A Parent and Teacher's Guide to ADHD and Medications
# A Parent’s Guide to ADHD and Medications

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Chapter 1

What Is Attention-Deficit/ Hyperactivity Disorder?

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurologically based medical problem. It's a developmental disability that is estimated to affect between three and five percent of the U.S. school-age population. No one knows exactly what causes ADHD. Scientific evidence suggests that in many cases, this disorder is genetically transmitted, and results from a chemical imbalance or deficiency in certain neurotransmitters. (Neurotransmitters are chemicals that help the brain regulate behavior.) In addition, a landmark study conducted by the National Institute of Mental Health showed that the rate at which the brain uses glucose, its main energy source, is lower in subjects with ADHD than in subjects without ADHD.

ADHD is now divided into three subtypes, according to the main features associated with the disorder: inattentiveness, impulsivity, and hyperactivity. The three subtypes are:

1. **ADHD Predominantly Inattentive Type**
   This child may have little trouble sitting still, or inhibiting behavior, but has great difficulty getting or staying focused on a task or activity.

2. **ADHD Predominantly Hyperactive-Impulsive Type**
   This child may be able to pay attention to a task, but loses focus. He or she has trouble controlling impulse and activity.

3. **ADHD Predominantly Combined Type**
   This child has significant symptoms of all three characteristics. This is the most prevalent subtype.

**What’s the difference between ADD and ADHD?**
Attention-Deficit/Hyperactivity Disorder is usually referred to as ADHD. However, many people, and some professionals, still call it ADD (which stands for Attention Deficit Disorder, a name it was given in 1980). The name of the disorder has changed as a result of scientific advances and the findings of careful field trials; researchers now have strong evidence to support the position that ADHD is not one specific disorder with different variations.

Definitions are from the work of Mary Fowler, an author, advocate, educator, and the parent of a child with ADHD. She is one of the leading authorities in the U.S. on ADHD. Through lectures and in-service presentations delivered to audiences nationally and internationally, Ms. Fowler brings parents and educators informed and practical approaches to ADHD. She has served as National Vice-President of Government Affairs for CHADD. (Children and Adults with Attention-Deficit and Hyperactivity Disorder), where she actively worked on legislative and policy issues regarding the education of children with ADHD.
Is your school-aged child fidgety, easily distracted, or always on the go? To find out if your child's symptoms fit the profile for ADHD, take this two-part quiz.

**Part One**
Your child has exhibited the following symptoms for at least the past six months:

1. Often fails to pay close attention to details, or makes careless mistakes.
   - Yes.
   - No.

2. Often has difficulty sustaining attention in tasks or play activities.
   - Yes.
   - No.

3. Often does not appear to listen when spoken to directly.
   - Yes.
   - No.

4. Often does not follow through on instructions, or fails to complete schoolwork or chores.
   - Yes.
   - No.

5. Often has difficulty with organization.
   - Yes.
   - No.

6. Often avoids or dislikes tasks requiring sustained mental effort (such as school or homework).
   - Yes.
   - No.

7. Often loses things needed for tasks or activities (e.g., toys, school assignments, pencils, books, etc.)
8: Is often easily distracted.
☐ Yes.
☐ No.

9: Is often forgetful in daily activities.
☐ Yes.
☐ No.

Scoring
Count the number of times you answered “Yes.”

If your score is 0-5:
Your child probably does not have ADHD Predominantly Inattentive Type (see definition, page X). To find out if your child has ADHD Predominately Hyperactive-Impulsive Type or ADHD Combined Type, continue on to Part Two of the quiz.

If your score is 6-9:
Your child may have ADHD Predominantly Inattentive Type (see definition, page X). Keep in mind that symptomatic impairment is often present before the age of seven years and must be present in two or more settings (for example, at school and at home). To find out if your child fits the profile for ADHD Predominately Hyperactive-Impulsive Type or ADHD Combined Type, continue on to Part Two of the quiz.

This quiz was adapted from the following resources:

This article used the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (4th edition, 1994) as a source for the diagnostic criteria of ADHD.

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) Fact Sheets:
http://www.chadd.org/fs/fs1.htm

Please remember: if you suspect that your son or daughter may have ADHD, you should talk to your doctor about getting a complete neuropsychological evaluation of your child. Only professionals trained in the diagnosis and treatment of ADHD can determine if your child has an attention-deficit disorder.
Part Two
Your child has exhibited the following symptoms for at least the past six months:

1: Often fidgets with hands or feet, or squirms in seat.
   - Yes.
   - No.

2: Often has difficulty remaining seated when it is expected.
   - Yes.
   - No.

3: Often runs around or climbs excessively when it is inappropriate.
   - Yes.
   - No.

4: Often has difficulty playing or engaging in activities quietly.
   - Yes.
   - No.

5: Is often "on the go," or acts as if "driven by a motor."
   - Yes.
   - No.

6: Often talks excessively.
   - Yes.
   - No.

7: Often blurts out answers before questions have been completed.
   - Yes.
   - No.

8: Often has difficulty waiting or taking turns.
   - Yes.
   - No.
9: Often interrupts or intrudes upon others (e.g., butts into conversations or games).

☐ Yes.
☐ No.

Scoring
Count the number of times you answered “Yes.”

If your score is 0-5:
Your child probably doesn’t have ADHD Predominantly Hyperactive-Impulsive Type.

If your score is 6-9:
Your child may have ADHD Predominantly Hyperactive-Impulsive Type. If you scored 6 or higher on both parts of the quiz, then your child may have ADHD Combined Type.

Keep in mind that symptomatic impairment is often present before the age of seven years and must be present in two or more settings (e.g., at school and at home).

If you suspect your son or daughter may have ADHD, talk to your doctor about getting a complete neuropsychological evaluation of your child. Only professionals trained in the diagnosis and treatment of ADHD can determine if your child has an attention-deficit disorder.

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Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) Fact Sheets: http://www.chadd.org/fs/fs1.htm
Chapter 3

ADHD: An Age-by-Age Guide
by Debra Rubin Berger

Debra Berger, M.A., is a project coordinator at the Home-School Connection Program at Tufts University's Eliot Pearson Department of Child Development in Medford, Massachusetts.

Recognizing Attention-Deficit/Hyperactivity Disorder (ADHD) in your child can be difficult (and requires a medical diagnosis). Symptoms usually start before a child reaches age seven, and last for six months or longer. What does ADHD “look like”? Here are profiles of three kids with ADHD.

