FACTSHEET on Boys and ADHD

We have written this factsheet for parents, partly because of increased concerns about the number of children being diagnosed with ADHD and partly because there are nearly five times more boys diagnosed with ADHD than girls and almost all children under the age of eleven with ADHD are boys.

Parents have some tough decisions to make if their son has some of the symptoms. This factsheet will help them make these [1].

How many?

The number of children (aged from six to sixteen) diagnosed with Attention Deficit Hyperactivity Disorder is about 370,000, with close to 350,000 being given Ritalin (or other psycho-stimulant medication) [2].

The dramatic increase in the last ten years, has been put down by some to increased awareness of the symptoms and improved detection, while others suggest the climbing numbers are due to poor or incorrect diagnoses. There have even been suggestions that some parents and / or schools welcome positive diagnoses as they bring benefits and increased financial resources.

What is ADHD?

Three related areas make up the symptoms of ADHD. They are: *hyperactivity* (fidgety, leaves seat, talks excessively); *impulsivity* (blurts out answers, interrupts); and *inattention* (careless mistakes, easily distracted, forgetful). All three of these are common in most children of course and even less of a surprise in most boys. So this isn't simply about whether children are restless, inattentive, easily distracted or impulsive, but more about *how much and how often* the symptoms can be seen. If your son has days where he is on the move and can't settle, BUT also has days where he is more settled, he is unlikely to have ADHD.

If he shows all of these symptoms with you at home, but when he is at his grandparents he is a bit of a handful, but behaves for them, then he probably doesn't have ADHD. This is because if he has ADHD the symptoms will show wherever he is (because they are inside him and not determined by his surroundings). In fact the person carrying out the assessment will need to observe him in at least two different places (usually home and school) to ensure that the same symptoms can be seen.

It has been suggested that there are up to thirty other conditions that 'look like' ADHD and that these can lead to misdiagnosis (these include hearing difficulties, allergies and sleep-related problems).

When children are being diagnosed, the symptoms also need to be seen over the course of at least six months. This is because symptoms can be brought on by an event and can disappear as quickly as they arrived.

Not all children have ADHD to the same level. The professional giving the diagnosis will determine whether it is mild, moderate or severe, usually basing his or her judgment on the volume and number of symptoms and the impact on the child's social, educational and emotional development.

What causes ADHD?

No one has come up with a precise cause for ADHD. Most agree that it is a brain-based disorder and studies have suggested that it could be related to premature birth; the mother smoking, drinking or taking drugs during pregnancy; a brain injury; food additives; a close family member having it; a complex interaction of genetic and environmental factors; lower activity in the brain's frontal lobes (lower levels of dopamine and similar neurotransmitters); or simply poor sleep.

How is it assessed?

Concerns of parents and / or schools often result in a visit to a GP who will then refer the child to a psychiatrist, a pediatrician (with expertise in ADHD) or the local CAMHS (children and adolescent mental health services).

Unlike many conditions, there is no blood test or brain scan. Assessment is based on observations of the child and a checklist of behaviour. There will be a physical examination (to eliminate other medical causes) and interviews with the child and parents / carers. The behavior checklist is based on internationally accepted symptoms where professionals and often the parents are asked to say whether and how often the child shows certain behaviours ('never', 'sometimes', 'often' and 'very often'). Questions are, for example: 'Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities', or 'Often leaves seat in classroom or in other situations in which remaining seated is expected.'

A professional carrying out an assessment will also take into account the age of the child and what behaviour would be expected from a child of that age. The ability to give close detail and sit still varies significantly for children of different ages.

Even if a child is thought to have ADHD, the professional will determine where he / she fits on a very broad spectrum. This ranges from 'mild' to 'severe' and whether all three areas of concern stand out (hyperactivity, impulsivity and inattention).

