The A.D.D. Guidebook

A Comprehensive, Self-Directed Guide to
Addressing Attentional Concerns
in Adults and Children

Dr. Teeya Scholten
Registered Psychologist

Part of The "Good News About A.D.D." Series

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A Comprehensive, Self-Directed Guide to Addressing Attentional Concerns in Adults and Children

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Dr. Teeya Scholten, R. Psych.

author of the
Good News About A.D.D. Series

The books in this series are:

- **"Attention Deluxe Dimension": A Wholistic Approach to A.D.D.**
- **The A.D.D Guidebook: A Comprehensive Self-Directed Guide to Addressing Attentional Concerns in Adults and Children**
- **Welcome to the Channel Surfers' Club!**
- **Riding the Wave: Behavior Management for Parents of Children with A.D.D.**
- **Turning the Tides: Teaching the Student with A.D.D.**
- **Overcoming Depression: Wholistic Strategies that Work**

May the Source of all wisdom guide you on your journey ...

Preface

A.D.D. is a part of my core self. I can accomplish a great many things in no time … if I have the time and space. I never thought of my ability to flit from topic to topic and let my imagination soar as problems. Of course, that was when I was in the company of other people with A.D.D.

I never really identified myself as having a problem until others, like pretty well all of my teachers, found me to be a puzzling pain. My educational history is very similar to Teeya's Story (page 193) but, unfortunately, I didn't get much support, if any. Strangely, my mother paid for me to go through a battery of standardized tests (I viewed that as not a great vote of confidence from her) to find I was sort of average and, probably, quite maladjusted. I persevered regardless, and continued to challenge myself, obtaining an undergrad degree, then Masters degree and finally my Ph.D. Lots of people were surprised by my achievements but I just stumbled my way into things that interested me.

I met Dr. Teeya at an agency where both of us worked. She and I could keep pace in conversation and I loved her humor and perspective on psychology. Then I heard her message about ADD as good news. I was intrigued – were all those teachers just wrong about my abilities and behavior? Sadly, they didn't understand and also sadly no one was able to provide insight to me … until I met Teeya.

I was relieved to find positive qualities in A.D.D. and that it wasn't necessarily a disability. I really have never considered myself disabled, just different and often a square peg that just didn't fit anywhere in particular.

Through Dr. Teeya and her writing, I found that I really did have positive, valued qualities. After she helped me understand how things affect my attention and some of the adaptive strategies (as well as some marginally maladaptive ones) that I used, my internal life and feelings about myself felt a lot more comfortable. I discovered that I was a lot brighter than everyone led me to believe. I really was smart but I had attention difficulties and was depressed and anxious – nobody understood!!

I am a research 'junkie' in that I regularly check studies as they're published. Twenty years ago when Teeya was talking about the impact of food allergies and sensitivities on attention and mood, it was treated with skepticism. Research in just the past few years is supporting everything she's talked about for more than twenty years.

Diagnosis of A.D.D. has generated heated discussion over the years. Dr. Teeya cleverly brought clarity to the different expressions of A.D.D. – not everyone with

A.D.D. looks the same. She sorted through different learning disabilities and how they can be entwined with A.D.D. She showed how personality type allows A.D.D to express itself differently and how some types were more likely to be diagnosed than others.

I am thrilled that she is making this book more widely available. Now more people can see A.D.D. for what it is and how it's expressed. There are many positive things about having A.D.D. and many concrete steps you can take to make life better.

Heather MacKenzie, Ph.D.

A Note about this Updated 5th Edition

A new edition of *The A.D.D. Guidebook*, marking the twentieth anniversary of its initial publication in 1998, provides an opportunity to update parts of the book on the basis of the experience we have gained over these past twenty years. The Empowerment Plus® model has been refined and we have had an opportunity to conduct research on its cost-effectiveness on over 1,000 clients within my own private practice and that of colleagues who were working under my supervision.

We have learned how important it is to differentiate how one is performing when feeling *interested* and *not interested* in certain activities when assessing attention challenges and evaluating intervention strategies. We have also learned how to understand a client as a whole person, which foods to eliminate from one's diet for a week, and how to conduct a medication trial which avoids side effects.

Although there is much more interest now in taking a positive approach to A.D.D., there is still a need for guidance on how to deal with the realities of the many challenges faced by the ADDer and his/her family. *The A.D.D. Guidebook* continues to offer hope and guidance for professionals as well as for adults and parents of children who want cost-effective help with attention concerns.

Dr. Teeya Scholten
Calgary, Alberta
May 2018

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Acknowledgments

So many people have contributed to my personal and professional development and this in turn, has formed the basis of the opinions expressed in this book.

My parents, Major Helen K. Rankin and Lt. Col. Glen Rankin, who were both officers in the Canadian army and over 40 years of age when they had their children: I am grateful for their love and encouragement. I am certain that the structured environment which they provided helped me to succeed. My mother, in particular, deserves very special credit. She believed in me, fought for me and ensured that I had the skills I needed, even when the school system thought I would never make it beyond Grade 8! In Teeya's Story (p.193), you can read more about my personal journey, if you like. Finding out about my own "brain sensitivity" to wheat and milk products was an answer to prayer, in my opinion.

Dr. David Randall, who was my first mentor and to Dr. Solveiga Miezitis who taught me about the power of consultation.

My friends and neighbors, clients and co-workers and the many other professionals who work and write in the area of A.D.D. To Dr. Mel Levine, Dr. Russell Barkley and Dr. Geraldine Farrelly who have so graciously allowed me to use material which they have developed. It certainly has allowed *The A.D.D. Guidebook* to become a compilation of innumerable years of collective personal and professional experience.

All of the innovators in the field of ADD: I wish you continued success and look forward to seeing how your contributions enable the field to develop.

All of my clients and colleagues who participated in the Empowerment Plus® approach: I have learned so much through our work together. To Dr. Heather MacKenzie, Dr. Ilze Matiss, Vivian Jones and my very own daughter, Christin Scholten and the many others who have been such champions and supporters in so many ways over the years.

Particular thanks goes out to John Breeze editor and designer for his incredible perseverance in bringing the new 2018 editions of all of my books to fruition. Also to Elissa Oman who helped to make *Teeya's Story* so engaging.

Lastly, my most wonderful husband, Nico Scholten, who continues to so graciously tolerate the excitement of my latest *obsession*. Thank you for providing the most gentle and accepting love possible, along with encouragement and wisdom throughout all (now more than 45 years!) of our marriage. I feel truly blessed to be able to journey with such a supportive partner.

Introduction – How to use this book

Why did I write this guidebook?

I wrote this guidebook in order to share the information I have learned in over 25 years of practice with people who want to help themselves and/or their children. Mental health professionals may also find it to be a valuable resource. The need for information on A.D.D.[1] is very great and is increasing every year. I have developed an integrative approach which I am calling the Empowerment Plus® model. It seems to work well and I want to share it with others. I can't get to everyone on my own, nor can everyone afford to see a psychologist privately. Nor does everyone HAVE to see someone else in order to help themselves. It is designed to help you explore many other factors which affect attention. If you have explored ALL of these and you still have concerns, it may be time to seek a professional who can make a diagnosis and/or assist you in understanding your needs. ***This book is NOT intended for you as a layperson to be able to make a diagnosis of A.D.D.***

My hope in writing this book is that you will be able to help yourself. You may even find that you are able to educate those around you - friends, co-workers and professionals, alike.

The contents of *The A.D.D. Guidebook* is a summary of what I did with my clients. Many of the ideas expressed in this publication are commonly accepted, but others are still somewhat controversial. They are all supported by various authors in the field, but do not seem to be commonly practiced by the majority of practitioners at this point in time (2018). All of the information contained in this book has been tried and tested with my own clients and those of other colleagues whom I have trained in the Empowerment Plus® method. Still, I encourage you to follow ***your own instincts*** about what you feel may be helpful to you.

The A.D.D. Guidebook offers an overview of factors which affect A.D.D. and strategies for addressing attentional concerns. YOU CAN CHOOSE which factors you wish to explore first.

[1] A.D.D. is used in this book to refer to Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder, and *Attention Deluxe Dimension* as explained on page xiii.

Diagnosing and Treating A.D.D. can be a challenge ...

The process of diagnosing and treating concerns about attention can be a difficult one. When you first become aware of symptoms of

- **distractibility**
- **impulsivity**
- **restlessness**

you may not know whether your symptoms are due to A.D.D. or to something else. If you wonder how serious a concern this might be for you, you may wish to turn to the *Screening Checklist for Attentional Concerns* (p.13), to see how many of these characteristics you have, particularly when you are NOT interested in the activity. If you have been like this ever since you can remember, maybe you do have A.D.D. But there could also be emotional, physical or personality factors that are causing some of your concerns. If your attentional concerns have just appeared lately, or seemed to begin after a major crisis in your life, then there is a strong chance that your attentional symptoms might be due to something other than what we call A.D.D.

Whatever the cause of your concerns, this book may be helpful to you ...

Whatever the cause of your attentional concerns, this book may be helpful to you in understanding how your attention is affecting the way you think and in providing you with ideas about ways to help yourself. ***But it is always important to rule out physical or emotional causes. If they are treated properly, your attentional symptoms might just be eliminated.*** Your family doctor should be able to help you with this.

Let's say that you think that you have A.D.D ....

If you think you may have A.D.D., the process of getting the appropriate help is often further complicated by controversy and sensationalism. ***It can be difficult to know where to begin and what to believe***. By giving you the facts, as I see them, I hope that you will be able to sort out fact from fiction.

A comprehensive assessment for A.D.D. can also be a very expensive undertaking, if done properly. However, a full psycho-educational assessment may not be necessary for everyone with A.D.D. Education and self-awareness MAY be all that is required to address your concerns. That's what this guide is all about.

Education and self-awareness MAY be all that is needed for you to address your concerns about A.D.D.

What is the purpose of this guidebook?

- to provide information on the factors which I believe SHOULD be explored in investigating A.D.D.
- as a personal guide to help YOU decide HOW you wish to explore A.D.D.
- to help you, when seeking professional assistance, to be AWARE of the kind of questions to ask and to ensure that the services are being provided in a comprehensive manner.
- to EMPOWER professionals and laypersons alike in the journey towards understanding and making the most of A.D.D. This guidebook and the tools and strategies contained in it may be all you need for yourself, your child or your patient/client to address attentional concerns.
- as a FIRST STEP in the exploration of your concerns regarding attention. The intention of this guidebook is **NOT to replace medical or psychological opinion**, comprehensive assessment, diagnosis or treatment for A.D.D., learning or physical concerns. It **IS** designed **to see how far you can go in helping yourself**.
- to guide you in the use of medication. Medication can be a valuable tool for treating A.D.D., but it may not always be necessary. If you choose to try medication, **The Farrelly Protocol** is a prudent way to identify the least amount of medication necessary to provide maximum benefits and minimum side effects.

The *A.D.D. Guidebook* is intended as a road map, to guide you on your journey of exploring ADD.

Some special symbols or icons have been used to help you to find what you need.

WHEN TO USE ...

tells you WHEN a particular tool might be helpful.

HOW TO USE...

tells you HOW to use the information to help yourself.

WRITE DOWN...

provides you with an opportunity to record your ideas, thoughts or information on local community resources which you may wish to access at some point.

MORE ABOUT ...

tells you about how to access further information in a particular area.

All of these symbols are part of your road map to discovering the "GOOD NEWS about A.D.D."!

If you are in need of a comprehensive assessment, please contact your local CHADD[2] or Learning Disabilities Association for the names of agencies or practitioners in your area who are qualified to diagnose and treat A.D.D.

Is this guidebook about "Attention Deficit Disorder"?

Yes, but I have intentionally NOT used the term Attention Deficit Disorder (A.D.D.) or the official term Attention Deficit Hyperactivity Disorder (ADHD) because I feel that it offers a limited view, based on deficits and pathology. (I use it in psychological reports or official records, however, and at other times when an "official diagnosis" is needed!) I do not use it with my clients. Throughout this publication, I refer to ***A**ttention **D**eluxe **D**imension*.[3]

The term *Attention Deluxe Dimension* originated several years ago, when I decided that I could no longer look another young child in the eye and say, "You have Attention Deficit Disorder." Life is too short. Labels can be too devastating. Sometimes, labels CAN serve a purpose, if they help us know how to treat concerns. But too often, they can create negative mind sets and that is never helpful. Also, I wanted to come up with a term that expressed some of the positive aspects other authors were writing about (Hartmann, 1993) and that I truly believed myself. If the A.D.D. brains were those that were really *wired for the 21st Century*, as these authors had proposed, then surely there was a way to celebrate this fact and learn how to work with the energies instead of feeling discouraged by this "condition".

***Attention Deluxe Dimension* offers a more positive view of a traditionally negative set of characteristics.**

[2] Contact information for your national and local associations can easily be found by an Internet search.
[3] See Scholten (2008) for a more detailed explanation of this term.

Using the term *Attention Deluxe Dimension* and then referring to it as A.D.D., I now explain to my clients and their families that the ADDer has a mind that is *wired for the 21st Century*. This recognizes that abilities such as mental channel-surfing and quick decision-making CAN be a great advantage a lot of the time. However, they can also create difficulties when ADDers are put in situations where they are required to think about only one thing at a time or if they are uninterested in a subject or find it particularly challenging.

In this way, they can celebrate the fact that they have special abilities while also being able to return to their classrooms or workplaces and let their teachers or employers know that they have A.D.D. and may require some special considerations. This approach seems to have worked very well, so far.[4]

Several authors in the field (Hallowell & Ratey, 2011, 2017; Kelly & Ramundo, 2006) have expressed a desire for a more positive label, since they are aware that there are many successful individuals who meet the criteria for A.D.D. Although successful, these individuals often still realize that they process information differently than a lot of other people. If they knew how to work WITH their *neurological make-up*, they could use their self-knowledge to create the kinds of environments they need to be even more successful. In answer to the expressed desire of some of the authors in the field of A.D.D. for a positive label, I proposed this one - "Attention Deluxe Dimension". Most people, who have heard it, love it and find it quite empowering. More on this in Part One – An Overview of A.D.D. – "The Good News."

This is YOUR book. Try to really own it. Don't let it own you!!!

This book is written to YOU, the consumer. You will have lots of opportunity to interact with the material being presented. I invite you into a conversation with me. Write on the pages. Underline what you think is important, cross out what you disagree with, put an exclamation mark beside information that surprises you, make a note of any questions you might have. This will probably help you to take in this information in a deep and meaningful way.

[4] See Scholten (2002), an upbeat little book that was written to welcome newly-diagnosed children into the "Channel Surfer's Club."

Part One:

A Brief Overview of A.D.D. "The Good News"

Part One: A Brief Overview of A.D.D.: the "Good News"

1. "The Good News" about A.D.D.

So, you think you might have A.D.D.…

Congratulations!

**Are you distractible, inattentive, impulsive,
and/or restless ...
OR...
are you observant, able to think about a lot of different
things at once, a quick-decision-maker,
and/or full of energy?
YOU DECIDE!!!**

You may have...

Attention Deluxe Dimension!

There are many experts in the field of A.D.D.[5] who strongly believe that A.D.D. can have advantages in our present world. Thom Hartmann, in his book *Attention Deficit Disorder: A Different Perception*, was the first to suggest the increasing frequency of A.D.D. in the population is perhaps a sign of natural selection taking place.

Individuals with A.D.D. have the kind of brain we will need for the 21st century and beyond … brains that can process information on a number of different channels at once!

Hartmann suggests that individuals with A.D.D. are like *hunters* living in a *farmer* environment. They are people who seem to thrive in a stimulating, multitasking environment. They are able to focus on the job-at-hand and complete assignments, but they run into trouble when required to do routine tasks or ones in which they are not interested. Routine tasks – plowing a field, feeding the chickens, or filing paperwork… are often a challenge for individuals with A.D.D. They just don't seem to be able to get motivated to get to them or finish them. Put them in a hunter environment, however, and they perform much better. Are these hunters not the entrepreneurs of the world?

If you were a *farmer*, it would be useful to be able to *focus* on one thing at time, to think only about what you are doing, and not be distracted by events around you. It would be crucial to get the crops planted on time and in even rows. It wouldn't matter if you took a while to ponder your decisions about which crop to plant next year.

But if you were a *hunter*, it would be useful to be *observant* and perhaps *distracted* by events around you. If you had to get food for your family, you'd need to notice the rabbit scampering across the field or a grouse flying overhead. It would be important to make a split-second decision to aim and fire. If you were a business owner, it would be good to be able to quickly identify problems and then, to just as quickly, be able to come up with a solution.

[5] Hallowell and Ratey, 2011, 2017; Hartmann, 1993, 1995, 2015; Kelly and Ramundo, 2006; Weiss, 2005 a & b

Below you can see how some A.D.D. characteristics traditionally viewed as negative can be an advantage in a hunter-like situation.

Table 1: A New View of A.D.D. as a natural adaptive trait

Trait as it appears in the *negative* view (as a Disorder)	**Trait as it appears in the positive *hunter* view**
Distractible	Observant: constantly monitoring their environment
Short attention span	Able to *switch gears* at a moment's notice
Poor planner: disorganized and impulsive	Flexible: ready to change strategy at a moment's notice, quick decision-maker
Distorted sense of time: unaware of how long it will take to do something	Tireless: capable of sustained and intensely focused drive when involved in some goal or activity in which they are interested

Adapted from Hartmann, 1993 (p.54)

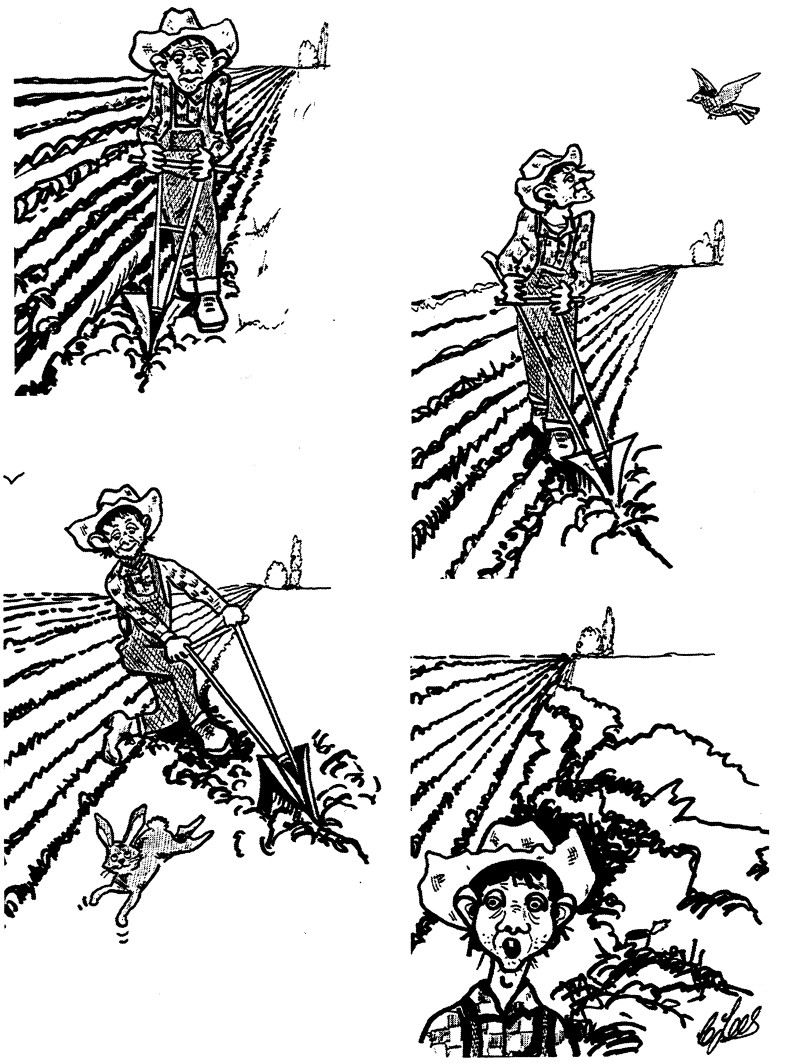
If you are a *hunter* in a situation which requires you to think and act quickly in response to a number of different demands, that's great. If you are a *farmer* in a situation that requires a step-by-step approach even in the most mundane tasks, then you are fortunate as well. But if you are a *hunter* and in situations with farmer-like demands, you may be feeling quite frustrated! If the routine (and often) mundane task needs to be completed – like plowing the field or filing your income tax, you will need to come up with strategies to be able to complete the task. That is what this guidebook is all about!

These *farmer/hunter* concepts are illustrated on the next two pages. My hope is that you can become aware of the qualities needed in different kinds of environments and learn to match your (or your child's or your employee's) natural abilities with tasks that allow you (and them) to achieve success and be able to develop to full potential!

Figure 1 - The "Successful" Hunter

The hunter is successful because of his ability to notice things like the rabbit hiding in the burrow and the bird flying overhead. Should that trait be considered **distractible or observant?** What if the hunter took several minutes trying to decide which one to go after? The bird and the rabbit would both have been long gone and his family would be hungry. Instead the hunter focused on the bird, raised his bow, aimed, and fired. Shall we call that **impulsive or quick-decision-making?** Finally, when the hunter ran home with food for his family, is that called **hyperactive or energetic and enthusiastic?**

Figure 2 - The "Not-So-Successful" Farmer



Notice how the farmer starts off plowing the field. He is focused on the task; the rows are neat and tidy, but he is bored and unhappy and soon ***distracted***. His plow goes off track when he notices the bird and he is further distracted when the rabbit scurries by. Soon he forgets what he was supposed to be doing – plowing the field! The result is a job that is ***messy and incomplete, and he is left wondering how things went so wrong so quickly***.

The farmer cartoon perfectly illustrates the **inconsistency** of the ADDer.[6] He starts off plowing the field and then somehow gets distracted. He is left feeling like a failure – unable to complete even a simple task. I'm sure that's how it feels to many individuals with A.D.D. when trying to function in an environment that does not make the best use of their unique characteristics! Sometimes they can complete a mundane task. Other times they can't. This is confusing to them as well as to their partners, parents, and teachers, who will often say, "She can do it if she really wants to!" Interest does help ADDers tune out competing frequencies in their brain and be able to focus, but it is usually not a question of whether or not they WANT to do something. It's more often an issue self-control. Part Three – *Behavior Management for Parents of Children with A.D.D*. describes the *Riding the Wave* approach[7] - a powerful way to help the ADDer develop self-control. In the meantime, I believe that we all have to make the best of a challenging situation. My proposal is that those of us with A.D.D. (and those around us), try to look at our neurological wiring in as positive a way as possible![8]

I invented the term *Attention Deluxe Dimension* in 1993 because I was looking for a more positive term that reflected the A.D.D. brain. I chose this term because people with A.D.D. seem to be able to think on many different channels at once. It's a deluxe or abundance of attention. It permits abilities such as *mental channel-surfing* similar to what you (if you have an A.D.D. brain) probably do while watching television. Not everyone can watch two or three programs at once and make sense of them!