The Early Years
At 11 months, Moira Munns' son, Zachary, was a whirlwind of activity. "I would be cleaning up one mess and he'd already be into the next one," says Munns, president of the Attention Deficit Information Network, Inc., an ADHD support organization based in Needham, Massachusetts. "This went on all day. When he learned to walk, I never sat down again." Zachary's interest in climbing and lack of a "sense of caution" led to the first of many trips to the emergency room, and eventually to a diagnosis of ADHD at age four.

In his book, Taking Charge of ADHD: The Complete, Authoritative Guide for Parents, Russell A. Barkley, Ph.D., says that potential predictors of ADHD include a family history of the disability, a greater-than-normal number of complications during pregnancy, and smoking, alcohol consumption, and poor health during pregnancy. The following symptoms may indicate that an infant, toddler, or preschooler has ADHD:

- A high activity level; finding it hard to sit still, being constantly in motion
- Demanding and being persistent in their desire for things
- An inability to play with a toy or do one activity for a long period of time
- Inattention, negativity, and a low capacity to adjust to change
- Difficulty sharing, waiting, and taking turns
- Poor eating and sleeping habits
- Serious defiance

The Elementary Years
Sitting at his desk in the classroom was next to impossible for "Adam," who was identified as having ADHD in second grade, according to his mother Amy. His difficulties with school didn't end when he came home.
"He didn't have his papers, books, and assignments," she says. "He couldn't concentrate and homework took him hours. He would stop a million times to go to the refrigerator or bathroom."

During the school years, demands are placed on children to listen, cooperate, organize, follow directions, and pay attention – activities that children with ADHD may find difficult. This inability to deal with the structure of school may interfere with learning and academic achievement. A child with ADHD may:

- Be easily distracted and not able to finish assignments or chores
- Fidget and squirm in his/her seat and wander around the classroom
- Talk at inappropriate times and often blurt out answers to questions
- Be disorganized and frequently lose things
- Be socially immature and have few friends

If untreated, 30 to 50 percent of children with ADHD between the ages of 7 and 10 are likely to show symptoms of conduct disorder and behavior problems such as lying or petty thievery, according to Barkley.

**The Teen Years**

"Edward" wasn't hyperactive. In fact, his mother, Mary, describes him as "extremely" relaxed and quiet. She felt he was a very smart kid, but he struggled through school.

"His teachers were always writing comments on his paper, 'Doesn't follow directions' or 'Has trouble following assignments,' she says. "He was easily distracted. Even his thoughts were distracting."

In his sophomore year of high school, Edward was diagnosed with ADD, which has the same symptoms as ADHD but without hyperactivity. He finally got the help he needed.

Research has shown that children usually do not outgrow ADD or ADHD. Russell Barkley says when the syndrome has gone unidentified and there has been no program of behavior management implemented by the pre-teen and teen years, problems often escalate. According to Barkley,

- Thirty to 45 percent will receive special educational assistance by the end of sixth grade.
- Thirty percent of teens with the disorder may experiment with or abuse substances such as alcohol and marijuana.
- Thirty-five percent quit school before completion.
• Teens with ADHD are three times more likely than those without the disorder to fail a grade, be suspended, or be expelled from school.

Please remember that seeing signs of ADHD doesn't necessarily mean that a child has the syndrome. It's important that parents discuss their observations with a pediatrician.
Chapter 4

How Is ADHD Treated?
by Mary Fowler

Mary Fowler, author, advocate, educator, and parent of a child with ADHD, is one of the country’s leading authorities on the subject. Through lectures and in-service presentations delivered to audiences nationally and internationally, Ms. Fowler brings parents and educators informed and practical approaches to ADHD. Ms. Fowler has served as National Vice-President of Government Affairs for CHADD. (Children and Adults with Attention-Deficit/Hyperactivity Disorder), where she actively worked on legislative and policy issues regarding the education of children with ADHD.

Is There a Cure for ADHD?

No cure or "quick fix" exists to treat ADHD. The symptoms, however, can be managed through a combination of efforts. Management approaches need to be designed to assist the child behaviorally, educationally, psychologically, and, in many instances, pharmacologically.

Called multi-modal management, this approach consists of four basic parts: education about and understanding of ADHD, behavior management, appropriate educational interventions, and, frequently, medication. In some instances, individual or family counseling is also advised.

Understanding ADHD

ADHD has been called an “environmentally dependent” disability. The significant people in the life of a child who has ADHD need to understand that difficulties will rise and fall in relation to the environment’s demands and expectations. Problems often arise in environments where children are expected to be seen and not heard, to pay careful attention, and to use great self-control. When children with ADHD fall short of meeting these expectations, we often try to change the children, rather than changing aspects of the environment, including our own actions and reactions.

Parents and teachers need to be aware of the symptoms of ADHD and understand how those symptoms impact the child’s ability to function at home, in school, and in social situations. When the adults in the child’s life understand the nature of the disorder, they will be able to structure situations to enable the child to behave appropriately and achieve success. Remember, the child who has difficulty with attention, impulse control, and regulating physical activity needs help and encouragement to manage these problems.
From a thorough understanding of ADHD comes a change in the way the child's behavior is viewed. This change sets the stage for the effective use of other components of the ADHD management system.

**Behavior Management**

The main goal of all behavior management strategies is to increase the child's appropriate behavior and decrease inappropriate behavior. The best way to influence any behavior is to pay attention to it. The best way to increase a desirable behavior is to catch the child being good.

Behavior is defined as a specific act or actions. When thinking about managing behavior, many people focus on the act or actions. In actuality, behavior management is much broader. It takes into account that, before a specific act or action occurs, there is something that sets the stage for the act to happen (called an antecedent), and something that follows that either encourages or discourages a repetition of the act (called a consequence). Behavior management involves changing the antecedents and consequences so that the child's behavior changes.

Whether at home or in school, children with ADHD respond best in a structured, predictable environment. Here, rules and expectations are clear and consistent, and consequences are set forth ahead of time and delivered immediately.

Demands are limited. Rewards are plenty. Praise is frequent. Negative feedback is minimal.

By establishing structure and routines, preparing the child for changes in the routine, building opportunities for the child to be successful, setting consequences ahead of time, and anticipating where difficulties may arise, parents and teachers can change the antecedents and cultivate an environment that encourages the child to behave appropriately. When adults in the child's life do what they say they are going to do (and do so on a consistent basis so that the child knows their word has meaning), then they are providing the consequences that encourage the child to continue behaving appropriately.

