consequences.

When children are trapped in this cycle parents are often beset by feelings of powerlessness themselves.We may point to plenty of positive things about our child but sense our voice is being drowned out by an internal voice inside our child that screens out the good and emphasizes the bad parts of self. Here are some suggestions for coaching your child to a strong and stable self-esteem:

Empathy helps pierce the isolation. Correcting the problem begins with parents demonstrating love and acknowledging the child's painful feelings. Before healing can begin children must know that they can lean on us for understanding and guidance. Offer comforting words such as, “I've noticed how hard you are on yourself. I want us to understand why this is happening and talk about these thoughts and feelings.” Gently persuade them to answer your questions about the sadness, i.e., How much is it in your thoughts? Does it interfere with sleep? Do you still enjoy your favorite activities'

Find out as much as you can about the child's perceived foundation for their negative self-view. Although we may not agree with their self-assessment it's important to understand it's underpinnings. Listen and don't interrupt nor openly disagree as your child recounts all their reasons. When they're finished suggest that they sound disappointed in themselves and that you know how that feels, too. Explain what you mean by weaving some of their examples into your own personal database of mistakes or limitations. At this point the goal is to help them revise the self-punitive meaning they place upon their ”evidence.” If they can accept “disappointment in self.' in place of “hatred of self” you have helped them take a big step.

~ Suggest to them that everyone has a “negative voice” that sometimes gets loud and hurtful. One factor that often injures a child's self-esteem is the presence of a harsh conscience. Even young children can be taught about how the conscience is like an “internal policeman” looking over your shoulder, telling right from wrong. “Usually it does a good job of keeping people on the right path but sometimes it makes us think that we should never make mistakes and be great at everything,” is one way to introduce the notion of a self-critical negative voice. From that point provide examples of how your own negative voice sounds, perhaps using humor to take some of the sting out of the discussion, i.e., “My conscience is definitely working overtime when I have Grandma and Grandpa over.”

Offer the alternative “kind voice” to challenge the punitive one. Coaching more reasonable self measurement can be placed in the context of “letting the kind voice you use with others also speak to you.” Remind them of how they have shown forgiveness, overlooked mistakes in others, and appreciated others for who they are not what they are good at. Explain how this kinder and gentler voice is inside of them but also needs to come out when they are feeling disappointed in themselves. Give examples of how their kind voice might sound afterwards, i e., “Maybe I can't do this very well but that's okay. I can't be great at everything.”

Steven Richfield is a child psychologist in Plymouth Meeting, PA. He can be reached at 610-2384450 or director@parentcoachcards.com

Seasonal Affective Disorder:
Sydrome Triad in Children and Adolescents

—Norman E. Rosenthal, M.D.

In evaluating many patients with winter seasonal affective disorder (1), I have observed in some children and adolescents a triad of syndromes: seasonal affective disorder, delayed sleep phase syndrome (2), and attention deficit disorder (3). Informal polling of child psychiatrists and psychologists confirms that others have also observed this cluster of conditions. The first child E noted with this syndrome triad turned out to be prototypical.

Anne was a 9-year-old girl who had been diagnosed with attention deficit disorder since the second grade. She had been treated for this condition with a regimen of methylphenidate, 7.5 mg/day, which markedly improved her ability to concentrate. Nevertheless, she continued to have difficulty getting to sleep and waking up at conventional times, especially during the winter months—a problem her parents had noted since infancy. In addition, since she was 6 years old, her teachers had remarked that Anne would lose interest in school and be “listless and day-dreamy after Christmas.” As often occurs with seasonal affective disorder, problems with lack of energy and drive were more prominent than sadness. Her mother also reported having suffered the symptoms of seasonal affective disorder for many years.

Light therapy (2,5OO lux), administered for 30~45 minutes in the morning, energized Anne, improved her ability to concentrate, and made it easier for her to fall asleep and wake up at conventional times. Her mother joined her in front of the light box each morning', which made compliance easier and gave mother and daughter an opportunity to spend some quality time together.

Follow-up after 7 years indicated that all three syndromes (seasonal affective disorder, delayed sleep phase syndrome, and attention deficit disorder) had persisted over time. Methylphenidate had remained helpful for treating her attention deficit disorder, while light therapy had continued to be effective for the other two conditions.

Abnormally delayed circadian rhythms have been hypothesized to result in the symptoms of seasonal affective disorder (4). While there is controversy about this putative causal association, there is agreement that at least some patients with seasonal affective disorder do exhibit delayed circadian rhythms. Delayed sleep phase syndrome has been noted to occur more commonly in young people (5) and has been shown to respond to bright light exposure in the morning and environmental light restriction in the afternoon and evening (6).

It is unclear at this time whether this triad is simply a coincidental onset of three common childhood conditions or whether it represents a syndrome with a specific underlying biological and perhaps genetic basis. Since stimulants are indicated for treatment of attention deficit disorder, whereas light therapy is indicated for treatment of seasonal affective disorder and delayed sleep phase syndrome, it would behoove clinicians who encounter one of these three conditions in children and adolescents to inquire about the other two. Whether this syndrome triad is more than a chance finding and, if so, what the underlying mechanism might be remains to be determined by further research.

References

1. Rosenthal NE, Sack DA, Gillinn JC, Lewy AJ, Goodwin FK, Davenport Y, Mueller PS,Newsome DA, Wehr TA: Seasonal affective disorder: a description of the syndrome and preliminary findings with light therapy. *Archives of General Psychiatry* 1984; 41:72-80.

2. Weitzman EN, Czeisler CA, Coleman RM, Spielman AJ, Zimmerman JC, Dement W, Richardson G, Pollak CP: Delayed sleep phase syndrome: a chronobiological disorder with sleep-onset insomnia. *Archives of General Psychiatry* 1981; 38:737-746.

3. Weiss G: Attention deficit hyperactivity disorder, in *Child and Adolescent Psychiatry: A Comprehensive Textbook*. Edited by Lewis M. Baltimore, Williams & Wilkins, 1991.

4. Lewy AJ, Sack RL, Miller LS, Hoban TM: Antidepressant and circadian phase-shifting effects of light. *Science* 1987; 235:352.354.

5. Palayo RP, Thorpy MJ, Glovinsky P. Prevalence of delayed sleep phase syndrome among adolescents (abstract). *Sleep Res*-1988:392.

6. Rosenthal NE, Joseph-Vanderpool IR, Levendosky AA, Johnston SH, Allen R, Kelly KA, Souêtre E, Schultz PM, Starz KE; Phase-shifting effects of bright morning light as treatment for delayed sleep phase syndrome. *Sleep* 1990; l3:350361.

Reprinted with permission from Norman E. Rosenthal, M,D. Rockville, MD. *American Journal of Psychiatry,* 152:9, September 1995.

CHADD of Greater Baltimore

316 Wichersham Way
Baltimore, MD 21030

The Harbour School

More than a Great Education for Special Kids

A Safe Harbour Where Children with Learning & Other Disabilities Find Success

The Harbour School

www.harbourschool.org
Grades 1–12

1277 Green Holly Drive
Annapolis, MD 21244
410-974-4248

2603 Rolling Road
Baltimore, MD 21244
410-944-1212

Look for our new Baltimore Campus, 11215 Dolfield Boulevard, coming to Owings Mills in Spring, 2002!

Since 1982