However, if a boss, your partner, or your teacher is talking on one channel while you're channel-surfing, you might miss an important piece of information. They might have just told you what time the next meeting is while you were thinking about the talk you just had with your co-worker, or what's happening on the weekend. In this situation, you might appear to be inattentive! Actually, you were attentive - just attending to a number of different things rather than focusing on their conversation! ☹

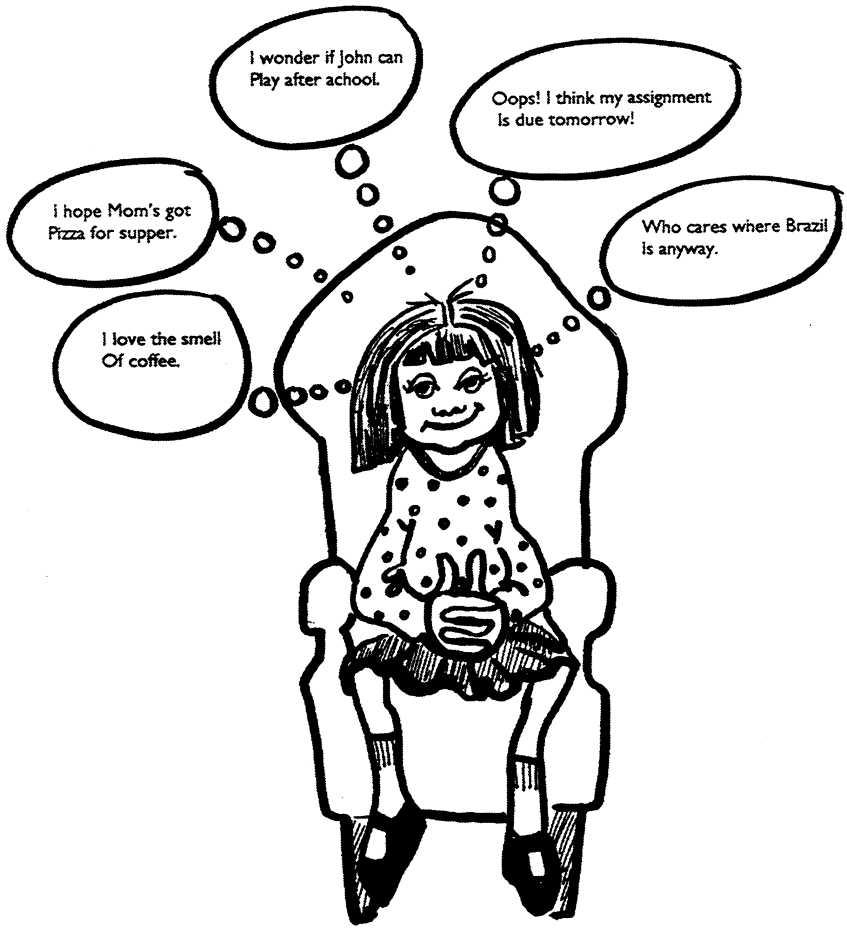
People with Attention Deluxe Dimension can actually attend to a lot of different things at once!

[6] ADDer is a term coined by ChADD, an international organization dedicated to helping children and adults with ADD or ADHD

[7] See Scholten (2018b) for detailed instructions on how parents can use this approach.

[8] Scholten (2018c), written for teachers, explains how to apply these concepts and techniques in the classroom.

Figure 3 – The "Channel-Surfing Brain" of someone with "Attention Deluxe Dimension"



When an ADDer has A.D.D. *with* hyperactivity you see the physical movement. When they have A.D.D. *without* hyperactivity, the body tends to be quieter. But, in both kinds of A.D.D., the brain is very busy, channel-surfing, and thinking of all sorts of things and in new and different combinations. No wonder individuals with A.D.D. often come up with such creative ideas!

So, if this is "good news"...
...then what is all the fuss about?

There can be problems for people with A.D.D. when ...

a) they can't do what they are supposed to do – complete tasks, get to school on time, carry on a focused conversation in a social setting…

b) they don't think they have a problem, but they actually do, and it is interfering with their work, school, relationships….

c) they want to find out if they have A.D.D. and discover it is a complicated, time-consuming process just to have a comprehensive assessment.

More specifically, IF the individual who has A.D.D. is YOU and...

a) YOU can't do what you HAVE to do:

- you need to do a task in which you are not interested, and it doesn't get done or doesn't get done on time or doesn't get done properly
- you are experiencing learning discrepancies (LD) and are caught up in the cycle of failure and discouragement with school or work performance
- you learn in a different way than you are taught and subsequently don't grasp certain concepts quickly or easily
- you have physical challenges which may be interfering with your energy levels or thinking ability
- even though you have been treated with medication for A.D.D., you are not doing as well as you would like to be doing

b) YOU don't think you have a problem, but you actually do:

- you are very smart, but you are not achieving to your fullest potential
- you feel like a *square peg in a round hole* and don't know why you don't feel like you quite *fit in* or *belong*

- you have a difficult time getting up the energy to do your work or perhaps you keep yourself stimulated by over-committing to various projects – always over-promising and often under-delivering
- you feel depressed and no one (including yourself) knows why
- you have been treated for A.D.D. without first exploring the possible effects that learning, physical, or environmental factors might be having on your attentional functioning

c) YOU want to find out if you have A.D.D., but discover it is a complicated and time-consuming process to have a comprehensive assessment and:

- you don't know where to get the help you need
- you can't afford to pay for a full psycho-educational assessment
- you don't want to put yourself or your child on medication without exploring other options first
- you don't know where to begin in separating fact from fiction in all the information there is about A.D.D.

If you have any of these concerns, *The A.D.D. Guidebook* has been written for you!

Let's get started!

Note: The publications by Scholten (2003, 2007) provide a review of the *Empowerment Plus Model*® as described in this book along with some of the research results. See the Annotated Bibliography for more details.

Instructions for doing a Baseline Assessment

1. Screening Checklist for Attentional Concerns

When you fill out the *Screening Checklist for Attentional Concerns* for the first time, start by making a copy of the Checklist (don't write on the original, because you might want to use it again!) Choose three activities in which you are *interested*. Examples of these might be doing art, playing video games, or competing in sports. For each activity rate yourself (from *not at all* to *very much*) to indicate how you function in these areas.

WRITE ABOUT...

List three activities which you are usually interested in doing:

	Interested	Not Interested
1,	_____	_____
2.	_____	_____
3.	_____	_____

Now, do the same thing for three activities you have to do which you don't like doing or are *not interested* in doing. Examples of these might be vacuuming, sorting through paperwork, filling in an expense report. (Don't use activities in which you may be experiencing learning discrepancies such as spelling or reading.) For each activity rate yourself (from *not at all* to *very much*) to indicate how you function in these areas.

Is there a difference in how you function when you are doing things you are *interested* in and when you are doing things you are *not interested* in? If you have a total of four or five (or more) checkmarks in the Pretty Much and Very Much columns, when you are doing things in which you are *not interested*, then we say that you have a concern in the area of attention. What we don't know just yet is the cause.

It is also helpful to have someone else (like a parent, teacher, partner, or friend) fill out the *Screening Checklist for Attentional Concerns* based on their observations of you. Have them do this now and then do it again after you have tried various interventions, like dietary changes or during a medication trial.

2. Symptom and Food Diary

Note that the *Screening Checklist for Attentional Concerns* (p.13) and the *Symptom and Food Diary* (page 14) should both be completed before you begin any of the subsequent interventions.

Screening Checklist

for Children and Adults with Attentional Concerns

NAME:_____DATE:_____RATER:_____

	OBSERVATION	NOT AT ALL	JUST A LITTLE	PRETTY MUCH	VERY MUCH
1.	Difficulty with details - makes careless mistakes				
2.	Difficulty sustaining attention to current task				
3.	Does not **seem** to listen or sustain attention to discussions, may ask for questions/statements to be repeated				
4.	Difficulty following through on instructions				
5.	Difficulty starting/finishing tasks				
6.	Loses things necessary for tasks or activities				
7.	Easily distracted by noises or other surrounding activities				
8.	Fidgets or doodles				
9.	Uncomfortable staying seated for periods of time or leaves seat frequently				
10.	Talks excessively or dominates conversations inappropriately				
11.	Blurts out answers before questions have been completed				
12.	Interrupts others inappropriately				
13.	Daydreams				

COMMENTS:_____

Adapted for use with adults and children by Dr. Teeya Scholten, R. Psych, Calgary, AB
from a checklist developed by the Calgary Learning Centre, 1996.

Symptom and Food Diary

1. Write down what you ate today (or on a typical day)
2. Put a number (0, 1, 2, or 3) in each box on the Baseline Symptom and Food Diary (on the next page) that describes your symptoms or how you felt after each meal.

BREAKFAST _____

MORNING SNACK (if applicable) _____

LUNCH _____

AFTERNOON SNACK (if applicable) _____

SUPPER _____

EVENING SNACK (if applicable) _____

SYMPTOMS: 0 - no symptoms, 1 - mild, 2 - moderate, 3 – severe

TIME OF DAY SYMPTOM	BEFORE BREAKFAST	AFTER BREAKFAST	AFTER LUNCH	AFTER SUPPER	DURING NIGHT
TIRED OR DROWSY					
IRRITABLE					
OVERACTIVE					
HEADACHE					
RESPIRATORY (Stuffy Nose, Cough)					
DIGESTIVE (Nausea, bellyache)					
URINARY (Frequent or Wetting)					
OTHER (please specify)					

COMMENTS: (Mention anything that happened to you today that might account for your symptoms other than food or any observations or ideas you may have, including cravings, etc.)

Adapted in 1996 by Dr. Teeya Scholten C. Psych. from a rating format used by Dr. William Langdon, London, Ont.

WRITE ABOUT...

After competing the *Screening Checklist for Attentional Concerns* and the *Symptom and Food Diary*, write about what you have previously done to try to help yourself with your symptoms and concerns - what has worked in the past and what hasn't.

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Now, we're going to turn to a summary of many of the factors which can affect attention and see how this relates to your life.

2. Factors Which Influence Attention

There are many factors that affect our ability to attend to one thing at a time. These can also impact upon other characteristics commonly associated with A.D.D. All of these factors need to be ruled out or investigated in exploring whether or not you have a brain that is *wired for the 21st Century!* Some of these are:

Physical
- thyroid
- hypoglycemia
- improper nutrition
- *brain allergy* to substances in the environment (such as dust, wheat, milk, corn, sugar, alcohol, etc.)[9]
- substance abuse

Emotional
- depression
- post-traumatic stress
- bipolar
- thought disorder
- psychotic reactions

Environmental
- learned behavior through living in a chaotic environment
- reaction to ongoing stress on the job or in relationships
- a reaction to past or present physical, emotional or sexual abuse

Personality
- some individuals tend to be talkative, procrastinating, as well as prone to careless errors. They might look and act as if they have A.D.D., but they don't. They probably just need help with time management. On the other hand, it is easy to overlook individuals who actually have A.D.D. but who are quiet, sensitive, and value accuracy and task completion and therefore don't meet the diagnostic criteria.[10]

Learning
- some people have learning styles in which they like to tackle problems in a random order rather than doing things in a step-by-step manner. These people might look like they have A.D.D. when they don't.
- learning discrepancies/disabilities/difficulties may result in symptoms that look like A.D.D. because it can be difficult to concentrate on something that is very difficult to do.

[9] See Mandell and Scanlon, (1988)
[10] See Scholten (2014) for a complete explanation of this.

WRITE ABOUT...

how you feel you are doing in the *Factors Which can Influence Attention* and what you have done in the past to help yourself with some of those challenges.

Identify any areas that might need further exploration.

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_____

_____

_____

_____

You may be able to explore most of these areas on your own. However, you may have concerns or need assistance in exploring physical, emotional, and environmental factors. If this is the case, please enlist the help of your family physician or appropriate health-care professional(s).

Note: If you or someone you are caring for is struggling with depression, please contact your family physician, your health-care provider, or 911 immediately.

In Part Two: *The Toolbox - Ways to Help Yourself* you will learn how to begin to explore the impact of physical, personality, and learning factors on your functioning. In some cases, the information will provide you with all the tools you need. For other individuals, the information contained in the toolbox will at least provide a beginning to the journey.

Understanding yourself as a *whole* person
is important to
***being the best you can be as naturally as possible*!**

The hereditary link ...

There is a strong hereditary link in A.D.D. If you are wondering about your child having A.D.D., you may wish to also look at yourself and vice versa. Addressing your own A.D.D. may assist in your levels of patience with your children and improve your functioning in your job and in your relationships.

When investigating the possibility of A.D.D., all possible causes of attentional difficulties should be ruled out first.

WRITE ABOUT...

who else in your family (parents, aunts, uncles, brothers, sisters …) seems to show some of the characteristics that you associate with attentional challenges. (Don't forget about the quiet ones or very intelligent ones who didn't seem to achieve to their potential - or how about the ones who own their own business and have been a great success!)

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Throughout this book, I have included case studies. These are true stories about my clients. They are written in shaded boxes and show how the various factors we have been discussing apply to real life situations. The names have been changed (except in my own case) to protect the identity of these people, but the details are all true.

Real-life Personal Stories

That's the overview…about twenty pages…you made it!

So where do you want to go from here?

You may wish to turn to Part Two*: The Toolbox - Ways to Help Yourself* (p.37) and get started right away

OR

continue reading about the steps involved in the formal assessment and treatment of A.D.D., the professionals involved, and how to make the most of your A.D.D.!

3. Steps in the Assessment Process

A formal clinical diagnosis of A.D.D. usually begins with an in-depth history, in which mental health and educational professionals explore many of the factors mentioned previously in this guidebook. It is important to establish that the attentional symptoms are due to A.D.D. and not to other reasons.

In a comprehensive assessment, physical reasons are ruled out, learning difficulties are explored and treated, and several intervention strategies are usually tried prior to looking at drug treatment. Unfortunately, drugs are easy to prescribe, and the cost is usually covered by health-care plans, so medication as a first resort can be a temptation. For some individuals, medication provides the brain with the chemical it needs, but in many cases, other important issues (such as learning and health problems) can be overlooked when medication is the first resort.

Medication has its place, but it should be tried as a last resort and under careful supervision. (See *The Farrelly Protocol for Conducting a Medication Trial,* p.137).

What professionals are involved in the assessment and treatment of A.D.D.?

- Psychologist
- Medical Practitioner
- Teacher
- Social Worker
- Speech and Language Pathologist
- Occupational Therapist
- Tutor/ Learning Strategist

A number of different professionals should be involved in a comprehensive clinical assessment.

How are these Professionals Involved?

Psychologist
- offers academic and intelligence testing
- involves other professionals depending on the areas of concern
- makes a diagnosis
- may offer counselling or parenting programs

Medical Practitioner
- includes Physician, Pediatrician or Psychiatrist
- rules out physical causes of attentional symptoms
- makes a diagnosis
- monitors medication trials

Teacher
- assists in the investigation of attentional difficulties
- monitors the effectiveness of medication trials
- implements remedial strategies to improve skills
- uses academic accommodations to facilitate success

Social Worker
- assesses the effects of family functioning
- offers treatment for family and/or marital issues

Speech and Language Pathologist
- evaluates and remediates language and processing concerns

Occupational Therapist
- evaluates and remediates concerns in fine-motor coordination, visual-motor functioning and other aspects of written expression

Tutor/Learning Strategist
- implements remedial strategies to teach needed skills (reading, spelling, organization of written work, proofreading, math facts …)

WRITE DOWN...

the name and phone number of several of each of these types of professionals with expertise in the area of A.D.D. who practice in your community:

Type of Professional	Name	Contact Information	Estimated Cost of Service
Psychologist	1. 2.		
Physician	1. 2.		
Pediatrician	1. 2.		
Psychiatrist	1. 2.		
Social Worker	1. 2.		
Tutor	1. 2.		
Speech and Language Pathologist	1. 2.		
Occupational Therapist	1. 2.		

You may wish to contact these people, to gather information about their services and to determine who you feel comfortable having involved in your life, should the need arise.

What other resources are available?

CHADD (Children and Adults with A.D.D.) http://www.chadd.org/ is an international organization with many local chapters. It circulates regular newsletters and is a good source of information about support groups and programs for children and adults with A.D.D. and their families.

CHADD Help Line 1-800-233-4050

WRITE DOWN...

the name and contact information for your local CHADD group.

_____

Your National Learning Disabilities Association (LDA) https://www.ldac-acta.ca/ in Canada (https://ldaamerica.org/ in the United States) is a good source of information about practitioners with expertise in A.D.D. The association can also be very helpful if you suspect that you or your child has learning disabilities.

WRITE DOWN...

the name and contact information for your local LDA Chapter.

_____

What Should I Do if I Want to Find Out if I Have A.D.D?

Now that you have some idea of the factors to be considered in understanding and addressing your attentional concerns, what should you do?

Remember, that you *cannot* diagnose yourself with A.D.D., but you can begin to rule out other causes of your attentional symptoms. You can also begin the process of understanding *how you work best.*

The steps outlined below are those which you would follow if you had initially turned to Part Two and just began. They are summarized below:

a) Complete the *Screening Checklist for Attentional Concerns*
b) Complete the Levine Information Processing Questionnaire
c) Explore other factors relating to attention
d) Get professional help, if needed
e) Get a professional diagnosis if you wish to try medication
f) If you don't want to try medication, consider alternative treatments

Note: It is important to check with your physician or health-care provider if you have any physical, emotional, or psychological concerns for yourself or your child.

a) Complete the *Screening Checklist for Attentional Concerns* (p.44)
You can ask a partner, parent, teacher to also fill out the form and then compare the ratings. If there are more than four or five checkmarks in the Pretty Much/Very Much columns when you rate how you do in activities in which you are NOT interested, there may be a problem. You don't know yet if it is A.D.D., but it might be worth investigating further. This *Screening Checklist for Attentional Concerns* can also be used to assess the effectiveness of any subsequent interventions. You can use it as often as needed to measure the success of the various strategies you implement, including a medication trial.

b) Complete the *Levine Information Processing Questionnaire* (p.48)
You can also ask someone who knows you well to fill out the form. Dr. Mel Levine identified twelve possible areas of information processing that can be affected by attention. In any given individual, there are usually four to five areas which are affected.

Once you have identified the areas of information processing that are affected by attention, you can refer to *Strategies for Improving Attention* (p.55). This may be all you need to understand and work with your attentional concerns! Note: Teachers and employers often find this information extremely helpful.

Many factors can affect our attention.
It is important to understand
how YOU work,
if you are going "to be the best you can be"!

c) Explore other Factors relating to Attention (p.81)
If you still think that you want or need to understand more about how you function, I suggest having a look at your personality type. Identifying your personality type tells a lot about how you relate to others and the type of learner you are. Understanding how we are unique helps us to appreciate ourselves and others.

Whether or not there is a history of allergy or food sensitivity in your family, you may want to explore the possibility that certain foods are causing problems in how you function. See *Methods for Investigating the Influence of Food on Attention* (p.93).

If there is a family history of learning difficulties, it is important to investigate whether you also have a marked discrepancy in your ability to learn various types of information. We all have areas of strength and challenge, but some of us experience a bigger difference in our functioning in certain areas. It can help us to understand and accept ourselves if we know what our abilities and challenges are. It can also help us to learn strategies or accommodations that can be used in school or the workplace to help us succeed. See *Learning Discrepancies: Common Areas of Difficulty, Strategies and Accommodations* (p.63) and *Common Reasons for Reading Difficulties* (p.73).

Thom Hartmann's books (listed in the Bibliography) give a positive and encouraging view of A.D.D. Be sure to include these in your reading.

d) Get Professional Help, if needed

If you think that you still have challenges that need addressing, you may want to go further into the investigative process. If you need help with any of these steps, talk with your family physician or contact your local or national LDA or CHADD group. They may be able to direct you to the type of professional practitioner you need. A formal diagnosis is usually not needed (in my opinion) unless, of course, you want to try medication. If you have reading or writing difficulties, getting help with these challenges can bring much needed relief. Awareness of your *channel-surfing* abilities and use of the *Strategies for Improving Attention*, (p.55) may be all you need for now.

e) Get a Clinical Diagnosis if You Wish to try Medication

If you decide to pursue a formal clinical diagnosis, you may want to first complete the *Barkley Interview* (p.117). The information from this interview should be helpful to the practitioner involved in the diagnostic process. Note: If you are an adult, always ensure that the psychologist, psychiatrist, or other mental health professional working with you has had experience in the field of adult A.D.D., is qualified to make a diagnosis, and has a good reputation! Doing a proper medication trial involves following a procedure in which the dosage is slowly increased and the responses to it are monitored carefully by several individuals. For specific instructions, see *The Farrelly Protocol for Conducting a Medication Trial* (p.137).

Involvement of a professional is essential for making a formal diagnosis of A.D.D.

Using *The Farrelly Protocol*, it is possible to identify whether you are a *responder* to medication and what is the lowest dose of the medication which gives maximum results. As a result of following this approach, your health practitioner should be able to answer the following three questions:

1. DO you respond to this TYPE of medication?
2. HOW do you respond to this TYPE of medication?
3. What is the LOWEST dose which is most effective in relieving the symptoms?

Why is there so much controversy about the use of medication?

I believe that much of the controversy surrounding the use of medication to treat A.D.D. arises because medication is often prescribed at the beginning of the diagnostic process, bypassing the possibility that the attentional symptoms might be due to other factors.

My research results from the past twenty-plus years, using the Empowerment Plus® approach, indicate that 85% of the people who show attentional symptoms will turn out to have A.D.D. while 15% will have other causes, such as food sensitivities, physical problems like hypoglycemia, eye co-ordination problems, or other academic issues such as learning discrepancies.

It is my opinion that in the treatment of A.D.D., medication belongs at the caboose of the train, not near the engine … that is, after everything else has been tried. I can't blame physicians for trying to help their patients. They probably think that if a pill could save a distraught parent from the frustration of trying to manage a seemingly unmanageable child, then why not try it? Or perhaps the medical practitioner has been incorrectly taught that if someone responds to medication then they actually have A.D.D.? Not all physicians are qualified to investigate the effects of learning, personality, and diet on behavior. But this is still not a valid excuse for a quick prescription. Neither is medication a valid excuse because of the expense of getting a private psychological assessment.