Behavior management is a skill. It requires practice -- and it requires patience. Changing behavior takes time.

Behaviorally trained professionals often encourage the use of behavior modification charts. Charts are designed to provide the child with a clear picture of what behaviors are expected. The child then can choose whether to meet those expectations. Parents or teachers provide feedback to the child about his or her choices by delivering consequences. Charts provide high motivation and
enable the child to develop an internal sense of self-control -- specifically, that he or she can behave appropriately.

There are two basic types of chart programs.

**Token Economy:** Here, the child earns tokens (chips, stickers, stars) for appropriate behavior. Tokens can be exchanged for various rewards.

**Response Cost:** In this chart program, the child is given the tokens for free. Tokens are withdrawn for inappropriate behavior (e.g., out of seat, off task, etc.). The most effective programs use both types of chart systems and work on a give-and-take basis. In this combination system, the child is given a token for behaving appropriately and loses a token when misbehaving.

When creating and implementing a behavior modification chart, you may wish to follow these suggestions:

- Make a list of problematic behaviors or ones that need improving.
- Select the behaviors to be modified. Parents (or teachers), with input from the child, review the list of problematic behaviors and select three, four, or five to work on at a given time. The behaviors charted should be ones that occur daily, such as going to bed on time, doing homework, or getting ready for school on time.
- Design a reward system (Token Economy, Response Cost, or a combination).
- Parents (or teachers) need to pay attention to the child's behavior throughout the course of the day and provide frequent rewards when the child behaves appropriately. At the end of the day, tokens can be exchanged for rewards, such as extended bedtime, playing a game with Mom or Dad, or a favorite snack.
- Remember, a reward is only effective when it has value to the child. Rewards might have to be changed frequently.

**A Word About Punishment**

Children with ADHD respond best to motivation and positive reinforcement. It is best to avoid punishment. When punishment is necessary, use it sparingly and with sensitivity. It is important that parents and teachers respond to a child's inappropriate behavior without anger and in a matter-of-fact way. These children need to be taught to replace inappropriate behavior with appropriate behavior.
Time-Outs

When the child is misbehaving or out of control, time-out is an effective way to manage the problem. Time-out means the child is sent to a predetermined location for a short period of time. A place out of the mainstream of activity is best; for example, one particular chair may be specified as the time-out chair. The time-out location should not be a traumatic place, such as a closet or dark basement. The purpose of time-out is to provide the child with a cooling-off period wherein he or she can regain control.

An important aspect of time-out is that the child no longer has the privilege of choosing where he or she would like to be or how time is spent. In general, the child stays in time-out and must be quiet for five minutes. Preschool-aged children are usually given two or three minutes in time-out. For toddlers, 30 seconds to a minute is appropriate.

Medication

Medication has proven effective for many children with ADHD. Most experts agree, however, that medication should never be the only treatment used. The parents’ decision to place a child on medication is a personal one and should be made after a thorough evaluation of the child has taken place and after careful consideration by both the parents and the physician.

Stimulants are the most widely prescribed medication ADHD. Drugs such as Ritalin® (the most commonly used), Dexedrine®, and Cylert® are believed to stimulate the action of the brain's neurotransmitters, which enables the brain to better regulate attention, impulse, and motor behavior. In general, the short-acting stimulant medications (e.g., Ritalin®, Dexedrine®) have only a few mild side effects. For children who cannot take stimulant drugs, anti-depressant medications or Clonidine® are used.

The prescribing physician should explain the benefits and drawbacks of medication to the parents and, when appropriate, to the child. Doses are generally administered gradually, so that the child receives the lowest dose needed to achieve the best therapeutic benefit. Parents should dispense the medication as prescribed and monitor closely how their child responds to it, noting any side effects. Such monitoring generally includes feedback from the child's teacher(s), which is usually based on the use of behavior rating scales. Parents should communicate with the physician as often as necessary to determine when medication has reached the proper level for the child, and to discuss any problems or questions.
A note of caution: Many parents and teachers have heard that megavitamins, chiropractic scalp massage, visual/ocular motor training, biofeedback, allergy treatments, and diets are useful treatments for ADHD. However, ADHD experts have not recommended these treatments for the simple reason that they have not stood up under careful scientific scrutiny. As their child's primary caregivers and advocates, parents need to become informed consumers and exercise caution when considering such treatments.

Educational Intervention

Many children with ADHD experience the greatest difficulty in school, where demands for attention and impulse and motor control are virtual requirements for success. Although ADHD does not interfere with the ability to learn, it does wreak havoc on performance. Thus, in the school arena, ADHD is an educational performance problem. When little or nothing is done to help these children improve their performance, over time they will evidence academic achievement problems. This underachievement is not the result of an inability to learn. It is caused by the cumulative effects of missing important blocks of information and skill development that build from lesson to lesson and from one school year to the next.

Generally, ADHD will affect the student in one or more of the following performance areas:

- Starting tasks
- Staying on task
- Completing tasks
- Making transitions
- Interacting with others
- Following through on directions
- Producing work at consistently normal levels
- Organizing multi-step tasks

Those who are teaching or designing programs for these students need to pinpoint where each student's difficulties occur. Otherwise, valuable intervention resources may be spent in areas where they are not critical. For example, one child with ADHD may have difficulty starting a task because the directions are not clear, while another student may fully understand the directions but have difficulty making transitions and, as a result, get stuck in the space where one task ends and another begins. With the first child, intervention needs to focus upon making directions clear and helping the child to understand those directions. The second child would need help in making transitions from one activity to another.
The sooner educational interventions begin, the better. They should be started when educational performance problems become evident and not delayed because the child is still holding his or her own on achievement tests.

Reprinted from National Information Center for Children and Youth with Disabilities (NICHCY) Briefing Paper, Revised Edition, October 1994. Write to NICHCY at PO Box 1492, Washington, DC 20013-1492; phone: 800/695-0285 or 202/884-8200 (Voice/TT); email: nichcy@aed.org
Chapter 5

Making ADHD Medication Decisions
by Debra Rubin Berger

One Family's Story

Amy Schneier of Needham, Massachusetts, didn’t want to put her son Adam on medication for his Attention-Deficit/Hyperactivity Disorder (ADHD) until his second-grade teacher suggested that it might help.

"I didn't want him to become reliant on medication," Amy says. However, Adam's teacher said that she couldn't read his writing, he was distracted, and, when recess ended and his peers knew how to calm down in class, he couldn't."