Boys are more likely to be hyperactive and impulsive, while girls tend to be inattentive (this accounts for the average age for diagnosis of girls being much higher,

because parents and teachers are thought to notice poor concentration and inattentiveness at secondary rather than primary school).

What concerns have there been?

There have been concerns about over-diagnosis and also misdiagnosis. It is a worry that some parents over-stating symptoms, partly because of having to deal with the child every day. There is a fear that some professionals fail to carry out the assessment process (for example, not observing in two settings). Some commentators have been concerned that there has been too much reliance on parents' perceptions of their child's behaviour – the belief is that they are seeking a positive assessment at least in part because of the financial benefits that might follow. There are also concerns generally about over-medication of especially small children. Ritalin, the main drug on the market for ADHD, has a structure similar to amphetamines and, with very few studies looking at the long-term effects of this type of medication; serious concerns have been raised about prescribing the drug for use with children.

Treatment goals

The aim of treatment is not to 'cure' ADHD, but to reduce the symptoms so that a child's social, educational and emotional development can continue as normally as possible. Whether the treatment is medication, a parenting programme or a talk / skills-based approach with the child, its effectiveness has to be measured against whether the symptoms have reduced.

Treatment by medication

Medication is the usual treatment with trade named drugs such as Ritalin, Concerta and Equasym being the most common. For school-aged children slow-release tablets are used (so that only one will have to be taken each day) and very small doses will be given. These doses will be built up until the symptoms reduce (a process that can take several months).

Drugs are thought to stimulate the frontal lobes and generate more dopamine, which leads to increased brain activity and increased concentration. If effective this should allow the child to manage school and home life normally.

There are a range of common side effects including reduced appetite, weight loss, sleeping problems, headaches, stomach pain, irritability and nausea. There can be some more extreme (but less common) side effects such as feeling depressed and liver damage.

If medication is given, this needs to be very closely monitored to enable the right dosage to be established. The National Institute for Clinical Excellence guidelines [3] suggests that there should be a six-monthly review where medication is stopped in order to see whether the symptoms have reduced. Children sometimes grow out of the symptoms in their mid-teens, but recent studies have shown that the numbers who still have the symptoms into their twenties is increasing.

Other treatments

The NICE guidelines also recommend that at least two approaches be used (not just medication). While there is a broad range of treatments on offer, evaluations of these are poor and only three types are thought to be effective. They are parenting training; teacher support programmes; or individual or group-based (cognitive, behavioral therapy and / or social skills) support for the child. In younger children, where symptoms are mild, then non-medicinal approaches are usually tried first and can be effective.

Further reading

NICE clinical guidelines CG72 (2008) *Attention Deficit Hyperactivity Disorder: diagnosis and management of ADHD in children, young people and adults.*

http://www.adhdtraining.co.uk/
A website aimed at professionals, but accessible.

There are a number of other websites targeted at parents of children and others. See for example www.addiss.co.uk.

Notes

[1] This factsheet aims to give parents general information about ADHD, and is not intended to be used as a tool to determine whether or not your child has ADHD.

[2] While ADHD is the most common terminology; in the UK Hyperkinetic Disorder is a broadly similar condition. The behaviour checklist used to assess ADHD comes from the American Diagnostic and Statistical Manual (DSM-IV), while the International Classification of Diseases 10 (ICD-10), produced by the World Health Organisation (WHO, 1992), is used to assess Hyperkinetic Disorder.

[3] The NICE guidelines produced in 2008 recommend the standard that all professional services need to be delivered.

Boys' Development Project

BDP develops projects and programmes targeted at boys and young men and their families. The organisation provides consultancy and training to professionals who want to develop their work with boys, young men and their families and carries out research and investigations that will add to the growing body of knowledge.

Trefor Lloyd of the Boys' Development Project wrote this factsheet, and there are regular workshops for parents to discuss the impact of ADHD on their sons. BDP can be contacted on 0207 732 9409 or tlloyd@ boysdevelopmentproject.org.uk.

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