In my opinion, there is a role for medication in the treatment of A.D.D., but it is at the CABOOSE of the train, not the engine.

Other concerns about medication come from reports which are highlighted in the news, in which parents claim that their child was put on medication and started to *act like a zombie*. If these children were properly diagnosed with A.D.D., they are probably over-medicated and would respond well to a lower dose of medication. That is why I have included the *Farrelly Protocol for a Medication Trial* so that your family physician can have some guidelines as to how to do a responsible medication trial for properly-diagnosed patients.

When medication is used under these conditions (at the caboose of the train, rather than as the engine and using the correct protocol), you will get the best results. Among my clients whom I diagnosed with A.D.D., about two-thirds wanted to try medication. The others felt that they now understood enough about themselves to function better while others were simply not open to medication at that time. For those who wanted to try medication, we used the *Farrelly Protocol* and had very good results with NO adverse side effects!

Using the *Farrelly Protocol* will result in a minimum of side effects and a maximum of success, in my experience.

How does medication work?

Throughout the years, there have been a variety of explanations about how and why medication works. A particular puzzle was the seemingly *paradoxical effect* of stimulant medications. How is it that a drug that acts as a stimulant can calm down a busy child? As the years have progressed, so has our understanding of how the brain works. We are getting more and more detailed information concerning parts of the brain and relating this to A.D.D.

The explanation below is one which I shared during lectures and with my clients. It is NOT precisely accurate, but it does offer a general overview that might help you

when you are explaining A.D.D. to your child or your family members or co-workers.

In the brain, there are neurons with *axons* and *dendrites*. These are like battery terminals in that they don't touch each other. There is a gap between each *axon* and *dendrite* which is called the *synapse*. At the *synapse,* there are chemicals which are called *neurotransmitters*. These chemicals must be present and activated (or stimulated) if the electrical transmission is to be sent from the *axon* to the *dendrite* and if the brain is to work properly.

A person with A.D.D. can often handle high levels of stimulation. Remember the *channel-surfing brain* can think of a number of different ideas within a short period of time and can usually carry on a conversation, fix a light bulb, and plan a dinner menu at the same time. This can be a great ability to have.

On the other hand, it often takes high levels of stimulation to get a person with A.D.D. started. So the ADDer comes up with strategies - leaving things to the last minute so there is a sense of urgency, jiggling one's foot, doodling, or ripping up styrofoam cups in meetings - which all serve to **stimulate the brain** and help the A.D.D. brain to focus. Unfortunately, some of these strategies are not always helpful and not always appropriate in certain situations.

What medication does is to stimulate the brain so that the ADDer can focus. If you respond to medication, you may discover that you can start on a task or project, even one in which you might not have a lot of interest. It won't do the work for you, but, as Dr. Geraldine Farrelly says, it gives you the choice as to whether or not to do it.

As an example of understanding how movement can stimulate the brain, I remember how my eight-year-old daughter used to wriggle and fidget during church services (both my daughter and I are ADDers). Instead of seeing her as a squirmy distraction, I came to realize that her moving around during the service was her unconscious way of trying to stay focused on what was happening.

As our knowledge develops, there will be many more theories or explanations as to how medication works in treating A.D.D. For now, I hope that this gives some understanding of the basic ideas involved.

f) If you don't want to try medication, consider alternative treatments.

Many individuals who are diagnosed with A.D.D. are *willing to try* medication, but do not necessarily want to be on it for the rest of their lives. Some want to try anything and everything else *before* resorting to medication. Others do not want to try medication *ever*. Which category do you fit into?

If you are hesitant about medication, there are alternative treatments available including nutritional supplements.

In the last few years, there have been some major advances in the area of nutritional supplementation. It is beyond the scope of this book to provide an up-to-date list of some of the many options on the market. Some of the most popular forms of nutritional supplementation are: Phyto-bears for children, Manapol for adults, Efalex Focus, and Q96 or EMPowerplus.

I have seen very good and surprisingly fast (with a few weeks) results from supplementation but I still can't tell you which product which would best for you. Your local health food store or health-care provider is probably a better source of information on the options.

I suggest that you do the research, try a product for a month, and then go off it. This should give you a good idea as to whether or not it is doing anything for you (or your child). It may not help your attentional symptoms, but you may find that you are feeling better in other ways. Keep your eyes, ears, and mind open! ☺

My hope is that someday, we will be able to tell which people are most likely to respond to which types of interventions. Until then, it seems to be somewhat of a guessing game.

WRITE DOWN…

Alternative treatments for A.D.D. that you are interested in finding out more about.

_____

_____

_____

4. Making the Most of Your A.D.D.

Perhaps you have already had a diagnosis of A.D.D. or ADHD and are wondering if there is anything more you can do to help yourself, your child, or partner.

The first thing about which you have a choice is HOW you look at A.D.D. It is completely up to you how you feel about it. You can consider it as a curse or a blessing. I choose to celebrate it, enjoy the creative, multi-tasking advantages and have patience with myself when I get caught channel-surfing at an inappropriate time! These are the steps I would recommend for making the most of your A.D.D.:

- Understand the pros and cons of A.D.D.
- Develop awareness of yourself and others
- Build on your strengths
- Reduce stressors
- Get support
- Build balance in mind-body-spirit

Understand the Pros and Cons of A.D.D

Try to understand how A.D.D. can help you accomplish your dreams so you can make a significant contribution to your job, your family, and to this world and where A.D.D. can get you into trouble. Enjoy the energy, enthusiasm, and channel-surfing potential of your *21st Century mind!*

Develop Awareness of Yourself and Others

Understand, accept and celebrate yourself and others. Accept your uniqueness and discover how it interacts with the gifts that your partner, family, and friends also bring to your relationships.

Understand the *whole person* and how your attentional patterns interact with your personality, your learning strengths, and your challenges. This information will also help you in getting along with others and in making the most of your abilities.

For more information about how to work with your personality type, see Briggs-Myers (1998), Kiersey (1993), Scholten (2018a) and Tieger and Barron-Tieger (2001).

Build on Your Strengths

Remember that the reason many of us ADDers move around or fidget and doodle is actually an attempt to stimulate the brain so that the neurotransmitters will fire and allow us to concentrate better? Interest also provides a lot of stimulation. That is why it is important to **understand ourselves**, what **our strengths** are, **what we are good at,** and the activities that most **interest** us.

If we don't find ways to provide this stimulation for our own brains in a healthy, natural way, we may find that we engage in addictive or high-risk behaviors or self-medicate in harmful ways. What are you good at? What do you enjoy doing? Are you doing it? If so, great! If not, why not?

Work with your strengths in the way that is most effective for you. Follow your passion.

Reduce Stressors

Most individuals tend to have a lot of stress in their lives. A certain amount of stress can be a good thing, but too much ends up preventing us from *being the best we can be.* Some things we can change, others not. We can examine our lives and find ways to reduce unnecessary stressors or we can also build up our ability to handle stress through rest, meditation, and exercise. Our diet influences our ability to handle stress. Even drinking enough water can be very important to our ability to handle stress.

For more information about your stress bucket and what you can do to reduce your stressors or build up the size of your bucket, please see How *to Investigate the Influence of Food on Attention* (p.110). If some of your stress is from trauma or past issues, Miller (2015) is very helpful in treating trauma and resolving past issues.

Get Support

Talk with others who understand. There are many local self-help groups. If you need professional assistance, make sure that your helper is knowledgeable in the area of A.D.D. There are many resources on A.D.D. that can assist you in taking a problem-solving approach to your situation. Material is also available through your local CHADD group or LDA (Learning Disabilities Association).

Use practical problem-solving strategies and the resources of experts to address areas of concern.

Resources I have found helpful are listed in the Annotated Bibliography (p.185). Of particular note are classics by Barkley (2013), Kelly & Ramundo (2006), Hallowell & Ratey (2011, 2017), Hartmann (1993, 1995, 2015) and Weiss (2005a & b).

Some of the promising developments in recent years include survival strategies for adolescents and adults suggested by Alan Brown in his ADD Crusher videos and recent book (Brown, 2017); Dr. Daniel Amen and his SPECT analyses and targeted treatment recommendations (Amen, 2013); the use of Micronutrients in the treatment of ADD and mental health issues (Gordon, Rucklidge, Blampied, & Johnstone, 2015); and the importance of gut health (Enders and Sobey, 2015). Terry Matlen (2014) has developed a wonderful support network for women. Lastly, if you want to take an upbeat approach, Rick Green, a comedian with ADD, does an awesome job in his book (Green and Jain, 2011), the Totally ADD series and the Friday Funnies. You will be able to find all of these on the Internet.

Build balance in mind-body-spirit

Most of us realize the importance of having a healthy mind and body as well as a fully-functioning spirit even though we don't always make it a priority to achieve that balance. Do you have a relationship with the Creator? If not, I encourage you to reflect upon this aspect of your life. It is very important, in my opinion. If you need some guidelines to help you reflect upon these areas in your life, you may wish to refer to *My Personal Profile* (p.147).

When you have areas of difficulty that need to be addressed, you can look for ways to *fix* them - this is called remediation. At other times, or until the problem is *fixed*,

we can often benefit from an *accommodation*. Accommodation is a support that is put in place, in order to help you succeed.

If you need help with:	**Consider:**
• Organization	hiring a professional organizer for your home office or taking time management courses to deal with school or work deadlines.
• Parenting	enrolling in a parenting course designed specifically for parents of children with A.D.D. (Part Three, *Riding the Wave* (p.159)
• Reading	asking for extra time on tests/exams
• Writing	being able to do written work on a computer
• Attention	taking exams or working in a quiet place

You may find that if you are able to get help in your area of difficulty, you'll be able to *fix* the issue. If you find that you still have concerns, consider taking a scientific problem-solving approach (See the *Positive Problem-Solving Worksheet*, p.151) to address challenges you are still encountering and then get professional help, if needed.

There are many resources available to assist you in problem-solving. Some are listed in the *Annotated Bibliography*. Resource material is also available through your local or National CHADD group, the Learning Disabilities Association, or the Internet.

The Inverted-V Curve

Years ago, Yerkes and Dodson proposed that there was an **inverted-U** relationship between stress and performance, but I believe that with ADDers, it is an **inverted-V**. If you have A.D.D., you already know from experience that you need just the right amount of stimulation to be your best. If you are under-stimulated it is often difficult to get started on a project or task, but if you are over-stimulated (or stressed), you may shut down completely. It is a fine tipping point.

Part of understanding how to work with your *Stress Bucket*, is learning the optimum conditions under which you thrive. How do you find what is the right balance

between under-stimulated and over-stimulated? Working through Part Two: *The Toolbox: Ways to Help Yourself* (beginning on p.37) should help you figure this out!

Once you have explored various factors involved in understanding A.D.D., you will need to decide if your problems been solved.

5. Where Do I Go from Here?

The process of understanding ourselves is a journey. Each of us sets our own pace. Wherever you want to begin, the resources in this ***The A.D.D. Guidebook*** are intended to help you on your journey. The information you discover about yourself along the way can be very useful in making you the best person you can be!

That's the overview of the Steps in the Assessment…

Congratulations! you made it!

Now turn to Part Two: The Toolbox - Ways to Help Yourself.

Part Two:

The Toolbox- Ways to Help Yourself

Part Two: "The Toolbox"
Ways to Help Yourself

What's in the Toolbox?

How to Use the Toolbox

The Toolbox

What's in the Toolbox?

(A Brief Description of the Tools In The Toolbox)

A - Screening Checklist for Children and Adults with Attentional Concerns (SC/A)

A rating scale, based on professional diagnostic criteria, which can be used to help identify the characteristics of attention which may be causing concern. It can also be used to measure progress while trying different strategies.

B - The Levine Information Processing Questionnaire

A list of interview questions originally developed by Dr. Mel Levine, designed to help identify areas of information processing that can be affected by attentional difficulties caused for any reason. Of the twelve possible areas, most people are affected in only four or five areas. Possible areas include: ability to maintain consistent alertness, taking in information deeply enough, passive or active processing, determining the importance of information, filtering out distractions, ability to satisfy oneself, preview of outcomes, behavioral control, pacing of activities, consistency of effort, self-monitoring and learning from experience.

C - Strategies for Improving Attention

A list of ideas for strategies, also originally developed by Dr. Mel Levine, based on the twelve possible areas of information processing identified in Tool C - *The Levine Information Processing Questionnaire*.

D - Learning Discrepancies:
Common Areas of Difficulty, Strategies and Accommodations

A chart which summarizes nine commonly-accepted areas of learning difficulty including: language, reading, spelling, visual-spatial, math, written expression, organization, attention, and social competence. Information includes a brief description, common labels, remedial strategies and accommodations which can be used to facilitate success.

E - Common Reasons for Reading Difficulties

Outlines common reasons for problems in decoding or reading comprehension, how to investigate and remediate these problems.

F - Personality Type

Includes two charts which provide:

i) a very brief summary of the main characteristics of Introverts and Extraverts[11], Sensing and iNtuiting[12], Feeling and Thinking and Judging and Perceiving;

ii) information which illustrates the advantages of these characteristics and how they affect one's needs in learning or workplace environments.

G - Methods for Investigating the Influence of Food on Attention

Explains what foods are most likely to be causing difficulties and provides guidance in a step-by-step manner in terms of how to find out if this is a problem. Sample menus for milk-free, wheat-free and corn & sugar-free diets are included.

H - Barkley Semi-Structured Interview

A standard psychiatric interview, originally developed by Dr. Russell Barkley, designed for adults and children in order to gather past information and rule out other possible causes for attentional concerns**.**

I - The Farrelly Protocol for Conducting a Medication Trial

Explains the method used by Dr. Geraldine Farrelly, Pediatrician, in performing medication trials.

[11] I use the spelling originated in the Myers-Briggs Type Indicator® (MBTI) literature that emphasizes the idea of externalization.

[12] Again, I use the spelling format from the MBTI literature.

J - My Personal Profile

A questionnaire to help you take a personal inventory of aspects of your life, including: physical, emotional, spiritual, environmental, personality, learning, and attention. It may help to guide you in the exploration of the possible effect that various factors might be having on your attention so that you can find that delicate balance every day of your life.

K - Positive Problem-Solving Worksheet

Presents a worksheet that can be used in guiding the problem-solving process when investigating any type of problem or concern. Illustrates the use of the worksheet with an actual case example. The worksheet was originally developed by Dr. Anne Knackendoffel and then adapted by Dr. Lorna Idol, Dr. Fred West, and most recently by myself, Dr. Teeya Scholten.

NOTE: As you can see, the Toolbox contains resources from a number of different practitioners. I have attempted to give credit to the original authors, even when I have adapted the material. I hope that you will do the same. Any material which is NOT referenced to another author, is a resource which I have developed myself**.**

How to Use the Toolbox

Fill out Tool A - The Screening Checklist for Children and Adults with Attentional Concerns (SC/A) (p.44).

I recommend that you do this NOW if you have not done so already (in Part One, p.13). This will give you a record of how you are functioning right now, before you begin to make any changes. We call this a "Baseline Measurement." As you try new strategies, you can check your progress by filling out the *Screening Checklist for Attentional Concerns* (SC/A) as often as you want. Always measure how you are doing in activities in which you are NOT interested (see p.12 for instructions on how to do this). And, as always, work on a copy of the page so you can use the checklist again in the fuure!

The next step is your decision!

The rest of the tools are designed to help you explore and address a number of areas which can affect attention. **HOW** you explore these factors might depend on the kind of learner you are.

If you like to proceed in a **Step-by-Step** fashion,

→ you may wish to take each of the Tools in the order in which they are presented in the Toolbox. This is the method I used with my clients as part of the Empowerment Plus® approach.[13]

OR

If you are the **Browse-and-Explore** type,

→ you may wish to explore the tools at random, after having completed the *Screening Checklist for Attentional Concerns* (SC/A) as a baseline.

You may want to go through this process by yourself or with a trusted friend, a colleague, a family physician, or with another helping professional.

[13] See Scholten (2003) for a description of the Empowerment Plus® model. Also, see Scholten (2007) for a description of clients who were served by the model.

TOOL A - Screening Checklist for Attentional Concerns for Children and Adults with Attentional Concerns (SC/A)

A rating scale, based on characteristics of A.D.D. as described in the professional diagnostic criteria. The Screening Checklist for Attentional Concerns can identify characteristics of attention which may be causing concern. It can also be used to evaluate what effect different intervention strategies are having on your attention.

WHEN TO USE ...

If you are concerned about yourself, a loved one, a student or an employee and wonder if you or they they might have A.D.D.

HOW TO USE...

Fill out the *Screening Checklist* (SC/A) following the instructions on page twelve for the *not interested* activities. If you have four or more checkmarks in the Pretty Much and Very Much categories combined, turn to Tool B – The *Levine Information Processing Questionnaire* (p.47) to find out how attention is affecting the way you handle information. Tool C – *Strategies for Improving Attention* (p.55) will provide you with lots of ideas for how to handle these challenges at home, school, or work.

Just follow the steps in this book!

If you have four or five areas of concern...
THIS DOES NOT NECESSARILY MEAN that
A.D.D. is present.
What it DOES mean is that there are
attentional concerns
and it is probably worth exploring further.

Screening Checklist
for Children and Adults with Attentional Concerns

NAME:_____DATE:_____RATER:_____

	OBSERVATION	NOT AT ALL	JUST A LITTLE	PRETTY MUCH	VERY MUCH
1.	Difficulty with details - makes careless mistakes				
2.	Difficulty sustaining attention to current task				
3.	Does not **seem** to listen or sustain attention to discussions, may ask for questions/statements to be repeated				
4.	Difficulty following through on instructions				
5.	Difficulty starting/finishing tasks				
6.	Loses things necessary for tasks or activities				
7.	Easily distracted by noises or other surrounding activities				
8.	Fidgets or doodles				
9.	Uncomfortable staying seated for periods of time or leaves seat frequently				
10.	Talks excessively or dominates conversations inappropriately				
11.	Blurts out answers before questions have been completed				
12.	Interrupts others inappropriately				
13.	Daydreams				

COMMENTS:_____

Adapted for use with adults and children by Dr. Teeya Scholten, R. Psych. Calgary, AB.
from a checklist developed by the Calgary Learning Centre, 1996.

 **WRITE DOWN...** which attentional symptoms you (or the person you are concerned about) scored in the Pretty Much or Very Much category.

_____

_____

_____

Are these symptoms a problem most days, or only at certain times and in certain situations? All of us tend to have these symptoms at times, but it can be a problem, depending on how often they occur and how severe they are.

 **WRITE DOWN...** How severe are these symptoms for you? Do they occur at home, school/work and in social situations?

_____

_____

_____

 **MORE ABOUT…** *The Screening Checklist for Attentional Concerns for Attentional Concerns*

This *Screening Checklist for Attentional Concerns* (SC/A) contains items that come from the manual used by mental health practitioners in making diagnoses. When making a formal diagnosis of A.D.D., the mental health practitioner must rule out all other possible causes of the attentional symptoms before deciding that the symptoms are due to A.D.D.

Yet there is a lot you can do as an individual before you seek a diagnosis of A.D.D. You can explore factors within your own control (e.g., diet, stress, learning style) and see if you can eliminate or reduce the attentional symptoms. If you can eliminate the symptoms, they are not likely to be due to A.D.D. If you still have the symptoms (to an extent that they are a concern to you, your teacher, your partner, or your employer), you may wish to proceed to a formal diagnosis by contacting a mental health professional in your area.

If you are a teacher or employer or parent of an adult child with attentional concerns …

If you are a teacher, employer, or parent of an older child, your intervention may be limited by the receptivity of the person with attentional symptoms.

What can I do if the person I care about isn't willing to do anything about their problems yet?

If the person with the symptoms is NOT willing to look at their attention or work at eliminating possible causes, then there is still a lot you can do.

Firstly, you can tell them how you feel about their behavior. I-messages in the form of "I feel _____ when you do _____" can be very powerful. For instance, saying "I feel worried when I see you running late." They need to know HOW you are affected by their behavior. Just be careful that you don't nag them about it.

You may also be able to work (together or alone) on understanding what makes them tick and how to use strategies to help deal with some of their symptoms (Tool B – The *Levine Information Processing Questionnaire*, p.47 and Tool C – *Strategies for Improving Attention*, p.55).

You might even consider learning *Riding the Wave*, a behavior management technique designed specifically for helping the person with A.D.D. to develop self-control (Part Three, p.159).

You can do ALL of the above without their active involvement. Once they begin to feel supported and understood, they may be open to exploring more.

Good luck!!!

TOOL B – The Levine Information Processing Questionnaire

A list of interview questions originally developed by Mel Levine, M.D., designed to help identify areas of information processing that can be affected by attentional difficulties (no matter what the cause). Possible areas include: ability to maintain consistent alertness, taking in information deeply enough, passive or active processing, determining the importance of information, filtering out distractions, ability to satisfy oneself, preview of outcomes, behavioral control, pacing of activities, consistency of effort, self-monitoring, and learning from experience. Once you identify these areas, you can try appropriate strategies (as outlined in Tool C-*Strategies for Improving Attention*, p.55).

WHEN TO USE …

If you have completed the *Screening Checklist for Attentional Concerns* (SC/A) and have scored a total of four or more items in the Pretty Much and Very Much categories.

If you have concerns about your attention and are not sure about the cause (e.g. depression, stress, physical factors, A.D.D.) you can still use *The Levine Information Processing Questionnaire* to identify the areas of information processing that are affected in YOU!

HOW TO USE ...

Just follow the directions at the top of the questionnaire. When you have completed the questionnaire, you will receive further instructions.

The Levine Information Processing Questionnaire[14]

The purpose of this questionnaire is to explore processing of information in children and adults, as it relates to their attention. These questions might form the basis for an informal interview with the adult or partner. Alternatively, they may be answered by observation in the classroom, home, or work setting. Also, note that responses to these questions are meant to be in comparison to others of the same age in the same setting or context. This questionnaire is NOT meant to be scored or otherwise turned into a standardized instrument.

Instructions

Place a Y (for "yes"), or an N (for "no"), or a "?" (if you are not sure of the answer or don't understand the question) in the space to the left of each question. It can be very helpful if more than one person fills in a separate questionnaire on the same individual.

A. Input of Information

Maintaining Consistent Alertness

1. Does s/he seem to be tired during the daytime? Are there signs of stretching, yawning, appearing tired? Does s/he fidget a lot?