After consulting with a neurologist and hearing positive things about Ritalin, Amy and her husband Eliot decided Adam should try it. Although his behavior and academic performance improved after taking the medication, they discontinued it after six months when he complained of stomachaches, nausea, and sleeplessness.

It wasn’t until he got Cs and Ds as a freshman and sophomore in high school that Adam decided to go back on Ritalin. He proceeded to make honor roll in his junior year.

"Before Ritalin, I had a million thoughts in my head, and I couldn’t do any of them," Adam said. "I was struggling and overwhelmed. When school became more of a priority, I knew that Ritalin would help me concentrate."

Now a junior at St. Lawrence University in Canton, New York with a 2.6 grade point average, Adam has learned how to manage the side effects of Ritalin. He eats before taking Ritalin to help settle his stomach and doesn’t take it too late so that he can’t get to sleep.

Achieving success in school and learning how to manage his condition have helped Adam feel more positive about himself.

"There are pros and cons to having ADHD. Some things I’m better at than other people because I have ADHD, such as thinking faster than everyone else."

Using Medication

Deciding whether to put a child with ADHD on medication can be difficult for parents. Edward Hallowell, M.D., a child and adult psychiatrist who is co-author
of the bestseller *Driven to Distraction*, says that the most important part of the decision-making process is to seek competent medical guidance, and, if you choose medication, watch for side effects.

"Consult with the child’s pediatrician and a child psychiatrist who knows medication and can explain the pros and cons," says Hallowell. "Make the decision only when you have all the facts. If you decide on medication and your child complains of side effects, listen and discontinue it or lower the dosage. The most common reason given for dissatisfaction with medication is that the side effects weren’t being monitored."

Although not a cure, when used properly, medication helps 80 percent of individuals with ADHD, says Hallowell. The principal benefit is "mental focus" – being able to stay on track and not getting distracted. Medication, he said, should be part of a comprehensive treatment plan that includes non-medication approaches such as the following:

- Getting enough sleep, exercise, and a balanced diet
- Structuring a child’s life -- family dinners, regulating TV and video access
- Hiring a coach and tutor
- Getting organized -- working at a desk, learning how to do homework
- Managing time

**Asking the Right Questions**

When deciding whether to put your child on medication, Jerome Schultz, Ph.D., learning disabilities and ADHD expert for FamilyEducation.com and clinical director of the Learning Lab in Cambridge, Massachusetts, says you should first consider the following questions:

*Has my child been helped by non-medication approaches?* Self-calming techniques, deep breathing, and yoga often can help children with ADHD.

*Has the school tried to teach my child to be more attentive and less active?* Is the decision to put my child on medication the result of behavioral observations over time and in different settings, such as in school and at home?

*When is my child at his or her best?* Is it when he’s fishing with his uncle or playing video games? Help the physician understand how pervasive or selective the problem is.

*Does my child have other conditions that can be mistaken for hyperactivity?* Children who have been exposed to toxic chemicals or who have undiagnosed
learning disabilities and low-level anxiety disorder may produce similar behaviors.

**Consult these books for more information:**

- *Hallowell, E. M., Ratey, J., Driven to Distraction (Pantheon Books)*
- *Silver, L.B, Dr. Larry Silver's Advice to Parents on ADHD (American Psychiatric Press)*
- *Barkley, R. A., Taking Charge of ADHD (The Guilford Press)*
Chapter 6

Preschoolers and Drugs: How Young Is Too Young for Ritalin?

Should a two-year-old be given a stimulant like Ritalin?
Should a three-year-old be put on an anti-depressant like Prozac?

A 2000 study reported in the Journal of the American Medical Association (JAMA) found that the rate at which preschoolers were given such drugs doubled, perhaps even tripled, between 1991 and 1995. Researchers at the University of Maryland School of Pharmacy analyzed 200,000 preschoolers’ prescription records from two state Medicaid programs and an HMO in the Northwest over a five-year period. Among the findings:

- 1.5% of children between the ages of 2 and 4 received stimulants, anti-depressants, or other anti-psychotic drugs.

- In the Medicaid programs, the number of prescriptions for anti-depressants given to preschoolers more than doubled.

Although the researchers did not note the conditions children were being treated for, nor the training of the medical staff who prescribed the drugs, the study has been given serious attention because it suggests that nationally, as many as 150,000 children under age five may be taking the drugs. Many are commonly prescribed to older children diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD).

Yet the Food and Drug Administration has approved only a few of the medications for use with toddlers and preschoolers. Methylphenidate, the generic form of Ritalin, carries a warning against prescribing the drug to children under age six (although it is legal for physicians to do so).

“Unresolved questions involve the long-term safety of psychotropic medications (with this age group),” wrote the study’s lead author, Dr. Julie Magno Zito. “The possibility of adverse effects on the developing brain cannot be ruled out.”

Prescription for Debate

Some doctors have been alarmed by the study’s findings. Dr. Joseph Coyle, chairman of psychiatry at Harvard Medical School, warns that even the diagnosis of ADD/ADHD in very young children is considered questionable, let alone the effects of the drugs on a developing brain. Coyle is among those calling for “much more extensive studies to determine the long-range consequences” of the use of such drugs at young ages.
But Dr. Joseph Biederman, Chief of Pediatric Psychopharmacology at Massachusetts General Hospital in Boston, angrily dismisses the study and accuses its authors of having “an ideological bent.”

“The purpose of the study is to alarm the public,” Biederman insists. “When you have a three-year-old devastating the household, I don't see any reason why the three-year-old should not be treated. We’re talking about serious out-of-control behavior with some of these children, not one temper tantrum.”

Biederman, who reviewed Zito’s research prior to publication, points out that the study does not indicate what, if any, previous treatment the children had received.

“If a child has asthma, would you delay treatment until the child is twenty?” he asks. “If a child has a cavity, it needs to be filled, whether the child is four or ten.” Moira Munns, who is a registered pharmacist, the parent of a child with ADHD, and a member of the board of directors of the parent-run ADD Information Network, has mixed feelings about the study.

“I’m a little alarmed,” she admits. “I hope parents are working with competent professionals, because anytime you have people who are desperate, they are easily taken advantage of.”

Munns advises parents to “proceed cautiously” regarding medication to treat ADD and ADHD in children. Behavior management programs or early intervention programs, she notes, are “frequently very effective.” “Personally, I always feel that medication is not a best first step,” Munns says. “Better to try other things first.”

To read the AMA article online, visit http://jama.ama-assn.org. The article is titled: “Use of Psychotropic Agents in Preschool Children: Associated Symptoms, Diagnoses, and Health Care Service in a Health Maintenance Organization.”
Chapter 7

The ADHD Medications

Please note: This is a list of common medications used for ADHD -- not an exhaustive one. New medications are under development. FamilyEducation.com is not in a position to recommend these medications, or to influence any parental decision regarding medication. You will find more comprehensive information about these medications from RxList.com

Adderall®
Generic name: Amphetamine Mixed Salts
Medication form: Tablets
General information: Adderall® belongs to the class of drugs known as psychostimulants. It is used in the treatment of ADHD and narcolepsy.

Catapres®
Generic name: Clonidine
Medication form: Tablets
General information: Catapres® belongs to the family of drugs known as hyperintensives. While the drug is sometimes used to treat the symptoms of ADHD, the drug is primarily prescribed for the treatment of high blood pressure.

Concerta®
Generic name: Methylphenidate (XR)
Medication form: Tablets
General information: Concerta® belongs to the class of drugs known as psychostimulants. It is used in the treatment of ADHD and narcolepsy.

Cylert®
Generic name: Pemoline
Medication form: Tablets, Chewable Tablets
General information: Cylert® belongs to the family of drugs known as psychostimulants. It is most often used when other drugs do not work. It is also used in the treatment of narcolepsy.

Dexedrine®
Generic name: Dextroamphetamine
Medication form: Oral capsules
General information: Dexedrine® belongs to the family of drugs known as psychostimulants. It is used in the treatment of attention-deficit disorder with hyperactivity. It is also used in the treatment of narcolepsy.
**Metadate®**  
Generic name: Methylphenidate  
Medication form: Tablets or capsules  
General information: Metadate® belongs to the class of drugs known as psychostimulants. It is used in the treatment of ADHD and narcolepsy.

**Norpramin®**  
Generic name: Methylphenidate  
Medication form: Tablets or capsules  
General information: Metadate® belongs to the class of drugs known as psychostimulants. It is used in the treatment of ADHD and narcolepsy.

**Pamelor®**  
Generic name: Nortriptyline  
Medication form: Capsules  
General information: Pamelor® belongs to the class of drugs known as tricyclic antidepressants.

**Prozac®**  
Generic name: Fluoxetine  
Medication form: Tablets  
General information: Prozac® is best known for its effectiveness in treating depression and Obsessive Compulsive Disorder. It belongs to the family of drugs known as antidepressants.

**Ritalin®**  
Generic name: Methylphenidate (HCL)  
Medication form: Tablets  
General information: Ritalin® is the most commonly prescribed medication for treating the symptoms of ADHD. It belongs to the class of drugs known as psychostimulants.

**Tenex®**  
Generic name: Guanfacine  
Medication form: Tablets  
General information: Tenex® belongs to the class of drugs known as antihypertensives.

**Tofranil®**  
Generic name: Imipramine  
Medication form: Tablets  
General information: Tofranil® belongs to the class of drugs known as tricyclic antidepressants.
**Wellbutrin®**
Generic name: Bupropion  
Medication form: Tablets  
General information: Wellbutrin® belongs to the family of drugs known as antidepressants.

**Strattera™**
Generic name: Atomoxetine HCl  
Medication form: Capsules  
General information: Strattera™ is a selective norepinephrine reuptake inhibitor. It's the only non-controlled substance and non-stimulant medication approved for the treatment of ADHD.
Chapter 8

Expert Answers to Parent’s Questions

Meet Our Experts

Dr. Jerome Schultz, Ph.D., is the founding clinical director of the Learning Lab @ Lesley University, a program that provides assessment, tutoring, and case management services for children with learning challenges. A former classroom teacher, he is a licensed clinical neuropsychologist who maintained a private practice for over two decades prior to assuming his position at Lesley. Dr. Schultz holds a Ph.D. from Boston College, and has completed postdoctoral fellowships in both clinical psychology and pediatric neuropsychology. He has served on the faculty of Harvard Medical School and has been a consultant for Harvard on the development of a teaching module designed to sensitize young physicians to patients with special needs. Dr. Schultz serves as an international consultant on issues related to special education. He has created several award-winning videotapes, and has written many articles about LD and ADHD. Dr. Schultz is a former vice president of the board of the Learning Disabilities Association of Massachusetts.

Eileen Marzola, Ed.D., has worked with children and adults with learning disabilities and attention-deficit disorders, their parents, and their teachers for more than 20 years. She has been a regular education classroom teacher, a consultant teacher/resource teacher, an educational evaluator/diagnostician, and has taught graduate students at the university level. Dr. Marzola earned her doctorate in special education with a focus on learning disabilities from Teachers College, Columbia University. She has written for many professional publications, presented papers at national and international conferences, and conducted numerous staff development and parent workshops for those interested in improving instructional services for children and adults with learning disabilities and ADHD. Currently, Dr. Marzola is an adjunct assistant professor of education at Teachers College, Columbia University, and Hunter College of the City University of New York. She also maintains a private practice in the evaluation and teaching of children with learning disabilities and attention-deficit disorders. Dr. Marzola serves on the Board of Directors of the New York Branch of the International Dyslexia Association.

Dr. Henry Bernstein, D.O., is the associate chief of the Division of General Pediatrics and director of Primary Care at Children's Hospital, Boston. He also has an academic appointment at Harvard Medical School. Dr. Bernstein has extensive clinical experience as a primary-care pediatrician in a variety of settings: in private practice, at a health center, in a medically underserved area as a member of the National Health Service Corps, and in a children's hospital, where he teaches medical students, pediatric residents, and fellows.
How can I explain “ADHD” to my child?

**Question:** My seven-year-old takes Adderall for ADHD. He also has severe anxiety. How do I explain ADHD to him in terms that will not scare him or make him think that he's “sick”?

**Jerome Schulz, Ph.D.:** It is very important for all children with ADHD to have a good understanding about their medication. Many parents share your concern, so your question is one that will help others who are looking for an answer. The more your son understands about his condition and the medication, the more he can work with the medication to help it help him. Little kids can often relate to ADHD in terms of "putting on the brakes." Here's a way to make that concept real to your son. Take him to a paved playground or a safe parking lot and have him ride his bike, roller blade, or run toward a chalk line you draw on the pavement. Tell him to "hit the brakes" when he hits the line and see how much farther he goes after that. Draw a second chalk line where he stops. You can tell your child: "When kids have ADHD, they may have trouble putting on the brakes in their head. Sometimes they can't stop what they're doing. Sometimes it's even hard for them to stop thinking about something, so they keep on thinking about it over and over and over."