2. Does s/he seem to tune out or daydream during conversations, or while working on tests, or while working on projects?

3. Is there a history of unusual or difficult sleeping patterns?

4. Is it necessary to keep repeating instructions for him/her?

Taking in Information Deeply Enough

5. Does s/he have a hard time remembering what is said (i.e., short-term memory)? Does s/he ask for information to be repeated right away because s/he has forgotten?

6. Is there inconsistency in his/her understanding of information that has recently been given?

7. Is s/he absent-minded?

[14] This questionnaire was originally developed by Mel Levine, M.D., for use with children. It was adapted in 1993 by Dr. Teeya Scholten, R. Psych. and other staff at the Calgary Learning Centre for use with adults and children.

Passive or Active Processing

8. Does s/he give very brief answers to questions? Is s/he only able to elaborate on the details of subjects that are strong areas of interest?

9. Does s/he daydream richly and with great frequency?

10. Is this someone who memorizes information rather than trying to understand it?

11. Does s/he seem to have a hard time relating new information or knowledge with material that has been learned before?

12. Is this a person who seems to have no strong interests in any academic subject matter?

13. Does s/he complain of feeling bored much of the time in school or at work?

Determining the Importance of Information

14. Are there indications that this person has a great difficulty deciding what's important and what's irrelevant?

15. Does s/he have trouble focusing on important details while performing academic work?

16. Does s/he have a hard time summarizing or paraphrasing information that has been learned (i.e., more difficulty than would be expected by someone with his/her overall ability to express his/her ideas)?

17. Does s/he have trouble understanding the meaning of what s/he reads or hears (even when s/he understands the main idea of stories, instructions, or explanations)?

Filtering out Distractions

18. Does s/he look around a great deal during work/class? Does s/he stare off into space frequently?

19. Are these signs that this person is tuned in to background noises?

20. Does this person fidget with his/her fingers or other objects at inappropriate times?

21. Is it especially hard for this person to filter out noises from others in order to finish tasks?

Ability to Satisfy Oneself

22. Is this person especially hard to satisfy?

23. Is this the sort of individual who wants "things" all the time and loses interest rather quickly when s/he finally acquires what s/he wanted?

24. Does s/he appear to crave highly intense experiences? Does s/he create provocative situations to "stir things up" in order to produce excitement or high levels of stimulation?

25. Is it necessary for there to be ultra-high levels of stimulation or personal interest in order for this person to concentrate effectively?

B. Output of Information

Preview of Outcomes

26. Does this person fail to look ahead? Are there signs that s/he doesn't think about the consequences before doing or trying something?

27. Are there signs that this individual works impulsively (i.e. without exerting sufficient planning) at home, work or school?

28. Does s/he have a hard time estimating how long tasks, projects, or assignments might take?

Behavioral Control

29. Does s/he have a hard time controlling his/her own behavior at work, school, or in social groups?

30. Does s/he do many things the hard way?

31. Is this someone who seems to lack alternative strategies for learning, for coping with stress and/or relating to others?

32. Are there signs of poor motor control (i.e., clumsiness) when trying to start or stop an activity?

Pacing of Activities

33. Does s/he do many things too quickly?

34. Are there activities or pursuits where the individual operates too slowly?

35. Is this someone with a weak sense of time - its allocation, its sequences, and/or its planning implications?

36. Does s/he make many careless mistakes because of rushing?

37. Are there indications of over-activity in this person?

Consistency of Effort

38. Are there signs of extreme performance inconsistency (e.g., a lot of variability in quality of work or test scores)?

39. Does his/her performance deteriorate over time when s/he is trying to complete a task or assignment?

40. Is it often hard for this individual to mobilize the effort needed to get started with work?

41. Is this person unpredictable in work output (e.g., accomplishing tasks, submitting work/homework)?

42. Does s/he seem "lazy" or somehow poorly motivated?

Self-Monitoring

43. Is there a tendency to fail to notice when s/he makes errors in work? Is s/he highly reluctant to check work or proofread?

44. In social interactions, does s/he have trouble knowing how s/he is doing? Are there problems interpreting social feedback cues from others?

45. Does this person behave in inappropriate ways without seeming to realize early enough that s/he may be getting into trouble?

Learning from Experience

46. Does s/he have a hard time learning from his/her mistakes (i.e., an inadequate response to negative learning experiences?)

47. Does this individual seem unresponsive to rewards or praise?

48. Are there indications that s/he fails to learn from experience?

49. Is this person relatively unable to make use of feedback given by others?

☑ HOW TO INTERPRET ... *The Levine Information Processing Questionnaire*

Once you have answered the questions, count the number of areas in which more questions have been answered with a "Yes" than with a "No". When you do this, you will probably identify the four to six areas which are most strongly affected by your attention. (If you have identified more than six areas, you may wish to count only those areas where you have said "Yes" to every item. If you have less than three areas, you may wish to consider looking at the areas where you said "Yes" to one or two questions.)

If you have asked someone else to fill out the Questionnaire on you or your child, have them use the same procedure to interpret this questionnaire. Each person completing the questionnaire should do so separately. We are looking for individual opinions, not a consensus! Then compare the results. See if there are common areas of concern.

✍ WRITE DOWN...

The 4-6 areas of information processing which are most affected by your attention**.**

_____ _____

_____ _____

_____ _____

See Tool C - *Strategies for Improving Attention* (p.55) in order to address these concerns.

MORE ABOUT... *The Levine Information Processing Questionnaire*

REMEMBER! *The Levine Information Processing Questionnaire* was developed originally as an interview. I use the Questionnaire as something which can be completed by clients in their own time. This saves money for the client when I am being paid by the hour and it also gives people a chance to think about their answers. The actual categories and questions and the suggested way of interpreting the results have not been standardized, nor are they meant to be put into a rating scale format and scored. Dr. Mel Levine cautions any user against this development, which he terms *pseudo-science*.

TOOL C - Strategies for Improving Attention

A list of ideas for strategies, originally developed by Dr. Mel Levine based on the twelve possible areas of information processing that can affect attention.

WHEN TO USE ...

If you have identified four to six areas of information processing which are affected by your attention (using Tool B - *The Levine Information Processing Questionnaire*, p.47)

HOW TO USE...

Choose ONE area of information processing you would like to work on improving. Read the strategies listed and pick ONE strategy that appeals to you. Try the strategy for three to four weeks and DECIDE whether or not it has helped. Depending on the results, you may choose to try another strategy if you want to.

Strategies for Improving Attention[15]

A. Input of Information

Maintaining Consistent Alertness

- Preferential seating in class
- Ensuring adequate sleep for alertness during work or class times
- Reduction in "chunk size" of work, frequent breaks (or opportunity to move around)
- Use of hands for physical activity (e.g., "stress ball", pieces of Plasticine®, doodling)
- Consultation with physician re: medication trial to determine if this will facilitate alertness
- Use areas of strength (i.e., interests/abilities) in school/workplace

Taking in Information Deeply Enough

- Stress on rehearsal strategies or verbal mediation (e.g., "How am I going to accomplish my goals?") through self-talk or note-taking
- Self-testing techniques to see if material is being understood
- Paraphrasing
- Repetition of instructions or explanations
- Demonstrate activity to illustrate understanding of material/instructions

Passive or Excessively Active Processing

- Reminder cards ("Am I being passive or is my mind too active?")
- A disciplined approach to thinking more deeply about a subject (e.g., "What are the things you already know that this new material reminds you of? How is it pretty much like it? How is it new and different?")
- Acquisition and long term pursuit of knowledge and expertise in areas of interest
- Keeping score of how often there are mind trips and/or wake up calls.
- Recording and making use of ideas which are generated during periods of daydreaming or creative thinking.
- Encouragement of high quality processing of information in a top down fashion (e.g., "What are the major concepts involved?" "How does this new information fit into the overall scheme?")

[15] These strategies were developed by Mel Levine, M.D. for use with children experiencing attentional difficulties. Areas of need are identified by using Dr. Levine's Questionnaire of Areas of Information Processing Tool B, (p.47). Dr. Teeya Scholten, R. Psych. and other staff of the Calgary Learning Centre adapted these strategies for use with adults and children.

Determining the Importance of Information

- Stress on development of paraphrasing and summarization skills
- Games emphasizing vigilance and attention to fine detail
- Margin monitoring, underlining, and circling skills when reading/studying
- Practice crossing out irrelevant information (e.g., in math word problems)

Filtering Out Distractions

- Minimizing distractions at home, work, and school
- Use of consistent background sounds (e.g., using ear plugs, or listening to music) when reading or studying
- Frequent, but timed breaks from study

Ability to Satisfy Oneself

- Use of high motivational content for learning - give choices (e.g., "What are you most interested in learning today - option a or option b?")
- Stress on sharing, timed delays of gratification (e.g., "When it's break time, in another 20 minutes, there'll be a chance to do . . .")
- Identification and acknowledgment of areas which are not interesting and in which there will be low motivation
- Everyday use of the vocabulary of insatiability (e.g., "You want to be doing exciting things!") with minimal moralization/judgment about it (e.g. Avoid saying things like: "You're never satisfied with anything." "Isn't anything interesting enough to keep your attention for long?")

B. Output of Information

Preview of Outcomes

- Application of "what if … ?" exercises to imagine future outcomes - in behavioral, social and/or cognitive-academic areas
- Stress on articulating and describing final products (e.g., "What do I want this to look like when I finish?" "What is it I want to say in this report?" "What do I want this person to think about me?" "How do I want my behavior to be in the lunch room?")
- Diagramming of previewed outcomes
- Practice estimating answers

Behavioral Control

- Review of alternative strategies (cognitive - academic, social, and/or behavioral) and selection of the strategy which has the best chance of working out (i.e., best-bet), along with back-up strategies in case one is needed
- Use of hypothetical case studies for above review
- Submission of work plans and social survival plans
- Using flow charts to diagram alternative choices involving acting or inhibiting behavior and the respective consequences
- Review of outcomes and exploration of other alternatives that might have worked better

Pacing of Activities

- Development of time management (in scheduling procedures at home and in school).
- Serve as a time manager at school/work
- Stress on time estimation ("How long should this take me?")
- Elimination of incentives for quick completion of tasks (i.e., no advantages to finishing or "getting it over with quickly")
- Use of time landmarks for writing/reading, projects (e.g., where you should be when...)
- Discussions of time and time management

Consistency of Effort

- Regularly-scheduled work breaks
- Conscious attempts to document graphically on times and off times for effort
- Self-description - verbally and/or in writing- of what it feels like to be running out of mental energy
- Rotation of homework or reading sites at home
- Getting assistance in getting started without being accused (e.g., jump starting efforts by saying, "It's 7 o'clock - didn't you say that you wanted to begin your project at that time?")

Self-Monitoring

- Stress on mid-task and terminal self-assessment ("How am I doing?" or "How do I think I did?")
- Use of self-grading and commenting before submitting tests/work assignments - with credit for accurate monitoring
- Proofreading exercises (e.g., COPS - Capitalization, Organization, Punctuation, Spelling)
- Routine proofreading of own work at least 48 hours after completion

- Use of hypothetical case studies to demonstrate the impacts of poor self monitoring on behavior and interpersonal relating
- Inclusion of quality control measures in work and social plans
- Building self-monitoring as a step in planning actions or strategies

Learning from Experience

- Stress on very consistent consequences for actions
- Need for changing incentives in order to maintain their novelty
- Use of personal diaries to document outcomes of actions - possibly in diagrammatic form
- Lists of "What I've Done Right Today" and "Where I Went Astray Today" with a stress on lessons learned for the future
- Use of a mentor (with whom one has a valued relationship) at home/work/school to whom one can feel accountable for attaining the personal goals which have been set

 **WRITE DOWN...** Which area of information processing you would like to improve? Which strategy are you planning to try first?

Area of Information Processing: ***The strategy I am going to try:***

_____ _____

Pick ONE area you want to work on
Pick ONE strategy you want to try
Try the strategy for three to four weeks

Then DECIDE whether or not it has helped.

You may even find that you have already developed some of these strategies on your own.

If, after you've explored the strategies for improving attention, you still have concerns about your attention, you may wish to pick another area from the Levine Questionnaire or work on other areas, such as:

- eliminating any possible causes for your attentional concerns (see Tool G – *Methods for Investigating the Influence of Food on Attention*, p.93);
- trying to understand the effects of personality type (see Tool F – *Personality Type*, p.81) and/or learning discrepancies (see Tool D – *Learning Discrepancies*, p.63 and Tool E - *Common Reasons for Reading Difficulties*, p.73) on your attention;
- other factors such as emotional or spiritual concerns (see Tool J – *My Personal Profile*, p.147 and Tool K - *Positive Problem-Solving Worksheet*, p.151).

MORE ABOUT... Strategies For Improving Attention

If you need assistance understanding or implementing some of these strategies, contact a teacher, tutor, or local practitioners or agencies for individual help or the names of books or additional resources. See the Annotated Bibliography (p.185) for additional assistance.

TOOL D - Learning Discrepancies: Common Areas of Difficulty, Strategies and Accommodations

A chart which summarizes nine commonly accepted areas of learning discrepancies, including: language, reading, spelling, visual-spatial, math, written expression, organization, attention, and social competence. Information includes a brief description, common labels, remedial strategies, and accommodations which can be used to facilitate success.

 **WHEN TO USE ...**

This information is intended to help you to begin the process of exploring your learning strengths and challenges. We all have different strengths and areas of challenge. But when our levels of ability in these areas are very different from each other, this discrepancy can become confusing and frustrating. For instance, I can speak, read and write three languages, but basic addition and subtraction have been a challenge for my entire life.

I have used the term *learning discrepancy* instead of l*earning disability*. I believe that understanding and addressing the effects as a *discrepancy* can be very helpful because some individuals experience the label *learning disability* as discouraging.

Labels CAN be useful when they help with accessing services and promoting understanding. (I have used the label "learning disability" in my reports and official communications, but prefer to use the label "learning discrepancy" with my clients).

 **HOW TO USE...**

The information listed in the following tables is meant as a very brief overview and is NOT intended as an *official test* for a learning disability, NOR is it meant to replace a thorough assessment.

Table 2 describes information that most professionals would agree with, irrespective of their opinion on what may or may not constitute a learning disability. It describes the nine areas of challenge or difficulty that may be experienced by some learners. Most people may have difficulties in one or two areas, some may have more. If you have differences that are pointed out on the chart, this does not necessarily mean that you HAVE a learning disability. You may be experiencing difficulty for a reason other than a processing problem.

Maybe you never learned how to perform a certain foundational skill and all you need is some specific tutoring in that area. Maybe you have felt so discouraged with your lack of success that you now begin to panic if asked to do anything in that subject area. (This often happens in math or reading!) Even if you do have a learning disability, you need to find ways to be successful in your learning and may benefit from the information included in the sections entitled Accommodations and Remediation.

Look at Table 2 and see if you can identify areas with which you have difficulty. Tell someone whom you trust. You may wish to use the *Positive Problem-Solving Worksheet* (Tool K, p.151) to investigate possible reasons for your difficulties and to identify strategies that you could use to overcome them.

Table 2 - Learning Discrepancies: Common Areas, Strategies, and Interventions[16] (Page 1)

AREA OF PROBLEM	CHARACTERISTICS	COMMON LABELS	REMEDIATION[17]	ACCOMMODATION[18]
1. Language	• problem in understanding and/or expression of language/reading • often strengths in non-language areas such as math, science, mechanics, design	• Language - Learning disabled	• training in grammar, syntax, vocabulary development, paraphrasing to check understanding	• provide several explanations (perhaps using diagrams) until concept is learned
2. Reading	• problems with decoding of single words, understanding what is read	• Specific reading disability • Dyslexia[19]	• teach decoding or comprehension strategies in practical, non-threatening ways • high-interest, low-vocabulary books	• provide additional time for reading • checklists with pictures • books on tape
3. Spelling	• misspell words either phonetically (e.g. "thot" for "thought) or non-phonetically	• Specific spelling disability	• teach self-analysis and spelling strategies in practical, non-threatening ways • encourage reading, dictionary of "problem" words	• if phonetic misspelling, use a spell checker • dictionary of commonly misspelled words • have editor proof read written submissions

Adapted from Scholten, Samuels, Conte and Price (1993)

continued …

[16] Note: These problem areas are mutually exclusive. Often individuals experience one or more areas of difficulty.

[17] This list provides some example of the types of remedial activities and is by no means exhaustive.

[18] Accommodations given for workplace and academic settings.

[19] The term "dyslexia" means "inability to read." Note that there are multiple possible causes for this.

Table 2 - Learning Discrepancies: Common Areas, Strategies and Interventions (Page 2)

AREA OF DIFFICULTY	CHARACTERISTICS	COMMON LABELS	REMEDIATION	ACCOMMODATION
4. Visual-spatial	• problems with math and sciences, written work, messy writing, directions; strengths often in language areas	• Visual-spatial learning disability • Non-verbal learning disability • Perceptual-Motor learning disability	• use verbal skills to "think aloud" and assist with problem-solving • math work on graph paper	• reduce written output (point form) • use a laptop or tablet
5. Math	• determine whether the cause of math problems is due to poor knowledge of math facts, or to steps in doing calculations, or carelessness, or to an inability to read or understand math questions. Use appropriate strategy to remediate cause.	• Specific math disability • Dyscalculia	• for math facts use of flash cards or manipulatives • recipe cards with steps • show how to determine the importance of information in understanding questions	• use a calculator
6.Written Expression	• messy writing, lack of logical sequence to writing, missing words	• Dysgraphia	• re-teach letter formation • planning strategies • proof reading	• use a laptop or tablet for written work helps in organization and presentation • provide scribed or oral exams

Adapted from Scholten, Samuels, Conte and Price (1993)

continued …

Table 2 - Learning Discrepancies: Common Areas, Strategies and Interventions (Page 3)

AREA OF DIFFICULTY	CHARACTERISTICS	COMMON LABELS	REMEDIATION	ACCOMMODATION
7. Organization	• problems sequencing, organizing work	Executive functioning issues	• teaching of metacognitive strategies such as systematic, planful approach to problem solving	• assist in learning organizational strategies • write list of step-by-step instructions • teach editing and multiple drafts • use a laptop or tablet
8. Attention	• problems filtering out distracting noises • impulsive • may occur with hyperactivity • problem completing tasks	Attentional difficulties Attention Deficit Hyperactivity Disorder *Attention Deluxe Dimension* Attention Deficit Disorder	• medication • remediation in areas of content difficulty • teach systematic problem-solving strategies and how to evaluate OWN performance	• work in a quiet area • provide frequent breaks or energy release • use earplugs or listen to music • avoid interruptions
9. Social competence[20]	• poor social skills, insensitivity, interrupting, passivity, or aggression		• life-skills training	• understanding by co-workers

Adapted from Scholten, Samuels, Conte & Price (1993)

[20] There is debate among experts as to the accuracies of social disability as a primary problem or as a problem which is secondary to other problem areas such as impulsivity or language.

MORE ABOUT .... Learning Discrepancies or Challenges

If you need assistance understanding or implementing some of these strategies, contact a teacher, tutor, local practitioner, or agency for individual help. See the Annotated Bibliography and your local LDA Association or library for resources which may provide additional assistance.

Ty's story...about a serious language-related learning disability

Ty was six years old when his Grade One teacher told his parents that she thought he had A.D.D. and should be put on Ritalin. They were upset by this suggestion, but decided that it would be a good idea to find out what was going on with Ty.

As it turned out, one of the reasons that Ty might not have been getting his work done, was because he had no idea what to write. He had not formed any sound-symbol connections and spent his time writing a meaningless string of capital letters. Testing revealed that Ty had a serious language-learning disability. He was a great hockey player and could build fabulous Lego structures, but language and reading did not come very easily to him. Eventually, a diagnosis was made of A.D.D. and he was put on medication. Even when he could concentrate, his academic progress was limited, due to the severity of his language problems.

His parents are now looking into placement in a special school for children with learning disabilities. He will need ongoing support to succeed academically.

Lana's story ... a gifted person with a visual-spatial learning disability

Lana was a 35-year-old gifted individual with a visual-spatial learning disability, A.D.D., and an ISTP personality type. She came from an abusive family and had been depressed all her life. Although she succeeded in getting a Law degree, (which had been her father's idea) she hated all the writing involved in being a lawyer, so she had left the field.

More than anything, she really wanted to become an emergency room physician, but felt that this was out of her reach. She needed Chemistry and Physics and she didn't seem able to pass these courses.

Throughout the time we worked together, she gained a lot of insight into her patterns of behavior. She realized that one of the reasons she had not been able to pass these courses was because they involved building blocks of foundational information that couldn't be crammed at the end of the course (her typical strategy with other courses!). So you actually had to go to class and stay there - a challenge for someone with hyperactivity.

After we worked on strategies to help her attend class with built-in breaks, she also planned to do more of her work on the computer and worked on improving the legibility of her writing for the times when the computer is not an option.

She's feeling a lot more encouraged about her future, and so am I. It will be interesting to see how it goes.

TOOL E - Common Reasons for Reading Difficulties

Outlines common reasons for problems in decoding or reading comprehension, and shows how to investigate and remediate these problems.

WHEN TO USE ...

If you have a concern about your reading, this section is for you. Reading is one of the most crucial skills in being successful in life. This is why I have chosen to address some concerns in this area and not in other core areas such as mathematics. These other subjects are important, however, and I encourage you to get help in any area in which you need it.

The reasons for reading difficulties are numerous. Determining the most likely cause for your reading difficulty is critical to you being able to improve in this area.[21]

HOW TO USE...

Generally speaking, reading difficulties can be categorized into difficulties with decoding or comprehension. Decoding refers to the ability to read single words. Comprehension refers to the ability to understand what you have read. Some people can decode very well without understanding and others can barely decode but are wonderfully adept at figuring out the meaning. Often individuals with attentional concerns CAN actually read very well. They know what single words are and can understand what they read. What they often experience, however, is a pattern of reading without understanding. They will often catch themselves reading while thinking about other things (I think what is really happening is that they are channel-surfing and, as a result, they are not taking in the information deeply enough to make sense of it). They realize that if they are interested enough in the material, or are careful to monitor their comprehension, they can understand what they read.

Difficulties in any or all of these areas takes energy and concentration and often results in a slower reading speed and a reluctance to read.

[21] See Scholten, Couture & Laudel (2014) which presents results on the use of coloured overlays to help improve reading.