You can use the chalk lines to show him the "before medication" and "after medication" behaviors. Then have him act it out (putting on the brakes and stopping sooner, walking a straight vs. crooked line, etc.). After he does this well, you can ask him "Who was in charge of how you just did that?" Get him to say that HE was, since it's very important for kids to understand that the medication does not control them, and that they are not out of control when they don't take it. He needs to hear you say: "The medication helps you have more control of yourself. It gives your brain energy to help it put on the brakes better." If you can let the medication help you, then you can do a much better job in school. You can use your brain to think better, stop and start faster, and be more organized."

Here's another tip: At seven, your son should know what “add” (+) means. Write down the name of his medication (Adderall) and make the ADD in one color and the ALL in another color. Point out that he can remember that he takes it to ADD to his brainpower, to help him get ALL his work done on time. This will help him remember the name, and also create a positive association with the medication.

You mention that your child is very anxious. Make sure that your doctor knows this, and make sure that he/she or a psychiatrist rules out what’s called a "generalized anxiety disorder." This is one of the most under-diagnosed conditions in children. It is more common than we once thought, and has a devastating effect on young lives. Most importantly, it can be treated. Besides medications and therapy for this condition, you should consider yoga for children, biofeedback, and regular vigorous exercise.
Is Ritalin the Only Solution?

**Question:** My son has ADHD, and I’m really worried about giving him Ritalin®. Is there another solution?

**Jerome Schulz, Ph.D.:** I certainly understand your concern about having your son take Ritalin®. There are a lot of children who are taking this medication who probably should not be (both legally and illegally). Also, we live in a world in which parents and children hear constant warnings about the use of drugs. However, it’s important to know that Ritalin® (methylphenidate) has been used successfully in the treatment of ADHD for several decades, and is helpful in alleviating the symptoms of about 85 percent of the children and adults who take it. When the medication is properly prescribed and monitored, the effect is quite often dramatic, helping to make learning accessible for many children.

A problem with the use of medication is that too often it is given too quickly, without exploring other important ways to help a child with ADHD. First, parents and teachers have to determine whether it is the inattention, the hyperactivity, or a combination of these characteristics that is getting in your child's way. Then teachers have to make reasonable accommodations in the classroom (setting up the room to allow for "productive" movement; creating materials that captivate attention, etc.) At home, parents need to work as partners in the appropriate management of a child with ADHD. This may involve family therapy.

There are other treatments for ADHD, but none of the so-called alternative therapies is based on research that is solid enough or convincing enough to allow most traditional practitioners (physicians, psychiatrists, psychologists) to endorse these approaches. These include megadoses of vitamins and minerals, diet manipulations (including food -- additive-free, sugar-free, and yeast-free diets), and amino-acid therapy. Biofeedback has gotten a lot of press lately, although there is no specific pattern brain activity in those with ADHD. Other treatments that may have some merit include:

- Sensory integration (check with the occupational therapist at school)
- Exercise (talk with the adaptive physical education specialist)
- Self-monitoring (in which the child is taught how to "pay more attention to attention")
- Psychoeducationally oriented therapy (in which the child is helped to understand the impact of the ADHD on learning, behavior, and social relationships)

Behavior modification is a well-established treatment used in schools and at home to reward appropriate behavior, while ignoring (or at least not reinforcing) troublesome behaviors. However, this can be a very effective technique if a
child's environment can be controlled. This is often difficult or impossible (who can stop the other kids on the playground from laughing at -- and reinforcing -- a silly behavior?) Also, the use of behavior modification assumes that the behavior is learned and can be unlearned. A child with ADHD most often gets into trouble because he is impulsive and does things without thinking, not because he has learned to do them. He does learn that certain behaviors get responses that he likes, so he may do those again and again, but that's not really part of the ADHD per se. Also, many professionals feel that behavior modification is more effective for children with ADHD if it is used in conjunction with medication. That's because the medication allows the child to attend to the treatment!

Two books that will give you a lot more information about this important topic are:

- *Attention-Deficit/Hyperactivity Disorder: A Clinical Guide to Diagnosis & Treatment*, by Larry Silver, M.D.
- *Do We Really Need Ritalin? A Family Guide to Attention Deficit Hyperactivity Disorder (ADHD)*, by Josephine Wright, M.D.
Should my five-year-old be tested for ADD or ADHD now?

**Question:** I have some concerns about my five-year-old son’s behavior. He’s in preschool, and I think he may be ADD or ADHD. His doctor doesn’t seem to want to do anything about it until he’s in kindergarten. I feel that getting on top of the situation now will make kindergarten better for him and his teacher. Do all ADD/ADHD children have to be on Ritalin? Are there other effective ways of managing them? I feel like I’m always yelling at him to calm down, and he never does. I just want to have a good relationship with my kids. I’m at my wit’s end.

**Eileen Marzola, Ed.D.:** Your concerns are certainly understandable. It’s not at all unusual for parents to suspect that their preschooler might be exhibiting signs of ADHD. In fact, in detailing the diagnostic criteria for ADHD, *The Diagnostic and Statistical Manual of Mental Disorders* notes that, to be considered ADHD, the symptoms must be present before the age of seven years, persist for at least six months, and be "inconsistent with a child's developmental level."

Unfortunately, diagnosis of ADHD is not an exact science. There isn’t one sure test to make an absolute judgment about the presence or absence of the condition. Diagnosis is particularly challenging when viewing young children. Youngsters mature at different rates and there is a range of what might be considered "normal." Normal differences in temperament, personality, and energy level may lead some to label a child as ADHD when he is merely immature or just exuberant. However, that said, a clinician with a strong background in normal development as well as ADHD can help to tease out whether your child fits the criteria and might need some direct intervention at this point.

Not all young children diagnosed with ADHD have to be medicated. Many times a behavioral intervention plan monitored by a professional has a significant impact. If your pediatrician is not willing to give you a referral for an evaluation for ADHD, try contacting Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) at 1-800-233-4050. This parent advocacy group has branches throughout the country and is an excellent resource for parents and professionals. They should be able to help you to make a connection with a professional who can give you some guidance and support. Some branches even sponsor parent education groups that can help you to learn new strategies for coping with your child’s behavior. Equally important, they will give you an opportunity to share concerns and ideas with other parents who are in the same situation as you. You might also want to read *Dr. Larry Silver’s Advice to Parents on ADHD* (Times Books, 1999). This excellent resource guides parents on how to handle behavior problems.
You are right to try to get a handle on your child's needs while he is still very young. Early intervention can help to make your child's adjustment to kindergarten a smoother one.
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What are the pros and cons of Ritalin?