If you have identified a difficulty in decoding or reading comprehension, try to arrange for an accommodation, such as reducing the amount of required reading, using books on tape, and/or allowing extended time on tests or exams. If it is a question of attentional factors interfering your concentration, refer to (p.55) and look at Taking in Information Deeply Enough in Tool C - *Strategies for Improving Attention*. Choose a strategy that appeals to you and see if it works! If you have difficulty figuring out what the words say when you are reading and/or understanding what you read, even when you are concentrating deeply, refer to Table 3 on (p.77). It lists a number of common causes for reading difficulties and ways to investigate and/or address them. It may help to have your investigations guided by the use of the Positive Problem-Solving Worksheet (Tool K, p.151).

Clarke's story...about a reading difficulty

Clarke was seven years old and beginning to misbehave in class. His family physician thought he might have A.D.D. and referred him to me for a closer look. Clarke complained of feeling tired a lot and he had a history of frequent ear infections. When his reading was checked, he seemed to be having a lot of trouble with the vowel sounds. Because of his frequent ear infections, milk products were eliminated and Clarke reported feeling more energetic. He was taught the vowel sounds and his parents practiced with him daily for a few weeks. A developmental optometrist ruled out any eye co-ordination problems.

A six-month follow-up indicated that he was feeling good, achieving well in school, and his behavior was no longer an area of concern.

Table 3 Common Causes of Reading Problems, Symptoms and Remedial Strategies (Page 1)

DECODING PROBLEMS

Cause	Symptoms	Investigation	Remediation
Visual acuity	– may squint	– regular eye examination	– eye glasses
Eye co-ordination	– may complain of losing one's place, skipping lines, or may use finger to track words	– examination by a developmental optometrist	– eye co-ordination exercises, special glasses or any combination of these – Ann Arbor Tracking Program[22]
Scotopic sensitivity syndrome (SSS)	– may complain of words getting blurry or running off the page at the end of the lines – may not even realize that there is any other way to see	– examination by someone trained in SSS	– use of colored plastic overlays or special colored glasses
Difficulty knowing sounds the letters make (especially vowel sounds)[23]	– may guess at words and make errors where vowels are involved	– ask to repeat hard and soft sounds made by each vowel	– teach remedial strategies re vowel sounds and rules – some people need the intensive remediation involved in Auditory Discrimination In Depth Program
Difficulty breaking the words into syllables	– may read small words fine and seem to look at the first few letters and then guess at longer words	– show familiar and new words with three or four syllables and ask to read them	– teach syllables by feeling movement of jaw or clapping while saying longer words such as "intelligent" – teach how to break words into syllables of 2-3 letters with a vowel in each syllable

continued …

[22] For more information about any of the programs mentioned specifically in this chart, contact your local Learning Disability Association

[23] **Bolded sections** indicate the possible reasons for reading difficulties that are most commonly experienced by those with A.D.D.

Table 3 Common Causes of Reading Problems, Symptoms and Remedial Strategies (Page 2)

COMPREHENSION PROBLEMS

Cause	Symptoms	Investigation	Remediation
Poor vocabulary	– may miss the meaning of passages due to lack of knowledge of word meaning	– ask student to tell you the meaning of key words in the passage (even though they may have been read correctly)	– work on building vocabulary through the use of a personal word dictionary
Reading books that are too difficult	– may take a very long time to read a short passage	– check that books are at an appropriate level of difficulty	– use the 5-finger rule - ensure that book has no more than 5 words per page that the person does not know (i.e., either how to read it or the meaning of it).
Problems making visual pictures of material being read	– may read quickly but without intonation which suggests a comprehension problem	– ask person to paraphrase or re-tell the meaning of what they have just read – some people need the intensive Visualizing and Verbalizing Program	– practice visualizing what is being read
Not taking in the information deeply enough[24]	– may read but realize afterwards that they were thinking about something else	– ensure that person can decode and comprehend what is being read, ask them about symptoms	– use margin monitoring with a pencil or pen in order to create an interaction between author and reader
Not connecting new information with prior knowledge	– may show passivity in identifying what they already know about topic being studied and may not be making connections as they read	– ask person what they already know and how they are remembering the new information	– give practice activating prior knowledge before reading and help them to organize new information through semantic mapping (see the K-W-L strategy on p. 80 below)

[24] **Bolded sections** indicate the possible reasons for reading difficulties that are most commonly experienced by those with A.D.D.

MORE ABOUT .... Reading Strategies

Whenever anyone has a concern with reading, I recommend that they be examined by a developmental optometrist who checks for both acuity and eye co-ordination. **Whenever there is a reading difficulty, the possibility of eye co-ordination problems should always be explored.**

There are many different remedial strategies which are very effective in developing reading skills. Local tutoring or remedial services should be of assistance in determining the cause of the reading difficulty.

In the section below, I have included the three most common intervention strategies that I recommend. All reading methods (such as visual, phonics, and whole language) have their value, because we all learn in different ways.

Difficulties arise when one technique is taught to the exclusion of other methods. Under these circumstances, different sets of "disabled" readers tend to be created. I now see more teachers presenting children with a variety of ways to learn to read and that is encouraging. Remember, a particular strategy should be used only if you feel that is the reason for the reading problem in the first place. Be sure to try it for a few weeks and then evaluate whether or not it seems to be working. If it isn't helping, try something else. Tool K - *Positive Problem-Solving Worksheet* (p.151) may help you approach this area in a systematic way.

A. Decoding Strategies

The following three strategies may be tried for improving decoding skills when there is **difficulty knowing sounds the letters make (especially vowel sounds).**

1. Vowel Sounds - vowels have two basic sounds - a hard and soft sound. The hard sound is when it says its name (a - as in ape). The soft vowel sounds are the first sound in the following words:

a - apple
e - elephant
i - igloo
o - ostrich
u - umbrella

2. **When Two Vowels Go Walking** …

"When two vowels go walking the first one does the talking (i.e., says its name)." For instance, in the word *peat* there are two vowels (i.e., a diphthong). The way you sound out the vowel is to say the name of the first vowel in the pair, which is "e" (as in *even*).

3. The Silent "E" Rule

When there is an "e" at the end of the word, after a consonant, the vowel before the consonant says its name. For instance, in the word *flake* there is an "e" after the consonant "k", therefore the "a" says its name (as in *ape*).

B. Reading Comprehension Strategy

K-W-L

The K-W-L strategy below is very effective in developing reading comprehension when the difficulty is due to **not taking in the information deeply enough** or **not connecting new information with prior knowledge.** I recommend it to parents and teachers alike, for all ages of students.

K	**W**	**L**
What do I already **K**now?	**W**hat do I want to learn?	What did I **L**earn?

Start by filling in the **K**, and then the **W**, before beginning to read about a certain topic. Once questions are identified, the student will find it easier to get involved in the reading and will recognize when answers come to their questions. After reading, complete the **L**. The student will be amazed at what s/he has learned!

TOOL F - Personality Type

Includes two charts which provide:

i) a very brief summary of the main characteristics of Introverts and Extraverts, Sensing and iNtuiting, Feeling and Thinking, and Judging and Perceiving;
ii) information which illustrates the advantages of these characteristics and how they affect one's needs in learning or workplace environments.

WHEN TO USE ...

This information is intended to help you begin the process of exploring your personality type and the relationship between your personality type, attentional patterns, and learning styles. The information listed below in Table 4 and Table 5 is meant as a very brief overview and is NOT intended as an official test, nor does it replace any other publications that explain the Jungian types (including the MBTI)[25]. The results may or may not be accurate depending on how strong your preferences are and if you are able to identify them accurately. For a description of how ADD can look very different in various personality types, see Scholten (2014).

HOW TO USE...

Personality preferences are a little like handedness. Although we generally have two hands available, we tend to feel more comfortable using one hand more than the other. This is what we call our dominant hand. If need be, we can learn how to use the other hand, but this doesn't change our natural preferences.

Like handedness, some preferences are easier to determine than others. In some people these preferences are very strong. In others, the difference is less obvious and the personality harder to detect. If you are not sure of your preferences, please consider seeing a professional trained in the administration of the MBTI. This will help you to obtain an accurate determination of your personality type.

But for now, let's just make a make a best guess as to your preferences!

[25] MBTI denotes the Myers-Briggs Type Indicator®, a registered trademark of the Myers & Briggs Foundation.

First, look at Table 4 and mark your preferences or tendencies.

Second, refer to Table 5 and notice how your personality affects your needs, energy, and learning preferences.

Third, compare YOUR preferences with those of your partner, child, teacher, or friend. Appreciate your similarities and differences and decide if conditions in your educational or workplace settings are consistent with how you learn/perform best.

Fourth, read more about the MBTI and enjoy learning more about yourself! A number of relevant books are listed in the *Annotated Bibliography*, including the works by Briggs-Myers and Myers (1980), Lawrence (1979). If you can obtain a copy of the manual by Isabel Briggs-Myers (1987) called *Introduction to Type,* you may want to look up the one-page description of your personality type and see if it describes you.

Lastly, if you need assistance or would like an *official* MBTI test done, contact a local mental health professional who is trained to give the test. It can be a very interesting and healing experience. Many books have been written and a lot of research has been done on the MBTI, particularly in relation to career counseling. The books by Tieger and Barron-Tieger (1993) and Briggs-Myers and McCaulley (1985) are wonderful references to guide you in career exploration.

If you ARE an adult with A.D.D., you will want to ensure that you are in a job to which you are suited and in which you are INTERESTED. Interest has a very stimulating effect on the nervous systems of people with A.D.D.: it is amazing what can be accomplished if interest is there!

What is your best guess as to your personality preference?

Table 4 - An Overview of Personality Type Preferences

Initial	Characteristic	Preference for or tendency to:
E	Extraverted	- make quick decisions - get energy from being with people
I	Introverted	- want time to reflect before making any decision - get energy from being alone
N	iNtuiting	- interested in the *big picture*, generalizations, theories - process in a random-abstract way
S	Sensing	- interested in details, accuracy - prefer things to be neat and tidy and done in a step-by step manner
T	Thinking	- think logically - have a hard time telling how others are feeling unless you ask them or observe carefully
F	Feeling	- able to tell how others are feeling - avoid arguments if possible
P	Perceiving	- live life spontaneously without a lot of planning
J	Judging	- live life in a planful manner, with to-do lists and schedules to guide activities

Circle YOUR preference: E or I , N or S, T or F, P or J

Write your preferences on these lines: _____ _____ _____ _____
This may be your personality type.

Table 5 - How your personality affects your needs, energy, and learning preferences

Write your personality preferences on this line: ____ ____ ____ ____

If this is your personality type, the information in this table may be true of you.

Initial	Characteristic	Gifts you bring to the world	What you need in a learning or workplace environment
E	Extraverted	A quick thinker	- a chance to talk over your ideas with others in order to develop them
I	Introverted	A deep thinker	- time to reflect before being asked for your ideas - time alone everyday in order to stay energized
N	iNtuiting	Innovative approaches	- a chance to work in a random-abstract manner - presentation of the big picture, or theory, before being asked to deal with details
S	Sensing	Factual and accurate	- have material presented in a logical step-by-step manner - assistance with organizing facts into major concepts/theories involved (if you have to know this)
T	Thinking	Logical and analytical	- have an opportunity to consider the logical side of an idea - be told how others feel, so that you may respond to their needs
F	Feeling	Aware of how others feel	- identify what you care about and how your work is relevant to the things you value - encouragement to express your feelings or ideas, so that others may respond to your needs
P	Perceiving	Flexible and adaptable	- assistance with time management strategies and motivators for completed tasks
J	Judging	Persistent	- an opportunity to complete assignments or projects - encouragement in changing or adapting plans, if necessary

 **WRITE DOWN...**

Your personality type and how it affects your learning and/or attention.

My Personality Type: **How I learn best:**

_____ _____

_____

How does my personality type affect the way I relate to others or behave in social or work situations?

_____

_____

What other questions do you have about your personality type?

_____

_____

 **WRITE DOWN...**

The names of professionals in your community who are qualified to administer and interpret the Myers-Briggs Type Indicator®. You can find this information on line.

_____

_____

MORE ABOUT ...

The Myers-Briggs Type Indicator® (MBTI)

This is a personality test which can be administered only by properly-trained professionals who are qualified to give and interpret the test. However, a number of books have been written through which people can help themselves identify their most likely personality type. Once we know what our personality preferences are, we can understand how we relate to the world and how we might be the same or different from others. Use of the MBTI information can promote a better understanding of ourselves and others and in so doing, have a positive effect on relationships between people at home, at school, and in the workplace.

Books which might be of particular interest are by: Briggs-Myers and Myers (*Gifts Differing*), Tieger and Barron-Tieger (*Do What You Are*), Lawrence (*People Types and Tiger Stripes*), Briggs-Myers and McCaulley (*Manual: A Guide to the Development and Use of the Myers-Briggs Type Indicator*).

EVEN MORE ABOUT...

The Myers-Briggs Type Indicator® (MBTI) and A.D.D.

This section is for mental health professionals who have used the Myers-Briggs Type Indicator extensively and are familiar with A.D.D.

People with certain personality types may appear to have A.D.D. when they really don't.

I have noticed that many individuals with an Extraverted-iNtuiting-Thinking-Perceiving (ENTP) personality type CAN LOOK like they have A.D.D., even when they don't!!! This is because they are friendly, talkative people who are quick and innovative thinkers who tend to operate in a random-abstract (rather than concrete-sequential or step-by-step) way.

Some people call ENTPs simultaneous processors of information, rather than sequential processors. As a result, ENTPs can appear to be *all over the place*. They blurt out ideas or answers somewhat impulsively, skip from topic to topic in conversations, think of innovative ideas, and seem as though they are not listening. They also tend to be interested in the *big picture* more than in the details of a situation. As a result, they make careless errors and often report that they easily lose or misplace things. They are logical, but may not be as sensitive to the feelings of others as other personality types. As a result, their interruptions may seem inappropriate. They tend to prefer to continue gathering information rather than making decisions. As a result, they tend to avoid making decisions and resist committing themselves to schedules. This helps them to be flexible and adaptable, but often results in difficulties finishing the tasks they have started.

If you refer back to the *Screening Checklist for Attentional Concerns* (on p.44), you will notice that in describing a typical ENTP we have mentioned characteristics #1, 2, 3, 4, 5, 6, 9, 10, 11, and 12. These are ten out of the thirteen characteristics used by mental health professionals to identify A.D.D. So, if someone scores high on the *Screening Checklist for Attentional Concerns*, does it mean that they have A.D.D. or are their *symptoms* more a result of their personality type? OR is it that ENTP types with A.D.D. run into more difficulties in life than other personality types? These are compelling questions that some mental health professionals are just beginning to realize.

There is no doubt in my mind that there is a significant interaction between MBTI personality types and the challenges mentioned typically by people with attentional concerns. The more I have worked with individuals of differing personality types who DO have A.D.D., the more I have begun to identify unique patterns of A.D.D. in certain personality types. For instance, an ISFJ with A.D.D. tends to be very quiet and often over-focused, even obsessive at times. Can you see how this looks very different from an ENTP who might also have A.D.D.?

How to avoid False Positives and False Negatives ... it's a challenge!

Just as the ENTP has a high chance of being diagnosed A.D.D. when they are NOT (a false positive), the ISTJ has a high chance of being NOT diagnosed A.D.D. when they very well COULD have it (a false negative)!!! That is why it is very important to understand personality types when trying to make a diagnosis.

If you are interested in learning more about this topic, see Scholten (2014). In my opinion, it is a crucial factor in understanding ourselves and how we learn. Having information on MBTI personality type also helps me to more accurately diagnose A.D.D. when it is present.

Brent's story ... the role of personality type

Brent was a divorced, 42-year-old father of two who had an ISFJ (Introverted-Sensing-Feeling-Judging) personality type. He was a quiet, sensitive, responsible man who felt discouraged about what he had accomplished in life and reported that he had constant headaches and was a "chronic worrier". He did NOT look like your "classic ADD stereotype" and could have easily been overlooked or misdiagnosed as having an anxiety disorder.

Brent reported that he had always had difficulties in school and had never read much. In trying to understand Brent from a wholistic point of view, he was first referred to a developmental optometrist to rule out any eye co-ordination problems which would explain his long-standing problems with reading. He was okay in this area, however, he found it much easier to read with a blue plastic overlay. Because he had done so little reading over the years, his vocabulary was not as good as it should have been, so he started to work specifically on improving it.

When he took milk out of his diet for a week, he reported having much more energy and less gas in his stomach. In monitoring his physical symptoms, Brent noticed that he always had a headache after a "night out with the boys" where drinking might be involved. He wanted to see what would happen if he eliminated alcohol completely from his diet. His headaches disappeared! However, he was still worried about what others might think of him if he didn't drink socially. We worked on some self-concept issues and assertiveness training and problem-solved what he would drink in social situations. Although he felt much better off milk and alcohol, he still met the criteria for A.D.D.: Predominantly Inattentive Type. He was interested in a medication trial.

At 10 mg. of Brand Name Ritalin twice a day, Brent found that he could concentrate better at his job and while reading. He was even able to get daily chores done at home. For reading, he no longer needed the blue plastic overlay. He also reported feeling much less anxious. He is now doing well and will be continuing to take courses in his field to upgrade his skills.

TOOL G - Methods for Investigating the Influence of Food on Attention

Explains what foods are most likely to be causing difficulties and provides guidance in a step-by-step manner in terms of how to find out if this is a problem. Sample menus for milk-free, wheat-free, corn- and sugar-free diets are included. There are also tips for managing your *stress bucket*.

WHEN TO USE ...

If you have physical symptoms and no one can find a medical reason ... OR if you are concerned about attentional symptoms in yourself, a loved one, a student, or an employee and wonder what might be causing the problem. There can be a lot of possible reasons why you are experiencing attentional symptoms. Some physical reasons may be:

- hypoglycemia (low blood sugar)
- depression
- thyroid problems
- food or environmental sensitivities

Why not find out THE FACTS?
Is something physical causing your attentional symptoms or not?

Be very careful that you do NOT try to eliminate more than five foods from your diet without medical supervision. You do not want to run the risk of malnutrition. If you find that you are sensitive to a lot of substances, you may wish to consider a five-day rotation of the offending foods, rather than complete elimination. A referral to an allergist, clinical ecologist, naturopath, homeopath, or dietitian may also be prudent.

The information given here is **NOT intended as a substitute for proper medical care.** It **IS** intended as a place to begin investigating whether or not your attentional symptoms might be affected by physical factors such as food sensitivities and what you can do about them.

Symptom and Food Diary*

1. Write down what foods you ate yesterday or **on a typical day**.

BREAKFAST _____

LUNCH _____

SUPPER _____

SNACKS: (State time of day _____

_____

Symptoms

2. Put a number (0, 1, 2, or 3) in each box in the table below describing symptoms or how you felt yesterday, or **on a typical day**.

TIME OF DAY/ SYMPTOM	BEFORE BREAKFAST	AFTER BREAKFAST	AFTER LUNCH	AFTER SUPPER
TIRED OR DROWSY				
IRRITABLE				
OVERACTIVE				
HEADACHE				
RESPIRATORY (Stuffy Nose, Cough)				
DIGESTIVE (Nausea, bellyache)				
URINARY (Frequent or Wetting)				
OTHER (please specify)				

COMMENTS: (Mention anything that happened to you today that might account for your symptoms other than food... or any observations or ideas you may have, including cravings, etc.)

_____

_____

*adapted in 1996 by Dr. Teeya Scholten, C. Psych. from a rating format used by Dr. William Langdon, London, Ont.

Who Should Look Into This?

In my opinion, **everyone** who is wondering if they have A.D.D. should take at least **one food out of their diet** for seven days to see what happens. (See Step 2 on the next page to decide what food(s) you want to eliminate.) Over the last twenty years of practice, our research has shown that 85% of our clients showed improvement in their attention after removing certain foods for seven days. Of this group, 15% completely lost their attention difficulties, which showed that they didn't have A.D.D., they had a food sensitivity! Therefore, I can no longer feel comfortable in diagnosing A.D.D. without taking at least one food out of the diet. Which food(s) you eliminate will depend on your physical symptoms and preferences. We tend to avoid or be addicted to things to which we are sensitive.

I also believe that **anyone with any physical complaints** (e.g. frequent colds or ear infections as a child, asthma, headaches, stomach aches, joint pain, depression, frequent crying spells, bad moods) should investigate the possibility that something in their diet or environment is affecting them. Of course, these symptoms can be caused by many other factors, but why not rule out the possibility that our symptoms are being caused by something we are eating?

If you notice that every time your child eats broccoli, he breaks a window,
you might want to try eliminating broccoli for a while and see what happens!
Dr. Ted Hallowell, Jan. 31, 1997 Calgary, Alberta

☑ **HOW TO USE...**

1 Fill out the *Symptom and Food Diary* (SFD) and the *Screening Checklist for Attentional Concerns* (SC/A) as a Baseline.

2 Pick which food(s) you want to eliminate from your diet.

3 Make up a menu.

4 Take the test food(s) out of the diet for seven days.

5 Reintroduce each test food, one at a time, for three days.

6 Fill out the SFD and the SC/A every day of the food test.

7 Analyze the results.

8 Decide what you want to do next.

Step 1: Fill out the Symptom and Food Diary and the *Screening Checklist for Attentional Concerns* as a Baseline

We want to start with a measure of how you typically feel. Write down what you ate and how you felt yesterday or write down what you typically eat and how you usually feel. Add up all of the numbers to get your total score. This is your "Baseline" measurement. When you begin to experiment, by eliminating selected foods, you will compare the results with this Baseline.

Step 2: Pick which food(s) you want to eliminate from your diet.

If you are wondering which food to eliminate, consider the following:

MILK - If you crave or tend to avoid any milk products, if you have a family history of asthma, bronchitis, or *weak lungs*, if you get more than two colds per year, have frequent ear infections or had swollen glands as a child.

WHEAT - If you crave or tend to avoid bread, if you have a family history of celiac disease, or if you experience gastro-intestinal symptoms of gas, bloating, constipation, if you feel depressed, get irritable or in *bad moods* or have anger management issues.

CORN AND SUGAR - If you crave or tend to avoid any corn products (like popcorn) or sugar (like candy or alcohol) or if you have a sinus problems or a family history of diabetes or alcoholism.

This is not an extensive list of what these foods can do to anyone, it just happens to be guidelines that we used in working with our clients.[26]

You may want to experiment with only one food at a time or you may wish to eliminate all of the foods for which you *qualify*, based on the guidelines above. Then you just reintroduce each food one at a time.

 MORE ABOUT … eliminating sugar and going off caffeine.

If you want the best results for yourself and to feel as comfortable as you can throughout the process, please refer to the guidelines below on how to eliminate sugar

[26] Although there is a large number of food items that people can be sensitive to, we chose to focus on the three most prevalent allergic foods in the North American culture, namely cow's dairy, wheat and corn.

and to avoid toxic-die off if you meet the criteria for eliminating corn and sugar.

If you are a professional wanting to make an accurate diagnosis of ADHD, I suggest that you have your client or patient follow the guidelines below for eliminating caffeine for a week before doing his/her food elimination experiment.

Tips for Eliminating Sugar

For people who needed to eliminate corn, we also had them eliminate all forms of refined sugar at the same time. The criteria for removing corn and sugar are the same, so we decided we should eliminate both substances. Fruit (which contains fructose) is okay, but alcohol is not. This is not a Candida diet, but rather one that eliminates sources of refined sugar.

Because so many processed foods contain sugar, we found it was difficult to find sugar-free foods and we didn't want to introduce any artificial sweeteners. As you probably know, the contents of processed food are included on the ingredient list in order of the quantity being used. Therefore, we allowed products in which sugar was listed as the 5th or further ingredient. This seemed to work well.

We wanted the food trial to be manageable and reasonable for our clients. More extensive testing can be done later, if desired.

Avoiding Toxic Die-Off

Toxic die-off can occur when we choose to eliminate foods that feed Candida (yeast). We have not made a diagnosis of Candida; we have chosen refined sugar on the basis of the client's characteristics - cravings or medical history. Candida and some other intestinal bugs rely on sugar for nourishment. When we withdraw this form of nourishment, yeast and bacteria cells die and release waste and something called endotoxins which are toxic to the body. Because the immune system mounts a response to these endotoxins, we usually feel worse as we cleanse. We were fortunate to be guided by Dr. Peter Bennett, Naturopath, in a way to prevent this.

If you need to take out corn and sugar for a week, Dr. Bennett recommends that you drink plenty of water with lemon juice and that you begin 500 mg of non-chewable Vitamin C per day. These help your body cleanse itself and eliminate the toxins. After 500mg on the first day of the food elimination trial, increase the Vitamin C by 500mg each day so that by the fourth day, you reach 2,000 mg per day. Continue at this level until the end of the week-long food elimination phase.
If at any point, you reach *bowel tolerance* and begin to experience a lot of gas and/or diarrhea, cut back to the previous dose of Vitamin C and stay at that level until the

end of the food elimination phase. If there is any point at which you begin to feel cravings for the food(s) that have been eliminated or any other symptoms of toxic die-off (such as headaches, rashes, lethargy, insomnia, or flu-like symptoms), we encourage you to take one additional 500 mg Vitamin C tablet. We find that this intervention minimizes the discomfort from "toxic die-off" and helps you feel as well as you can during your one-week elimination experiment.

Going off Caffeine

If you are a coffee or tea drinker, be sure to have at least one cup of decaf coffee each day for the first three days of caffeine elimination. Decaf coffee actually contains a small amount of caffeine that helps to ease the withdrawal symptoms as you transition to no caffeine. After three days on decaf, drink only water or herbal teas.

 MORE ABOUT … for the professional making a diagnosis.

In order to make a valid diagnosis of ADHD, we also ask clients to remove caffeine for a week before the food trial and to stay off it during the elimination period. People often self-medicate with caffeine to help them concentrate. We want to measure how they function in their natural, non-medicated state when they have eliminated potentially allergic foods. If someone is on anti-depressants or anti-anxiety medication, we do not interfere with this or other forms of medication or addictions (like cannabis or tobacco) at this point. We feel that these issues can be addressed later, once the person is feeling better.

Step 3: Make up a MENU

I have provided sample wheat-, milk-, corn-and-sugar-free menus on the following pages. These are just to show you what kinds of things you CAN have. But it is important for you to read the information carefully and then make up your OWN menu for the seven days off the food(s) you have chosen. You want to be very careful as you remove foods **to ensure that your underlying nutrition is adequate**. You do not want to be hungry nor eat the same food every day. Variety is very important, as well as representation from the protein, vegetable, fruit, and starch food groups. So you have a little homework to do before you begin to eliminate the "suspected food(s)!"

You want to keep your diet as similar to your present diet as possible. You are testing the effect of CHANGING only ONE factor at a time. If you change more than one aspect of your life and you feel better, you won't know why.

You might also want to have your menu checked by someone who is knowledgeable in the area of nutrition. If you do NOT make up a menu and have it checked, chances are that you might accidentally include something with that selected food in it. Then your whole test will be ruined.

Make a decision about which food(s) you want to eliminate. Just vary the ONE factor! Otherwise, keep your diet similar to your normal regime.

If you don't have any idea of what you might be sensitive to, you might want to consider formal allergy testing.

If you want to get tested in a formal way, your decision will probably be based on what is available to you, what you think is effective, and what you can afford. There are many different forms of testing, such as the traditional allergy testing with needles or scratches, muscle testing, or electro-dermal testing. If you have the resources and interest, you may wish to use a more modern technique and arrange for blood testing, which is painless and can test for multiple allergens at the same time. Then you can see if you are sensitive and determine what are the major offenders.

Formal testing will tell you WHAT your sensitivities are, but it will NOT tell you the effect these sensitivities are having on your emotions, attention, or thinking.

Once you know what you are sensitive to, you will still need to take it out of your diet for a week to see what, if anything, this substance is doing to your attention.

Table 6 - A Sample Milk-Free Menu

Note: For toast and sandwiches, choose bread that is free of any casein or cow's milk products. Also see the note on the next page about milk products in general.

DAY OF WEEK	MON.	TUES.	WED.	THURS.	FRI.	SAT.	SUN.
BREAKFAST	Corn Bran cereal with Almond Milk Apples	Cheerios with Rice Milk and Bananas	Bacon and Eggs Toast Pears	Hash Browns Milk-free Pancakes	Oatmeal made without milk Brown Sugar Oranges	Corn Bran Blueberries	Rice Krispies Apples
LUNCH	Salami Sandwich Minestrone Soup	Chicken Noodle Soup Soda Crackers Carrots	Peanut Butter and Banana Sandwich Raisins and Walnuts	Salmon Salad with Mayo on Rye Cracker	Egg Salad Sandwich Celery Sticks	Tuna Sandwich Corn Chips	Chunky Soup Black Forest Ham on Finn Crisps
DINNER	Baked Chicken, Broccoli and Baked Potato	Spaghetti and Meat sauce (without Parmesan Cheese)	Pork Chops with Applesauce Sweet Potato	Vegetable Stir Fry Pasta	Hard Tacos without grated cheese Refried Beans	Baked Chicken with French Fries	Sweet and Sour Meatballs on Rice

MILK-FREE MENU continued...

Snacks: Can include potato chips, corn chips, popcorn, fruit wraps, tortilla chips.

Note: Milk products include milk, chocolate, yogurt, cheese, cottage cheese, sour cream, and milk in breads and pastries. Bread should be bought at places that sell bread in which no milk has been used. Anything which says *casein*, or *whey*, or *lactose* should be avoided. However, butter is allowed. Acceptable milk substitutes include almond, rice, and coconut milks. Orange juice should not be substituted for milk as it is another allergenic food. You may drink water or a variety of other juices. If you do have fruit juice, it's best to have a different juice every day. Mayonnaise is generally acceptable because it doesn't usually contain any milk.

Be sure to include healthy oils, such as olive, avocado, and/or coconut in your salads.

If you find that you are sensitive to milk products...

- it may be wise to consider switching to one of the pre-mentioned milk substitutes,
- ask your pharmacist for the name of a supplement that includes Calcium, Magnesium and Vitamin D,
- you may be fine if you choose to have milk products up to once per week. However, if you find that you are "cheating" and wanting them more often, it may be that your addiction is talking and you may need to abstain completely for a while.

Table 7 - A Sample Wheat-Free Menu

*If you found that you are sensitive to milk products, then you would want to exclude them in your wheat test for the whole ten days, too. Then just re-introduce the wheat. In this case, do not include the items which are written in bold in the menu. Use almond, rice, or coconut milk in place of cow's milk. You could also try 2% goat's milk.

DAY OF WEEK	MON.	TUES.	WED.	THURS.	FRI.	SAT.	SUN.
BREAKFAST	Corn Bran cereal Apples	Rice Krispies cereal Pears	Bacon and Eggs Bananas	Hash Browns **Yogurt** and Honey	Oatmeal Oranges	Corn Bran cereal Blueberries	Rice Krispies Apples
LUNCH	Dill pickles rolled in Salami Barley Muffin	Chunky Soup without noodles **Cheese** and Carrots	Celery with Peanut Butter Raisins and Walnuts	Salmon Salad with Mayo on Rye Cracker	Rice Crackers with Egg Salad	Tuna Salad with Relish Corn Chips	Chunky Soup without noodles Black Forest Ham on Finn Crisps
DINNER	Baked Chicken, **Cheese Sauce** on Broccoli and Baked Potato	Steak and Shrimp Green Salad with Thousand Island Dressing	Pork Chops with Applesauce Sweet Potato	Vegetable Stir Fry on Rice	Hard Tacos with Refried Beans	Baked Chicken with French Fries	Sweet and Sour Meatballs on Rice

Snacks: Can include potato chips, corn chips, popcorn, fruit wraps, tortilla chips.

WHEAT-FREE MENU continued...
NOTE: Wheat is found in bread, buns, pastries, pasta, pizza, and many soups with noodles. For the WHEAT-FREE week, consider using rye products such as Rye Crisp, Finn Crisp, Kavli, Pumpernickel, as long as there is no wheat flour in the ingredients. Dimpflmeier makes a 100% Rye Bread which can be toasted. Be careful as most rye bread have as a first ingredient *flour* and then *rye flour*. The word *flour* in this context bmeans *wheat*. Barley flour (and rice flour) make a great wheat flour substitute in muffins and in other baking. They are used in equal amounts to wheat flour in recipes.

If you find that you are sensitive to wheat products...

- you will want to switch to using different kinds of grains in your diet, such as rye, corn, oats, barley, millet, spelt, rice,
- if you choose to have wheat products once a week, you may be fine (we call this "junk day"). However, if you find that you are "cheating" and wanting them more often, it may be that your addiction is talking and you may need to abstain completely for a while.

FOR A CORN-AND SUGAR-FREE MENU - Eliminating the CORN can be extremely difficult because it is HIDDEN in a lot of foods and other products such as candy and toothpaste. This is where you may need the help of a nutritionist or dietitian who is familiar with food sensitivities. If you want to try, you may be able to use the menu guidelines above, but do NOT include anything which is made from Corn. This includes:

- Corn Flakes, Corn Bran as cereal
- Cornstarch for thickening (use regular flour, potato or rice flour instead).
- Corn Syrup and candies.

To eliminate SUGAR, you can have food that does not have sugar listed as one of the first 5 ingredients.

What are you going to try first?

☐ MILK-FREE ☐ WHEAT-FREE ☐ CORN and SUGAR-FREE

What do you normally eat?

Make your menu as similar as possible to what you normally eat. Be sure to include at last five options in each meal category. Never eat the same thing two days in a row. Variety is the spice of life!

Time of Day	Ideas for Meals
Breakfast	
Lunch	
Supper	
Snacks	

You may want to have a dietitian or someone knowledgeable about food double-check your menu to ensure that you have eliminated all the foods in the category you are testing and have created a menu that includes a reasonable balance of fruit, protein, vegetables. and starches.

Step 4: Take the test food(s) out of the diet for seven days.

This time period is usually long enough to tell whether or not the food(s) in question is having an effect on your physical or attentional symptoms. However, if you are addicted to the substance, the first three days of the week-long test can be quite difficult. You might feel extra tired or your mind will try to play tricks on you to try to get you to "cheat" or "quit the experiment." Your mind might say that "I could never live like this, that it is ridiculous, so why bother ..." If this happens, I find it helpful to remind my mind that I am on a "fact-finding mission." You want to know if this substance is hurting you. If you find out that it is not good for you, you will still have choices: to continue eating it, to reduce the amount eaten, or to build up your body so that it can handle it. This is usually enough to get over this hump of resistance.

If you can get through the first three days,
you are usually home free!

Step 5: Reintroduce each of the test food(s) one at a time for three days each time.

This is often a challenging step, especially if you are feeling a LOT better! But if you don't put the substance back in your diet, chances are that several months down the road, you will wonder if you really felt better because you eliminated the substance or because of some other factor. Be sure to fill out the *Symptom and Food Diary* and *Screening Checklist for Attentional Concerns* during this time, too.

MORE ABOUT … reintroducing test foods.

After the week of food elimination, you need to reintroduce the foods you have eliminated, one at a time for three days at a time. It's up to you which food to put back in first. It'll probably be the one you missed the most! However, if milk was one of the foods, we recommend you reintroduce it last in case it makes you feel stuffed up or sick, or if it results in a cold.

If you are testing more than one food at a time and felt worse when back on a particular food, it's a good idea to stay off it for the rest of the food trial and for at least three days before testing the next food. This allows your system to mostly clear itself enough of the offending food.

Step 6: Fill out a Symptom and Food Diary Sheet and *Screening Checklist for Attentional Concerns* EVERY DAY of the food test.

It is very important to fill out **both of these sheets every single day** of your food test. Having other people (e.g., teacher, parent, child, partner) fill out the *Screening Checklist for Attentional Concerns* (p.44) too before you begin and each day of the test will help you to gather information on the effects of food on your attention. Having multiple observers increases the power of your observations and ratings and makes them more objective.

Using these forms will give you actual numbers to compare along with your observations of how you feel, in general. You can show these records to your doctor, friend, or other professional who might be involved in helping you to interpret the results. Sometimes, the results will be obvious. Other times, it can be more difficult to tell.

If you **write down everything you eat** and you have an unexpected reaction or symptom, then you can look back at your records and see what you ate that day. It might be due to something you had never suspected!

Step 7: Analyze the results.

Once you have completed Step 6, you will need to decide if there is another substance you would like to explore or not. Be careful not to eliminate more than five substances from your diet at the same time unless you are under careful medical supervision.

Now, you will need to decide what to do with the information you have learned.

Do you feel better? ☑ **Yes** ☐ **No**

 **WRITE DOWN...**

what you learned about yourself. Did you feel any differently? Did your attentional symptoms change? What questions do you still have?

_____

_____

If you are feeling completely better...

If the results are obvious, and you feel a lot better - physically and in terms of your attention - your problems may be solved! You will need to decide how you want to handle this. See Step 8.

If you are better in some ways, but not in others...

Maybe you feel better physically, but your attentional symptoms are still present. These could be due to other unidentified allergens, personality type, learning discrepancies or simply A.D.D. You may wish to seek out more extensive allergy testing to investigate this possibility, try nutritional interventions, or find a professional who could provide you with further assessment of personality and learning concerns and/or ultimately a diagnosis of A.D.D. This last step is particularly important if you wish to try medication.

WRITE DOWN…

the name of an allergist, clinical ecologist or dietitian in your area.

Do you feel better? ☐ Yes ☑ No

Remember that 85% of our clients reported feeling physically better when they took selected food out of their diet. If you are not feeling better, I wonder if you:

- made up a menu for **yourself**
- filled out the Symptom and Food Diary every day (including the food you ate and a rating for each of the physical symptoms)
- had enough to eat
- ate a balanced diet

If you did all these things, then perhaps you accidentally included the food you had chosen to eliminate in your diet or chose the wrong food to eliminate. In this case, you may want to re-read the guidelines for selecting a food, consult a dietitian or find a professional with expertise in these areas. Or maybe you don't have a problem with any of these foods in the first place, which was the case for 15% of our clients.[27]

[27] For more information, see Scholten (2003)

 **MORE ABOUT ...** For the professional: making a diagnosis

At the end of the week of food elimination and before any foods are reintroduced, the client's goals should be re-measured, along with their functioning in terms of attention, depression and anxiety. Hopefully, you will have eliminated other possible causes of ADHD (p.17), treated any PTSD and understood learning discrepancies (Tool D, p.63) and personality type (Tool F, p.81).

At this point, you may wish to review the diagnostic criteria for ADHD to see if they qualify. Remember to ask them how they are functioning when doing activities in which they are NOT interested.

It is beyond the scope of this self-help manual to provide all of our assessment tools, but I would be happy to share this information with any professionals who may wish to adopt the Empowerment Plus® approach with their clients/patients or to study this model in greater detail.

Step 8: Decide what you want to do next.

If you have discovered that you are feeling much better OFF certain foods, you have some decisions to make. Do you want to continue to eat foods that are hurting you and simply endure the symptoms? At least you know that you do not have A.D.D. if eliminating certain foods took away the symptoms. You also have the choice to eliminate the food from your diet or consume it no more than once a week, treat the symptoms or build up your body's ability to handle it. It's your decision. Let's look more closely at these options.

If you decided to eliminate only one food at a time, and you felt the least little bit better after eliminating that one, be sure to stay OFF this food if you choose to experiment with another one or two foods. You want to find out how GOOD you can feel, as naturally as possible (I hope!☺) but you do not want to compromise your nutritional status. So proceed with caution.

If you are sensitive to certain foods, you have three basic choices:

1 Eliminate the offending substances,
2 Treat the symptoms,
3 Build your body's immune system.

Let's look at the first option ...

1 Eliminate the offending substances

Q: How strict do I have to be if I want to eliminate the food?
A: That depends on you and what your body needs if you want to reduce or avoid symptoms.

There are varying degrees of elimination and only by trying will you know what works for YOU. The goal is usually to see how little change you need to make in your normal routine in order to avoid having symptoms. Some allergists recommend complete abstinence for three months and then reintroduction of the substance to see if you can handle it better after this (Randolph and Moss, 1989). You may wish to completely eliminate the offending substances, or reduce the amount to which you are exposed on a daily basis, or just have it once a week on *junk day*.

Every BODY is different and you will only know what works for YOU by trying different options.

In 1976, I was told by our allergist, Dr. William Langdon, that if I concentrated on completely eliminating the one or two major offenders (i.e., wheat and milk products) for myself and my children and provided relief from the dust by sleeping in an allergy-free bedroom, that it would probably take care of the allergic symptoms. He was right! If you want to allergy-proof a bedroom, you can find information from any allergist's office or on the Internet about how to do it.

When my children were growing up, we found it easiest to use the once a week option. For us, Saturdays were our *junk* days. At first, they could have as much wheat and milk as they wanted on these days, but we soon noticed that they were coughing the next day! So, in our family, we had to cut back to one product from each of these groups on this day. Sometimes, we had pizza on Saturday. Another week, they might have a donut and an ice cream cone. They had choices, I found it easy to keep Saturday as our *junk* day and they didn't get sick any more. It worked for us!

If you are dealing with many food allergies you may wish to consider a *rotational diet*. Dr. Marshall Mandell[28] discovered that you can actually eat anything that you are not deathly allergic to, as long as you "rotate" the foods and do not eat a certain food more often than every five days.

[28] See Mandell & Scanlon (1988)

Let's look at the second option...

2 Treat the symptoms.

If you have discovered that you have inhalant allergies, such as to dust and molds, you may want to consider desensitization shots. There are also a number of health-care practitioners who believe that you can cure food and environmental sensitivities by homeopathic or other types of remedies. I have not had much experience with this to date, but every year there are more and more advances and research may prove them correct. You will need to do your own research. You may want to ask around for the names of naturopaths or homeopaths with a good reputation in your area. Sometimes acupuncture and chiropractic care can eliminate stresses from other sources which can result in a relief of your symptoms.

WRITE DOWN...

the name and phone number of ALTERNATIVE HEALTH CARE PROFESSIONALS as you discover them.

Chiropractor:_____

Naturopath:_____

Homeopath:_____

Acupuncturist:_____

Others:_____

Now let's look at the third option ...

3 Build up your body's immune system.

In this category, there are many choices. Which one you choose will depend on your personal preference. Stress is one factor that affects our immune system.

If you don't want to have symptoms, you can either reduce the stressors or increase the size of your *stress bucket*. In this way, it can be useful to consider what else in your life is stressful. Maybe there are some stressors that you CAN eliminate or reduce. You may find that if you are able to eliminate some stressors (such as anxiety, financial, social or work pressures) that this alone will reduce the stress on you enough to make your physical symptoms go away.

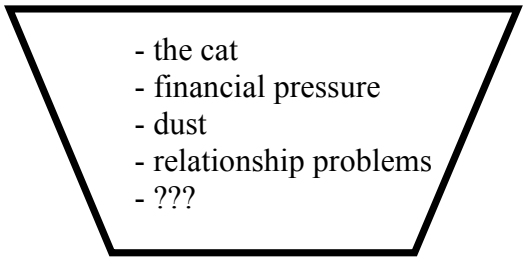
If you are experiencing back pain, stress due to pressures at work, financial obligations or relationship challenges, it may be helpful to address these.

Lowering your Stress Bucket

When we are filled with too many stressors, our bucket overflows and we have symptoms. The symptoms can be physical (i.e., sneezing or itching), mental (i.e., problems making decisions or concentrating) or emotional (i.e., crying or irritability). What are your symptoms when your stress bucket begins to overflow?

Too many stresses can result in ⇒Symptoms

WHAT'S IN YOUR STRESS BUCKET?



WRITE DOWN...

What are all of your stressors? Which ones can you eliminate and which do you need to just accept?

Stresses in my Life	Stresses I might be able to eliminate	Stresses I probably have to accept

You can't do it all at once, but you will feel better if you just begin …
what do you feel like addressing first?

WRITE DOWN...

the name and phone numbers of professionals[29] knowledgeable about A.D.D. in your area who might be able to help you eliminate some areas of stress in your life.

_____

_____

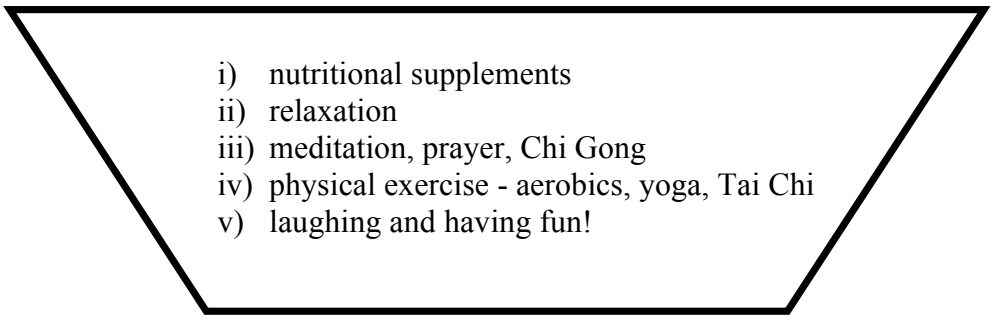
_____

[29] Have you considered the services of a Physiotherapist, Chiropractor, Massage Therapist, Acupuncturist, Dietition, Nutritionist, Herbalist, Naturopath, Psychologist, Social Worker, Counsellor, Speech and Language Pathologist, Occupational Therapist, Physician, Minister, Priest, Instructor in the areas of meditation, spiritual growth, Yoga, Tai Chi, etc?