**Question:** What are the pros and cons of children taking Ritalin? What are some of the long-term side effects? How long does a child stay on it, and who decides when the child will discontinue taking it?

**Dr. Henry Bernstein:** Many parents -- and teachers -- have questions about attentional difficulties, including what they are, how to treat them, and for how long.

Attention-Deficit/Hyperactivity Disorder (ADHD) is the most common behavioral disorder diagnosed in childhood and adolescents. A child with ADHD has problems with attention and with controlling impulses, but may or may not display hyperactivity. There are specific criteria used to make the diagnosis, but there is no cure. Treatment involves more than just medication; behavior modification and supportive counseling are equally important.

The decision to use any medication must be made jointly by the physician, family, and child. It is important to be familiar with the medications, how to give them, what their side effects are, and how well they are helping the child. I will focus here on methylphenidate (Ritalin), as you have asked, although this general approach could be applied to the use of any of the stimulant medications.

Methylphenidate (Ritalin) is the most popular stimulant medicine. It comes in short-acting and long-acting forms, and can given every day or only on school days. Some of the side effects experienced with it include decreased appetite, insomnia, stomachache, headache, mood swings, and nervous movements (tics). Although these are a frequent concern, they are not usually enough to stop the medication. There may be some differences between brand name and generic.

When first beginning to use methylphenidate, it’s important to have an initial trial period of several weeks to closely monitor the positive and negative effects. Using it does not require any regular blood tests. Parents and teachers need to observe the child's behavior on it and report to the physician, usually using a questionnaire. Then a decision can be made whether to continue it, change the dose, or consider a different medication.

Once a child settles into the medication, monitoring should take place every three months. A mean improvement of 75% has been reported, although each child’s response differs. How long to use methylphenidate must also be individualized to each child. Since this disorder can persist into adolescence and adulthood, a child should be followed over long periods so that adjustments can be made as needed to help that child reach his or her full potential.
Everyone’s rushing to medicate kids. Are we creating a generation of drug addicts?

Question: I have a problem with the current ADHD hysteria. It seems as though we’re creating a generation of drug addicts! It is normal for children under the age of seven to lose things, talk a lot, and find it difficult to sit still. It's cause for concern if a child is quiet and slow! We need to discourage parents from putting their children on drugs. It seems to me that lots of teachers aren’t doing their jobs, by encouraging parents to medicate their kids. If they don’t have the patience to teach, perhaps they are in the wrong profession.

Dr. Shultz, Ph.D.: I can understand why you have such strong feelings about this issue. As a professional, I know that this condition (ADHD) exists. I've sat at this crossroads long enough to know that there are kids who have such a difficult time focusing and sustaining attention, and who are so impulsive, that they will have a very hard time handling the tasks of school and life.

Don't be so quick to blast teachers, for the problem is not that simple.

Fortunately, some teachers are trained to "spot" ADHD, make appropriate referrals, and create effective research-based interventions. However, I do think that these teachers are still in a minority. I believe that schools have to do a better job of understanding the difference between active little kids and those who have neurologically based problems with attention, hyperactivity, and impulse control. More teachers have to be better educated in college and on the job so that they can provide the kind of environment these kids need to be successful. Teachers have to be able to tolerate (accept) a wide range of behaviors from children, so they won't jump to conclusions and "pathologize" behaviors that are developmentally normal.

While it's not accurate to say that we are creating a nation of "drug addicts," this is a very big problem that needs to be corrected. I also know that many children who are appropriately diagnosed benefit from medications that have very few side effects, if any. We finally have available a technique that can differentiate the brain function of those children with ADHD from those who don't have this condition: we use magnetic resonance imaging (MRI) devices, which monitor the uptake of certain chemicals in the brain. However, this procedure is expensive and is currently used only in experimental studies, so it isn’t widely available. The future holds great promise for more objective diagnosis of ADHD, but in the meantime, the best available diagnostic practices must be employed. Appropriate diagnosis has to involve:

• Taking a thorough developmental and family history
Analyzing Problems
Different problems require different approaches. Being able to determine what types of problems you’re dealing with will help you solve them. Before you jump in, take a look at the descriptions of the different types of problems you’ll be analyzing. You may find it helpful to refer to this page and its tips as you go through the worksheets.

Introduction to Problem Solving
Word problems can be intimidating. But don’t let them get you down! Just try to approach each problem slowly, breaking it down into these four steps:

1. Understand – What do you know? What do you need to find out?
2. Plan – Identify what you need to do.
4. Look back – Check your work.

Learning to use these steps automatically can really help reduce some of the stress of solving word problems.

Choose an Operation
“Choosing an operation” just means figuring out whether to use addition, subtraction, multiplication, or division to solve a problem. Finding the “main action” in the problem will give you the clues you need to choose the right operation. To find the main action, look for the question that’s being asked. For example, when a problem asks you to compare, take away, or find a missing part, you should subtract. When you’re asked to put things together, you should add.

Exact or Estimate?
Some problems don’t need an exact answer…sometimes an estimate will do! You’d use an estimate to talk about the number of words or letters in a book because there are too many to count. You’d use an exact number to talk about the score of a baseball game because you need an exact score to determine the winner. The words “about” or “plan” in a problem indicate an estimate: About how many people could you serve? Or how many pies should she plan to bake?

Multiple-Step Problems
Before attempting to solve any word problem, you should always read through it at least twice. Then make a list of details. To solve a multi-step problem, you must first identify the “main idea,” or what you’re expected to find. (This info usually appears at the end of the problem.) Then it’s all about collecting the details, identifying the steps, and solving them in the right order.

Too Much or Too Little Information?
You can solve problems when you have too much information, but you can’t solve problems with too little information. How can you tell the difference? It’s all in the details! Here are some tips:

• Read the problem slowly and more than once.
• Underline what you’re being asked to find.
• Circle the information that you need to solve the problem.
• Cross out any information that you don’t need.

And keep in mind that you may not realize that a problem has too little information until you get to the “plan” or “solve” step.