Increasing the Size of Your Stress Bucket

If you can't eliminate any stressors right now, you may want to increase your ability to handle them.

You can increase the size of your stress bucket in a variety of ways:



The challenge is to find out what kind of prayer or meditation is right for YOU!

 **WRITE DOWN** ...

Places that offer courses in the following areas:

Aerobics, Yoga, Tai Chi: _____

Relaxation, Meditation, Chi Gong _____

Any activity that you enjoy: _____

You will only find out by trying if these courses help YOU to feel better.

 **WRITE DOWN** ...Things I can do to reduce the stressors in my life and/or build up my ability to handle these stressors?

_____

_____

_____

Are you ready to make a plan? If so,

 **WRITE DOWN...**

What's my plan? How long will I do this? How will I know that it has been effective in helping me to feel better?

_____

_____

_____

 **ABOUT ...**

Food sensitivities and their effect on behavior, emotion, and attention.

There is a lot of controversy in the field of allergy. Some experts believe that **allergy testing** will tell you about your sensitivities. Others believe that it can tell you about how you react to substances that you breathe in or touch, but that it **doesn't tell you about the effect of food on your body or nervous system.**

Food goes through a number of different chemical changes during the process of digestion and you could be sensitive to a particular food at any one of these stages. Tests such as electro-dermal screening and blood tests may be able to show you what you are sensitive to, but will not tell you what these substances do to your attention, emotions, and behavior. I believe that you will only know for yourself if you try.

There are many authors[30] who have experience with the effects of food sensitivities on behavior and emotions. Dr. Theron Randolph has been writing about this since 1945, and only now, in 2018, is it finally being accepted!

What do you believe?

Well, by now you are pretty far through this book. It was intended to guide you through a process of self-exploration and help you to understand yourself or your child in a more complete or *wholistic* way.

So what's next???

If … then …

If … you have eliminated one or more foods from your diet, you probably feel better – physically, emotionally and/or attention-wise. But despite this improvement, what if your attentional symptoms are still a problem for you? Or for others?

and

If … you have tried to understand yourself by looking into your personality type, learning discrepancies and food sensitivities and you still have concerns,

and

If … you wish to try medication to see if it helps you…

[30] For example Mandell & Scanlon, 1988; Randolph and Moss, 1989

Then… it's probably time to get a diagnosis of A.D.D. You can't do this part yourself. You will need to find someone with expertise in this area to make the diagnosis.

Part of making the diagnosis is ruling out all other possible causes of your attentional symptoms. That's why it might be helpful for you to complete the *Barkley Semi-structured Interview Guide* in the next section to take to your health care professional. Once s/he is able to make a diagnosis, then you will have to decide what kind of treatment you want.

Combining medication with all of the other strategies you have already tried may be the key to your success! Who knows until you have tried?

Medication may be the key to your success.

If you are diagnosed with A.D.D. and you want to try medication, I urge you to show your doctor the *Farrelly Protocol for a Medication Trial* (Tool I, p.137). Ask him or her if they would be willing to use this approach in doing a medication trial. Using this approach, you will find out what the smallest dose of medication is which gives you the maximum results.

In this way, you and your physician will probably be able to prevent problems which often occur with overmedication.

Also, if you have felt the least bit better OFF a particular food, please stay OFF it during the medication trial. Once you know how good you can feel with as little medication as possible, then you may wish to start reintroducing it (once a week or just a little at a time!).

TOOL H - The Barkley Semi-Structured Interview

This is a standard psychiatric interview, originally developed by Dr. Russell Barkley. It is designed to gather past information and rule out other possible causes for attentional concerns. It is often used in the process of making a formal diagnosis of A.D.D.

WHEN TO USE ...

Before you decide whether or not to pursue a formal diagnosis of A.D.D. Just knowing this information may guide you somewhat in your own explorations.

OR

When you are ready to pursue a diagnosis. These questions would usually be asked during an interview with the physician or mental health professional you chose to see. If you fill it out ahead of time... it MAY save some time.

HOW TO USE...

Simply answer the questions. All of the questions will be appropriate for an adult, but some will not yet apply to a child, depending on his/her age. Just ignore these. The professional you see should know how to interpret the information you provide. S/he may ask you about certain areas in further detail.

WRITE DOWN… mental health care practitioners in my area who diagnose A.D.D. (or refer to chart in Part One, pp.23-24).

The Barkley Semi-structured Interview for A.D.D. in Adults [31]

Client's Name:_____ Date:_____

Date of Birth:_____ Age:_____ Grade:_____

Completed by:_____ Relationship to client:_____

1. What led you to seek an evaluation for A.D.D. now?

2. What is your understanding of A.D.D.?

3. What do you know about the treatment of A.D.D.?

4. Do you know anyone else who was diagnosed with A.D.D.?
    1. Yes
    2. No
    3. Not sure

5. If Yes, how were they treated for this disorder? (Circle any that apply)
    1. Ritalin or methylphenidate
    2. Other medication (please specify _____)
    3. Therapy (group or individual) only
    4. Not sure how they were treated
    5. Other

    Comments:

6. What are your greatest concerns about your behavior now?

7. When would you say these problems began? (Circle any one)
    1. 0-7 years
    2. 8-12 years
    3. 13-15 years
    4. 16-21 years
    5. 22 to present

[31] Adapted from Russell A. Barkley's *Interview Form and Rating Scales for AD/HD Adults*. From *Attention Deficit Hyperactivity Disorder: A Clinical Workbook*, (pp.23-39). Copyright 1991. Guilford Press: New York. This form may NOT be reproduced in any form without written permission of Guilford Press.

8. Now I'm going to ask you about some symptoms, and I'd like you to indicate if they were ever more of a problem for you than for others your age.

Symptom	Yes / No	Now it is: Same/Better/ Worse	Comments
a. Fidgetiness or feeling restless.			
b. Difficulty remaining satisfied.			
c. Being easily distracted.			
d. Difficulty waiting your turn.			
e. Blurting out answers before the question is completed.			
f. Difficulty following through on or completing tasks.			
g. Sustaining attention in tasks.			
h. Frequently shifting from one task to another.			
i. Difficulty doing tasks alone.			
j. Talking too much.			
k. Interrupting or intruding on others.			
l. Not listening to others.			
m. Losing important things or forgetting a lot.			
n. Engaging in physically daring activities.			
o. Always on the go, as if driven by a motor.			
p. Making decisions too quickly or acting too quickly.			
q. Impatient.			

9. Did you ever seek treatment for these problems before? (Circle one)
   a. Yes
   b. No

   If yes, when and where did you seek treatment? What was the recommended treatment and outcome?

10. Did your parents ever take you to see anyone about these problems when you were a child or adolescent?
   a. Yes
   b. No
   c. Not sure

   If yes, when and where did they seek treatment? What was the recommended treatment and outcome?

11. Did your parents complain that you were a difficult child to control?
   a. Yes
   b. No
   c. Not sure

   If yes,
   During what ages did they have this complaint? (Circle any that apply)
   a. 0-7 years
   b. 8-12
   c. 13-15
   d. 16 -21
   e. 22 +

   What did they complain about?

   What methods of discipline were used?

12. Now I'm going to ask you some questions about school. What is the highest level of school that you have completed ?
    a. Kindergarten - Grade 4
    b. Grade 4 - Grade 7
    c. Grade 7 - Grade 9
    d. Grade 10 - Grade 12
    e. Graduated from high school
    f. 1 or 2 years college or university
    g. 3 or 4 years college or university
    h. Postgraduate education (What was your field of study?_____)

13. Did you ever have any trouble starting school in kindergarten or in the first grade ?

14. Did you ever repeat a grade ?
    a. Yes
    b. No

    If yes, which grade did you repeat ? _____

15. Were you ever in any special classes in school ?
    a. Yes
    b. No

    If yes, in what kinds of special classes were placed? What was the outcome?

16. How would you describe your grades in school ?
    a. Average
    b. Better than average
    c. Worse than average

17. What was your best subject in school?

    _____

18. What was your worst subject in school?

    _____

19. Did your parents and/or teachers think you did as well as you could?
    a. Yes
    b. No
    c. Not sure

20. Were you ever truant from school?
    a. Yes
    b. No

    If yes, how often and during what grades?

21. Were you ever expelled or suspended from school?
    a. Yes
    b. No

22. Did you ever get in any physical fights at school?
    a. Yes
    b. No

    If yes:

    I. During which grades did you get into fights?
    a. K - 6th grade
    b. 7th or 8th grade
    c. High school
    d. other

    II. How many times did you get into fights?
    a. One time
    b. Two to five times
    c. Six to ten times
    d. More than ten times

    III. Did you sometimes start the fight?
    a. Yes
    b. No
    c. Not sure

    IV. Did you ever use a weapon in a fight?
    a. Yes
    b. No

    If yes, details:

23. Did you ever run away from home overnight?
    a. Yes
    b. No

    If yes:
    I. How many times did you run away?
        a. Once
        b. Two to five times
        c. Six to ten times
        d. More than ten times

    II. What was the longest duration you ran away from home?
        a. One night
        b. Two to five nights
        c. Six to ten nights
        d. More than ten nights
24. Did you ever get in trouble for stealing or damaging property as a child or teenager?
    a. Yes
    b. No

    If yes, details:

25. Have you ever been arrested or in trouble with the law?
    a. Yes
    b. No
    If yes, details:

26. Do you have a driver's license?
    a. Yes
    b. No

    If yes:
    I. How many traffic tickets (not parking tickets) have you ever gotten?
        a. None
        b. One
        c. Two or three
        d. Four or five

    II. How many car accidents have you ever been in?
        a. None
        b. One
        c. Two
        d. Three
        e. Four or more
    If no, why don't you have a driver's license?

27. Do you have problems with your temper?
    a. Yes
    b. No
    If yes, details:

28. Have you ever lost or temper enough to hurt anyone or damage any property?
    a. Yes
    b. No
    If yes, details:

29. Do other people complain about your temper?
    a. Yes
    b. No
    c. Not sure
    If yes, details:

30. How would you describe your mood most of the time?
    a. Normal or fairly stable
    b. Anxious or nervous
    c. Depressed, sad, or blue
    d. Labile; mood changes a lot
    e. Other:_____

31. Do you have any problems with your sleep?
    a. Yes
    b. No
    If yes, details:

32. Do you have any problems with your weight?
    a. Yes
    b. No
    If yes, details:

33. Do you ever use any diet preparations?
    a. Yes
    b. No
    If yes, which ones?

34. How much alcohol do you drink in a week?
    a. I never drink

b. 0-1 drinks
c. 2-4 drinks
d. 5-13 drinks
e. More than 13

Details:

35. Did you ever drink more heavily?
    a. Yes
    b. No

If yes, details:

36. Have you ever used drugs recreationally?
    a. Yes
    b. No

Drug	Used in the Past	Frequency	Using Presently	Frequency
a. Pot, marijuana, hashish, Cannabis				
b. Amphetamines, stimulants, speed, Crystal meth				
c. Barbiturates, sedatives, downers, sleeping pills, Seconal, Quaaludes				
d. Tranquilizers, Valium, Librium				
e. Cocaine, coke, crack				
f. Heroin				
g. Opiates other than Heroin (Demerol, Morphine, Methadone, Dragon, Opium, Oxycontin, Fentanyl)				
h. Psychedelics(LSD, Mescaline, Peyote, MDT, PCP, Extasy)				
i. Other (specify)				

37. If you are using drugs recreationally now, please indicate why.

38. Have you ever misused prescription drugs?
    a. Yes
    b. No
    If yes, details:

39. Have you ever seen a counsellor, psychologist, social worker or psychiatrist?
    a. Yes
    b. No
    If yes, details:

40. Have you ever been hospitalized for a psychological or psychiatric difficulty?
    a. Yes
    b. No
    If yes, details:

41. Have you ever had problems with depression?
    a. Yes
    b. No
    If yes, details:

PAST MEDICAL HISTORY

42. Have you ever had any problems with anxiety?
    a. Yes
    b. No
    If yes, details:

43. Do you have any medical problems?
    a. Yes
    b. No
    If yes, details:

44. Have you ever been hospitalized for medical reasons?
    a. Yes
    b. No
    If yes, details:

45. Have you ever had heart problems?
    a. Yes
    b. No
    If yes, details:

46. Have you ever had liver problems?
    a. Yes
    b. No
    If yes, details:

47. Have you ever had glaucoma?
    a. Yes
    b. No
    If yes, details:

48. Have you ever had seizures?
    a. Yes
    b. No
    If yes, details:

49. Do you have high blood pressure?
    a. Yes
    b. No
    If yes, details:

50. Are you ever troubled by chest pain or shortness of breath?
    a. Yes
    b. No
    If yes, details:

51. Have you ever had an injury to your head?
    a. Yes
    b. No
    If yes, details:

52. Have you ever lost consciousness?
    a. Yes
    b. No
    If yes, what was your first memory?
    Details:

53. Have you ever had encephalitis or a brain infection?
    a. Yes
    b. No
    If yes, details:

54. Have you ever had or do you now have tics or unusual movements of your body?
    a. Yes
    b. No
    If yes, details:

55. Have you ever had or do you have any vocal tics, or do you make any unusual noises? (Tourette's syndrome)
    a. Yes
    b. No
    If yes, details:

56. Are you right-handed or left-handed (indicate Right, Left or Ambidextrous as appropriate)
    a. Writing_____ c. Throwing_____
    b. Kicking_____ d. Sighting_____

57. Have you ever had any problems with your thyroid gland?
    a. Yes
    b. No
    If yes, details:

DEVELOPMENTAL HISTORY

58. As far as you know were there any problems with your mother's pregnancy or delivery of you?
    a. Yes
    b. No
    If yes, details:

59. As far as you know, did you walk, talk, and sit up on time?
    a. Yes
    b. No
    If no, details:

60. Did you have any childhood illnesses or operations?
    a. Yes
    b. No
    If yes, give dates and details:

61. Did you have normal relationships with your peers when you were a child?
    a. Yes
    b. No
    If no, details:

SEXUAL HISTORY

62. Are you sexually active?
    a. Yes
    b. No

    If yes, are you using any birth control?
    a. Yes
    b. No
    If yes, what type?

63. Do you have any concerns about your sexual activity?
    a. Yes
    b. No
    If yes, please specify

(Questions #64 - # 66 are for Females only - Males go to Question #67)

64. Do you intend to get pregnant within the next 5 years?
    a. Yes
    b. No

65. Are you trying to get pregnant?
    a. Yes
    b. No

66. Are you currently nursing?
    a. Yes
    b. No

MEDICATIONS

67. Do you take any prescription medication?
    a. Yes
    b. No
    If yes, details:

68. Do you take any over-the-counter medications?
    a. Yes
    b. No
    If yes, details:

69. Has anyone in your family ever been addicted to prescription medications?
    a. Yes
    b. No
    If yes, details:

ALLERGIES

70. Do you have any allergies to medications?
    a. Yes
    b. No
    If yes, details:

71. Do you have any other allergies?
    a. Yes
    b. No
    If yes, please indicate what you are allergic to and how you found this out:

FAMILY HISTORY

72. Are there any medical illnesses that run in your family?
    a. Yes
    b. No
    If yes, details:

Has anyone in your family had problems with any of the following:

- anxiety or depression?
    a. Yes
    b. No

If yes, details:

- abuse of alcohol or other drugs?
    a. Yes
    b. No

If yes, details:

- any psychiatric illness?
    a. Yes
    b. No

If yes, details:

- being in trouble with the law?
    a. Yes
    b. No

If yes, details:

- seizures or other neurological problems?
    a. Yes
    b. No

If yes, details:

Has anyone in your family had problems with any of the following:

- Tourette's syndrome or vocal tics?
    a. Yes
    b. No

If yes, details:

- movement disorder or any unusual movements?
    a. Yes
    b. No

If yes, details:

- heart problems?
    a. Yes
    b. No

If yes, details:

- high blood pressure?
    a. Yes
    b. No

If yes, details:

- attentional problems?
    a. Yes
    b. No

If yes, details:

- learning disabilities?
    a. Yes
    b. No

If yes, details:

SOCIAL HISTORY

73. How much do you smoke, in packs per day (ppd)?
    a. never smoked
    b. have quit for more than a year
    c. have quit for less than a year
    d. less than half a pack per day (ppd)
    e. half to one ppd
    f. one to two ppd
    g. two or more ppd

74. How much caffeine do you drink, including caffeinated tea and soft drinks?
    a. none
    b. 1-2 cups per day
    c. 3-4 cups per day
    d. 5-6 cups per day
    e. 7-13 cups per day
    f. 15+ cups per day

75. Can you give me the highlights of your work history as far back as you can remember?

76. Have you ever served in the military?
    a. Yes
    b. No
    If yes, details (highest rank, special honors, duties, discharge status)

77. What is your current marital status?
    a. single (never married)
    b. married
    c. separated
    d. divorced
    e. widowed
    f. other _____

78. Are you currently in an intimate relationship?
    a. Yes
    b. No

    If yes, for how long?

    a. less than 3 months
    b. 3-6 months
    c. 7 months - 1 year
    d. 1-5 years
    e. 5-13 years
    f. 13+ years

79. Do you have trouble in your relationships with others?
    a. Yes
    b. No

    If yes, details:

80. How many intimate relationships have you had that lasted more than 3 months?
    a. none
    b. one or two
    c. three or four
    d. five or more

I have asked you a lot of questions. Can you think for a minute and tell me if you have any other problems that you haven't mentioned?

TOOL I - The Farrelly Protocol for Conducting a Medication Trial

WHEN TO USE ...

A medication trial should ideally occur after:

- physical and emotional causes for attentional concerns have been ruled out and the patient understands how to work WITH any learning strengths and challenges and his/her personality type (See Part Two: Tools B to F),
- an assessment has been conducted by a physician, mental health practitioner, or team of professionals knowledgeable in the areas mentioned above,
- a formal diagnosis of A.D.D. has been made,
- a number of strategies have been tried to address attentional symptoms and more intervention is felt to be needed and
- information has been presented to the patient about the risks and benefits of any drug being considered.

There are a number of medications which are used to treat A.D.D. and it seems that another one is added to the list every year. For many years, the most commonly-used medication for both adults and children was Methylphenidate or Ritalin, the one which has been studied for the longest, produces the least number of side effects and is no longer active after a few hours. It was often tried first unless the physician had a reason for preferring another drug. However, the newer designer drugs are becoming increasingly popular.

Some physicians use certain drugs alone or in combination. Not everyone responds to medication, but you won't know until you have tried. Individual physicians may have a preferred method for performing a medication trial, but one of the most effective methods I have seen used is one which was developed by Geraldine Farrelly, M.D., F.R.C.P.C., a Developmental Pediatrician who practices in Calgary, Alberta, Canada. She developed this approach while working with children with A.D.D. I have seen this method used effectively with a minimum of side effects in both children and adults.

Having had such excellent results with Brand Name Ritalin with my own clients, I hope that it will remain available for many years to come.

☑ HOW TO USE...

Table 8 - The Farrelly Protocol for Conducting a Ritalin Trial

Always begin with regular or **brand name Ritalin.** If this is desired, the physician should check off "no substitutes" on the prescription pad; otherwise the pharmacist might substitute the generic brand or SR (Sustained Release). Dr. Farrelly considers these to be less effective than the brand name and suggests that the generic or SR can be tried once the medication trial has been completed to see if the same results are obtained.

Begin with a dosage of ½ tablet of Ritalin. Take it three times a day (i.e. just before breakfast, before lunch and between 4-5 p.m.) Never take the third dose after 6 p.m., as it may interfere with sleep. This third dose allows one to assess the effect of this amount of medication on homework, sports or other evening activities. Stay at each dosage level for three days. Increase the dose by 1/4 of a tablet per dose ***every three days,*** as follows:

Days	1-3	½ tab or 5.0 mg.
	4-6	¾ tab or 7.5 mg.
	7-9	1 tab or 10.0 mg.
	10-12	1¼ tab or 12.5 mg.
	13-15	1½ tab or 15.0 mg.
	16-18	1¾ tab or 17.5 mg.
	19-21	2 tab or 20.0 mg.*

Complete a *Screening Checklist for Attentional Concerns* every day of the trial so that responses can be monitored. Continue increasing the dosage level until signs of too much medication are noted (i.e., tiredness, irritability, light-headedness, feeling uncomfortable or *not oneself*). Then immediately cut back to previous level and stay on this dose until your next appointment. At this time, the Screening Checklists can be examined to see if you have responded to the medication and to identify the smallest dose that gave the optimal results. Once the correct dosage is determined, other medications that are taken once a day may be tried to see if similar effectiveness can be achieved. If Ritalin was not effective, other types of medication can be tried.

** Some individuals may require more than 20 mg. per dose, but this level should be very carefully supervised.*

Whenever possible, try to conduct the trial during a period of **stability** in the environment (i.e., avoid change in routine). **Each** individual is **unique** and their symptoms vary in severity. Individual responses may vary from dosage to dosage. The response can also be difficult to predict as some **small** individuals require **large** dosages, while some **large** individuals require **small** dosages. For this reason, a trial using **varying amounts** of medication is really the only way to determine the exact dosage required.

The **response** of the individual should be closely **monitored** across **many situations** such as home, school, workplace, and recreation by the use of **rating scales.** the *Screening Checklist for Attentional Concerns* (next page) should be completed by involved individuals (i.e., patient, partner, parent, teacher), considered in the context of activities in which they are NOT interested.

Screening Checklist

for Children and Adults with Attentional Concerns

PRESENT DOSE:_____

NAME:_____DATE:_____RATER:_____

	OBSERVATION	NOT AT ALL	JUST A LITTLE	PRETTY MUCH	VERY MUCH
1.	Difficulty with details - makes careless mistakes				
2.	Difficulty sustaining attention to current task				
3.	Does not **seem** to listen or sustain attention to discussions. May ask for questions/statements to be repeated.				
4.	Difficulty following through on instructions				
5.	Difficulty starting/finishing tasks				
6.	Loses things necessary for tasks or activities				
7.	Easily distracted by noises or other surrounding activities				
8.	Fidgets or doodles				
9.	Uncomfortable staying seated for periods of time or leaves seat frequently				
10.	Talks excessively or dominates conversations inappropriately				
11.	Blurts out answers before questions have been completed				
12.	Interrupts others inappropriately				
13.	Daydreams				

COMMENTS:_____

Adapted for use with adults and children by Dr. Teeya Scholten, C. Psych. Calgary, AB.
from checklist developed by the Calgary Learning Centre, 1996.