Overestimating and Underestimating
Overestimating means making a good guess that’s greater than the exact answer to a problem. Underestimating means making a good guess that’s less than the exact answer. You overestimate when you want to make sure you have enough of something, such as time or money. You underestimate when you want to find a safe limit, such as a weight limit. Ask yourself these questions when tackling this type of problem:

• How would you plan to solve the problem without estimating?
• What would happen if you overestimated?
• What would happen if you underestimated?

Interpreting Remainders
A remainder is what’s left over when you divide. Whether you’re divvying up pizza or allowances, you’ve got to know if those leftovers matter! Sometimes you need to consider remainders to solve a problem, but sometimes you don’t. Drawing pictures or using counters (beans, coins, etc.) can help you “see” when remainders matter and when they don’t.
Choosing the Right Strategy
Good problem solvers always have more than one strategy at the ready. Stuff a few of these tactics up your sleeve, and you’ll be on your way to solving all types of problems. You may find it helpful to refer to this page and its tips as you go through the worksheets.

Guess and Check
The guess and check method comes in most handy when working a problem that doesn’t give you all the information you need to solve it. You have to “guess” and then “check” your answer against a fact you already know. Keep in mind that words like “sum” and “together” mean use addition. The word “difference” means use subtraction. Take ___ + ___ = 19, for example. Say you know that the difference between the two addends is 11. You can guess until you hit on 15 + 4. It’s the right answer because their sum is 19, and their difference is 11.

Make an Organized List
When tackling word problems, listing pairs of information in an organized way can help you make sure that you’ve found all the possibilities and don’t have any duplications. List all the possible combinations for one item before you move on to the next. This will help you begin to identify patterns. Try writing the item abbreviations in a row (A, H, C, S, W). Take the first letter and pair it with all the letters that follow it in the row. Write down the pairs. Then take the second letter and pair it with all the letters that follow it, and so on until you reach the last letter.

Look for a Pattern
Patterns are all around us – in artwork, music, science, and in our behavior! And wherever there’s a pattern, there’s a rule. A “rule” describes what you do to each element in a pattern to get to the next element: Add 2, Subtract 3, etc. Be sure to read through the whole pattern at least once before you determine the rule.

Make a Table
When it comes to word problems, tables are your friends! If you’re solving a problem that involves a pattern – how many beads in a necklace, patches in a quilt, or tiles on the floor – a table can help you find the relationship between the numbers. Remember to approach each word problem slowly – step-by-step. Read through it at least twice before beginning the table. Making a drawing for each problem will also really help you “see” what each table represents.

Draw a Picture
When you’re solving a problem that involves the position of something and how it relates to other things – like runners in a race or seats in a theater – drawing pictures can really help. Read each problem through a couple of times before making a list of details and “positional” words, such as ahead, behind, right, left, etc. This information will be crucial to the picture you draw.

Work Backward
Working backward is a good method to use when a key bit of information falls at the end of a word problem. Take that information and reverse or “undo” the actions described in the problem to find the answer.

Use Objects/Act it Out
Using objects to solve a problem is a good approach if you’re being asked to place information in order or to make various combinations. Each object can represent one piece of information in the problem, and you can move the objects around to find an answer.

Use Logical Reasoning
A little logic will go a long way! Logical reasoning problems in fourth grade tend to be set up with the “clues” to the problem called out in bullets. The trick here is to find the main thing that you’re solving for, and then apply a little “if… then…” logic to the clues.

Solve a Simpler Problem
You’ve already covered how to look for a pattern to solve a problem. Now, you just need to take what you’ve learned and run with it! In tough problems, patterns can get complicated. The key to solving these problems is to find a simpler pattern first. Once you find the “rule” to that pattern, you can use it to solve the whole problem.
Making a Good Decision

Decisions, decisions… Here are some problems that you might encounter in your everyday life. Keep in mind that many of these problems don’t necessarily have a right or a wrong answer. Your job? Come up with a reasonable solution. Before you jump in, take a look at the following descriptions of the kinds of decision-making problems you’ll be tackling. You may find it helpful to refer to this page and its tips as you go through the worksheets.

Scheduling Time

To make a schedule, you need to have a good understanding of how time passes (how minutes relate to hours, how many hours there are in a day, etc.). If you’re having a hard time organizing a schedule, you may need a refresher on figuring out elapsed time (how long something takes). You can figure out elapsed time by counting the hours between two times and then counting the minutes.

Raising Money

To figure out how to rake in lots of cash, you need to sort through lots of facts first. Then figure out which facts are important, and organize them in a way that helps you solve the problem. Making a chart can help. Remember to approach each problem slowly – step-by-step. And keep in mind that you may need to make more than one chart to organize all the facts.

Finding the Greatest Area

To frame a picture, fence in a yard, or build a clubhouse, you need to know how to find both the perimeter and area of a rectangle. To find the perimeter of a rectangle, add the lengths of all 4 sides together. To find the area, multiply the length times the width. And remember, rectangles can have the same perimeters, but different areas!

Finding the Distance

When you’re trying to find the distance around a racetrack, be aware that the outside lane will always cover a greater distance than the inside lane. With that in mind, you can figure out where to position the start lines for each runner.
How young is too young for ADHD medication?

**Question:** My 3-year-old daughter was diagnosed with ADHD at 20 months. How old does she have to be before she can begin taking medication for this?

**Dr. Henry Bernstein:** ADHD can be a difficult and frustrating condition to deal with for parents, teachers, and, most of all, for the kids who have it. There are many ways to approach the treatment of a child with ADHD, and medicine alone is not enough. In short, most experts agree that medication should not be the first choice of therapy for preschool-aged children. Although stimulant medications are the most common and effectively used drugs to treat children with ADHD, the American Academy of Pediatrics (AAP) takes the position that these medications should not be used with preschool-aged children until parents have received appropriate counseling on behavior management techniques. It is believed that preschool-aged children with ADHD generally respond nicely with behavioral interventions.

The AAP does, however, note that medication can be used with this age group if it “becomes evident that the child’s behavior cannot be managed by experienced teachers in a preschool or nursery setting.” Therefore, it is important that you and your family meet with both your child’s physician and the specialists in your child’s school system to determine whether drug treatment is prudent at this time. It is possible that there are behavioral management strategies that have yet to be tried, or that your daughter could be placed in a more specialized educational environment. If all of the behavioral strategies have been maximized, medication might then be an option for your daughter. Whatever the final decision on medication is, it should be a decision that everyone makes together, in the best interests of your daughter.