Use of the *Screening Checklist for Attentional Concerns* will assist the physician and mental health practitioner in assessing the response to medication. Keep in mind that feedback from the person him/herself is essential, regardless of age.

Reminder!!! There are many reasons that a person might respond to the items on the *Screening Checklist for Attentional Concerns*. If there are four or five checkmarks in the Pretty Much to Very Much column, all this tells us is that there ARE attentional concerns, NOT the cause of these concerns. That is why it is so important to rule out physical and emotional causes and to understand educational and personality factors before making a diagnosis of A.D.D. and engaging in a medication trial. Mac's story (p.144) provides a good example of this.

How are the checklists used?

The *Screening Checklist for Attentional Concerns* should be filled out **before the medication trial begins** and **each day** of the trial. It is used in assessing the effectiveness of the medication and should be completed EVERY DAY by the individual and several other people who are in a position to observe objectively. This might be a parent, teacher or partner. Make a note of the actual dose being taken on one set of sheets (i.e. perhaps those filled out by a parent or patient). This is done so that when the results are reviewed after several weeks, it is possible to identify **if the individual is responsive to medication and what is the lowest dose which gives the maximum result**. The comments on the sheets filled out from home and school are extremely helpful, in addition to the checkmarks. Some people like to keep a journal of how they are feeling and what they are noticing about changes in their reactions.

The dosage is started off at a very low level and increased gradually, until optimum effects are noted (i.e., problem areas such as impulsivity diminishes or concentration and task completion improves) or signs of too much medication occur (i.e., tiredness, irritability, light-headedness, feeling uncomfortable or *not oneself*). These types of **problems** occur if taking **too much of any type** of medication, not just Ritalin or other stimulant medications. If the dose is too high, immediately cut back to the previous level. The individual then continues on this dose until his/her next appointment.

Begin with only ½ tablet (5 mg.), three times a day. It should be given ten minutes before meals. Follow the progression outlined in Table 8. Dr. Farrelly recommends booking an appointment with the patient at three and six weeks after beginning the medication trial. This allows direct observation of any changes in the patient, an opportunity to examine the *Screening Checklist for Attentional Concerns*, comments and/or journal entries to address any concerns and to discuss any changes in symptoms. If the patient has settled on an optimal dose before the next appointment, they should be told to be sure to be on this dose when returning for the appointment(s).

When the *Screening Checklist for Attentional Concerns* is completed everyday by several people, it is possible to see if any checkmarks move from the *Pretty Much* and *Very Much* columns to the *Just a Little* or *Not at All* columns. (This is considered to be the *No Problem Zone*.) If there are also no (or at least minimal) side effects, the drug is judged to be effective. The next step is to determine the lowest dosage that gives the maximum results. This will be evident from the checklists and patient self-reports.

Remember, medication is NOT to be used instead of other interventions,
but to be used in conjunction with other interventions and strategies!

How long will it take to perform the medication trial?

With children, Dr. Farrelly prefers to start the first dose on a Saturday so that the effects of the medication can be carefully monitored by a parent. She gives each dose for an entire week. With adults, it may be enough to stay at each level for three days in order to assess the results. Using this method, the medication trial should be over within three weeks if the dosage levels are increased every three days and within six weeks if each new dose is tried for a full week. It may be over sooner, if the patient responds well to lower doses and side effects begin to occur. It may take much longer if the patient does not respond and alternative medications need to be tried.

Why is Brand Name Ritalin recommended when the generic brand is cheaper and the time-release is more convenient?

Dr. Farrelly uses **Brand Name Ritalin** as she has found that the generic and time-release forms of Ritalin are less effective. However, these alternative forms of Ritalin can be tried once it has been established that the patient is a *responder*, the correct dose has been determined and the types of improvements in symptoms noted. Then it can be determined if similar results are achieved using the other forms of Ritalin or other medications.

When should Ritalin NOT be recommended?

When there is a history of tics or **movement disorders** (such as Tourette's Syndrome), caution should be exercised in prescribing any kind of stimulant medication. Many practitioners are also concerned about the potential for abuse of Ritalin. If there is a history of **substance abuse** in the patient, a careful assessment should be made. If the substance abuse was during adolescence and the patient claims a long period of abstinence, this should be verified and drug use should still be very carefully monitored on an ongoing basis (i.e., through urine screens). If the patient is currently abusing any kind of substance, s/he should be referred for addiction treatment.

At this point in time, the general policy seems to be that medication trials may be attempted under careful supervision once the substance abuse is under control. However, there is a lot of variation in practice. Some health practitioners are reluctant to consider giving medication EVER, because of the potential for abuse. Ritalin and Talwin are often called *Poor Man's Heroin* as they can be used together to create a similar effect to that obtained by Heroin. I have also heard of parents selling their children's Ritalin because of the high street value. One hopes that this is the extreme exception, but it is important to be aware of the possibility.

Most practitioners prefer to wait until the treatment for addiction is completed before prescribing any medication for attentional concerns. Some are willing to engage in a medication trial, once a diagnosis of A.D.D. has been made and it can be proven that the patient has no other drug in his/her bloodstream (i.e., weekly urine checks). However, it MAY be that providing the patient with a needed drug (i.e., Ritalin to treat A.D.D.), will assist in the effectiveness of his/her treatment for addictions.

It is my hope that future research may show us clearly whether or not it is better to delay treatment for A.D.D. until after addiction treatment or whether it should be introduced as soon as possible.

What other medications are used for treating A.D.D.?

Many other medications are used and can be tried if Ritalin is not advisable or found to be ineffective. These include Dexedrine, Adderall, Mydayis, Vyvanse, Imipramine, Prozac and many others. Some drugs are used in combination, depending on what other problems the patient may be facing. When combinations are used, the process should be **carefully supervised by medical practitioners with expertise** in the area of A.D.D. - a pediatrician or child psychiatrist in the case of children and a psychiatrist for adults.

Why not use a *double blind* approach to the medication trial?

In the past, there was some preference for a *double blind* test. (In this type of test, the real medication was given some of the time and at other times a look-alike pill was given. This was called the *placebo*. No-one except the pharmacist knew which type of pill was being taken at a particular time. Records were kept and analyzed at a later date. Then a decision was made as to whether or not the medication was effective in helping relieve the symptoms.) This method is not widely-used any longer, for a variety of reasons.

The most serious disadvantage in using a double blind approach has to do with lack of patient involvement and awareness in determining how the medication is affecting him/her. If there is a positive response to the drug, but you suspect a *placebo effect* (i.e., the symptoms are improving because the patient believes that the drugs are helping and not because of the actual action of the chemical on the brain), a double-blind test can be set up at a later date. However, such a placebo effect is rare and is usually short-lived.

Why not just give some medication to see if the individual responds? Doesn't this confirm a diagnosis of A.D.D.?

This type of information is found in some medical journal articles and older books on A.D.D. We now know that giving medication and observing the response is NOT a reliable way to make a diagnosis of A.D.D. It has resulted in medication being prescribed too early in the process of diagnosing A.D.D. I believe that it is this type of practice that has resulted in much of the controversy surrounding the use of

Ritalin. It is important to rule out physical, educational and emotional factors in the process of making a diagnosis, but that doesn't always happen. See Mac's story below.

Mac's Story … personality type, food sensitivity and medication

Thirteen-year-old Mac had been diagnosed with A.D.D. several years ago and put on Ritalin. A few weeks before I first met Mac, he had begun to refuse to take his medication. He had heard his mother telling the family doctor how much his "rebound" behavior upset her and he didn't want to hurt her in any way. He had an Extraverted-iNtuiting-Feeling-Perceiving (ENFP) personality type and was friendly, innovative in his thinking, sensitive to the emotions of others and a flexible and adaptable kind of guy. He wasn't particularly interested in details, accuracy, or finishing what he started. His family was in the process of moving overseas and felt that a comprehensive assessment of his A.D.D.[32] would be prudent in order to support Mac's attentional needs in his new school setting.

Testing revealed that he was highly intelligent and achieving well in all areas. However, it was hard for him to sit still and finish his work. He also had asthma. In view of his history of asthma, it was suggested that he try a milk-free week to see if this would alleviate either the asthma or attentional symptoms. It did both!!! But getting school work done was still a challenge.

Around this time, he spontaneously began to do his work at school. When asked what had happened, Mac indicated that his teacher had started giving detentions for incomplete work and he had decided that if he wanted to come home right away after school, he might as well do his work in school!

At follow-up six months later, the parents reported that at holiday time, Mac's diet was relaxed a bit and they saw the old behaviors return; but during the school term the diet was strictly followed. This dietary regime, together with very clear expectations for completed work, have helped Mac to become a very successful student in his new country.

[32] In my opinion, formal assessment of intelligence and achievement is not always necessary. I prefer to gather this type of information from the parents or client and test ONLY when the information is not available any other way.

In this case, Ritalin had been prescribed and Mac had responded well, except for a *rebound* reaction. Taking the medication probably helped him through a few years when nothing else seemed to be working. But it certainly was not a valid confirmation of his diagnosis of A.D.D. Nor was it necessary, once the milk sensitivity was discovered and he was encouraged to use the time management strategy of Work Before Play!

Data collected in the early years indicated that use of the approach outlined in this book (i.e., the Empowerment Plus® approach[33]) yielded the following results:

Of 50 clients presenting with six to thirteen symptoms on the *Screening Checklist for Attentional Concerns*,

85% were eventually diagnosed with A.D.D.
15% did NOT meet the criteria for A.D.D.

Of those diagnosed with A.D.D.,

67% chose treatment with medication
33% did NOT choose medication

Of those choosing medication,

100% showed a positive response to Methylphenidate (Brand Name Ritalin)

In our work with more than 1,000 clients over the past 20 years, these results have been consistent, using the Empowerment Plus® approach as delivered by myself and specifically trained colleagues working under my supervision. The method involves the elimination of one or more foods from the diet for a week together with the understanding of learning and personality factors prior to making a diagnosis of A.D.D.. Once the patient is diagnosed and if medication is desired, the *Farrelly Protocol for a Medication Trial* is followed by the patient's family physician for the medication trial.

[33] The Empowerment Plus® approach has been developed, used and refined since 1996. Despite these powerful results, it should be kept in mind that our research statistics are derived from people who have the resources to see a psychologist in private practice, and are therefore not necessarily representative of the population at large. Further study would be needed in a variety of settings, in order to fully validate the effectiveness of this approach for all types of clients.

MORE ABOUT ... The *Farrelly Protocol for Conducting a Medication Trial*

More is being learned every day about how the brain works and medications used to treat A.D.D. Family doctors should be encouraged to consult with experts in the field in order to be aware of advances as they occur.

TOOL J - My Personal Profile

This is a tool to help you take an inventory of aspects of your life. It may help to guide you in the exploration of factors that might be having an affect on your attention.

WHEN TO USE ...

As a way of summarizing information you already know and as you discover more about yourself.

HOW TO USE...

Fill in your thoughts and ideas. You may even want to include the opinions of others who know you well.

WRITE DOWN...

What you have discovered about yourself on the following page.

My Personal Profile

Name: _____ **Date:** _____

Physical

How is my physical health? Do I feel well, get enough rest, and am I well nourished? Do I have any medical problems that need attention? Could food or environmental sensitivities be affecting how I feel, think or perform daily tasks? See Tool G - *Methods for Investigating the Influence of Food on Attention*, (p.93) and additional books by as Randolph and Moss (1989), Mandell & Scanlon (1998), and Berger (1986).

_____

_____

Emotional

How is my emotional health? Self-esteem? How well do I get along with others? Handle stress or past issues? Do I have any emotional concerns that need attention? See p.111 for an examination of ways you deal with stress, and consider reading Eckhart Tolle's book *The Power of Now* on how to build attitudes of acceptance and how to live powerfully, in the present moment. Miller (2015) provides a useful technique for resolving past trauma.

_____

_____

Spiritual

How is my spiritual life? How do I nourish it? Do I have a relationship with a God (of your own understanding)? What activities seem to bring me feelings of peace? See Harpur's book (1995) on the powerful effects of prayer on the well-being of ourselves and others.

_____

_____

Environmental

How is my environment? Is it structured-for-success? Is my work meaningful? Do I feel suited to my present career or course of studies? Am I following my *passion* or my *purpose*? See Brown (2017), Hallowell and Ratey (2011; 2017), and Hartmann (1995; 2015) for additional help in this area.

_____

_____

Personality

What type of personality do I have? What are my preferences? Am I an Introvert or Extravert? A detail person or more of a broad-brushstroke type? Logical or sensitive to the emotions of others? Planful or spontaneous? How do these qualities affect my life, relationships with others, job/school performance? Do I celebrate my uniqueness? Am I able to appreciate the personality traits of others, even when they are different from my own? (See Tool F - *Personality Type*, p.81) Also see Tieger & Baron-Tieger (2001) for additional information.

Learning

How do I learn best? By seeing? By hearing? Or by doing? By proceeding in a step-by-step manner or in a more random kind of way? What are my areas of talent or ability? Do I use my strengths in my school or job situation? Do I have skills which are in need of improvement? How could I accomplish this? Do I need to have *special consideration* in showing others what I know (i.e., extended time on tests or exams)? (See Tool D - *Learning Discrepancies: Common Areas of Difficulty, Strategies and Accommodations*, p.63; Tool E - *Common Reasons for Reading Difficulties*, p.73.) Books by Covey (1989) and Nadeau (2006), present many good organizational strategies.

Attention

What areas of information processing are affected by my attention? (See Tool B - *The Levine Information Processing Questionnaire*, p.47). Which areas do I want to work on? What strategies do I want to work on first? See Tool C - *Strategies for Improving Attention*, p.55 as well as books by Hartmann (1993; 1995), Hallowell and Ratey (2011; 2017), Moss (1990) and Weiss (2005 a & b) offer lots of practical strategies.

WRITE DOWN...

What more would you like to find out about yourself?

_____

_____

WRITE DOWN...

How are you going to investigate these areas?

_____

_____

If you have gone through all of the steps outlined in Tools A – J and you still have concerns about your attention, emotions or just life's challenges in general, the next Tool K – the *Positive Problem-Solving Worksheet* (p.151) might help you in taking a more systematic approach to these concerns. I have used this tool in my own life and with my clients. It is amazing how quickly problems can be solved.

TOOL K - The Positive Problem-solving Worksheet

Presents a worksheet that can be used in guiding the problem-solving process when investigating any type of problem or concern. The use of the worksheet is illustrated with an actual case example. The worksheet was originally developed by Dr. Anne Knackendoffel and then adapted by Dr. Lorna Idol and Dr. Fred West, and lastly by Dr. Teeya Scholten and her colleagues.

WHEN TO USE...

If you are concerned about yourself, a loved one, a student or employee and wonder what might be causing any type of concern. This tool can help you to sort out your thinking and begin to work on solving the problem in a step-by-step, logical manner.

HOW TO USE...

Just follow the instructions on the sheet. It is a good idea to go through this with a friend, partner or colleague. You may have to recycle through the problem-solving process several times, before you find the *solution* to your problem or concern.

Even if you find that you can't solve this problem by yourself and decide to seek professional help, the information you gather by going through the process SHOULD be helpful. It is also a great technique to teach your children (or anyone else!).

Positive Problem-solving Worksheet
READY SET GO Method

1. READY – Identify the concern
    a) Brainstorm all possible reasons for the concern
    b) Decide how to investigate the possible causes
    c) Choose the most likely cause

2. SET – Make a plan
    a) Brainstorm strategies
    b) Prioritize the top three and pick one of these to implement first
    c) Decide how you will evaluate the success of the strategy

3. GO – Just do it!
    a) Track your progress
    b) Evaluate the success of your plan
    c) If it worked, great. If not, recycle.

Step 1 – READY – Identify the concern

---

a) Brainstorm all possible reasons for the concern with others and/or the student/client and list them below

1._____ 4._____

2._____ 5._____

3._____ 6._____

b) Decide how to investigate the possible causes
c) Choose the most likely cause

The most likely cause of the concern is:

This worksheet was adapted by Dr. Teeya Scholten and colleagues from the work of Drs. Idol, Knackdoffel, & West.

Step 2 – SET – Make a plan

a) Brainstorm strategies

Possible Strategies	Priority Rating (#1, #2, #3)
1.	
2.	
3.	
4.	
5.	
6.	

b) Prioritize the top three (#1, #2, #3) and pick one of these to implement first

What is your strategy? _____

What steps do you need to put the plan into action? _____

How long are you going to try it? (ten days to three weeks is reasonable) _____

c) Decide how you will evaluate the success of the strategy.

How will you know if your plan has worked? _____

STEP 3 – GO – Just do it!

a) Track your progress
b) Evaluate the success of your plan
c) If it worked, great. If not, recycle.

Did your plan work? Did it solve the problem? ☐ Yes ☐ No

If it worked, great! You solved the problem. If not, more problem-solving is needed. Ask yourself if you followed your plan. If you did it and your problem still exists, you may wish to refer back to Step 1-READY and see what other possible causes there might be for your problem and make a new plan. Just continue through Step 2-SET and Step 3-GO until your problem is solved.

Here's an **EXAMPLE** for you to consider:

Positive Problem-solving Worksheet
READY SET GO Method

1. READY – Identify the concern
    a) Brainstorm all possible reasons for the concern
    b) Decide how to investigate the possible causes
    c) Choose the most likely cause

2. SET – Make a plan
    a) Brainstorm strategies
    b) Prioritize the top three and pick one of these to implement first
    c) Decide how you will evaluate the success of the strategy

3. GO – Just do it!
    a) Track your progress
    b) Evaluate the success of your plan
    c) If it worked, great. If not, recycle.

Step 1 – READY – Identify the concern

Grace can't concentrate when doing essays, assignments and exams

a) Brainstorm all possible reasons for the concern with others and/or the student/client and list them below

1. *essay writing too difficult*
2. *she is worried about things*
3. *she can't shut out noises*
4. *blood sugar too low*
5. *milk sensitivity impairs thinking*
6. *other ideas?*

b) Decide how to investigate the possible causes

Turn the possible cause into a question. See the third column in chart on the next page. Then investigate the questions, record your results and come to a conclusion as to the most likely cause.

Conclusions Yes /No/ Maybe	**Possible Causes**	**Questions to be asked**	**Ways to answer questions** HOW can I find this out?	**Results of Investigation** WHAT did I find out?
No	*1. Essay writing is too difficult for her*	***Is written work difficult for her?***	*Observe her written output for consistency*	*Inconsistent - Writing is challenging for her, but she seems to be able to do it at times.*
No	*2. She is worried about other things*	***Is she worried about anything?***	*Ask her if she is worried about anything (like friends, family, home life, pregnancy, etc.)*	*She is worried, but says that she had trouble concentrating before she was worried about her current concerns.*
Yes	*3. She can't shut out noises*	***Is she distracted by noises?***	*Ask her if this is an issue at times other than when she is writing and observe what she does if there are loud noises in the hallway*	*She says that when it is quiet, she can do her work. However, when it is noisy she gets distracted and can't concentrate on anything - reading or writing.*
No	*4. Blood sugar is low*	***Does she have low blood sugar?***	*Notice her behavior prior to lunch - is she more lethargic at this time?*	*Energy levels are consistent throughout the day.*
Maybe	*5. Milk sensitivity is making it difficult for her to think and concentrate*	***Is she sensitive to milk products?***	*Observe her and recall the number of colds she gets per year*	*She reports having 4-5 colds per year. She always has a Kleenex in her hand and sounds "stuffed up".*

d) Choose the most likely cause

The most likely cause of the concern is:

#3 Grace can't shut out noises

Step 2 – SET – Make a plan

a) Brainstorm strategies

Possible Strategies	Priority Rating (#1, #2, #3)
1. work when it is quiet	
2. wear ear plugs to see if it helps to block out the noises	#1
3. use music on an iPod or other device to see if it helps to block out noises	#2
4. get a referral to a specialist to see if Grace has A.D.D. and consider taking medication to see if it helps her to block out noises better	#3
5. other ideas???	
6.	

b) Prioritize the top three (#1, #2, #3) and pick one of these to implement first

What is your strategy?

Grace will use ear plugs to see if that helps her block out noises

What steps do you need to put the plan into action?

Buy disposable ear plugs in a drug store

How long are you going to try it? (ten days to three weeks is reasonable)

Three weeks

c) Decide how you will evaluate the success of the strategy.

How will you know if your plan has worked?

As a pre-test, we'll have Grace rate how well she can concentrate on a scale of 1 to 10 when it is quiet and when there are noises. As a post-test, we'll have her re-rate her ability to concentrate when wearing earplugs when it is quiet and when it is noisy.

Step 3 – GO – Just do it!

a) Track your progress

Grace rated how well she could concentrate or shut out noises when it was quiet and when there was noise. Pre-test (where 10 out of 10 is being able to concentrate well.) When quiet 9/10, in noise 2/10. Post-test after three weeks, when quiet 9/10, in noise, wearing earplugs, 8/10.

b) Evaluate the success of your plan

With the increase in Grace's ability to shut out noises (2/10 to 8/10), we conclude that this plan was successful.

c) If it worked, great. If not, recycle.

Since the plan worked, we are finished! Grace will continue to wear earplugs when she does her essays, assignments and exams.

Did your plan work? Did it solve the problem? ☑ Yes ☐ No

If it worked, great! You solved the problem. If not, more problem-solving is needed. Ask yourself if you followed your plan. If you did it and your problem still exists, you may wish to refer back to Step 1 READY and see what other possible causes there might be for your problem and make a new plan. Just continue through Step 2 SET and Step 3 GO until your problem is solved

WRITE DOWN …

Anyone you know who could help you to problem-solve some of your concerns.

_____

_____

MORE ABOUT…. Positive Problem-solving

This guidebook is intended to provide you with BASIC information on how to use this problem-solving process. More detailed information about how to use this in educational settings may be needed.

Well, that's it! You have managed to finish Part Two! Congratulations! Do you know yourself a little better? Do you know where your challenges are and what strategies you need to be successful? Are you thinking about A.D.D. in a little more positive way?

Part Three presents a behavior management program that has been developed for parents of children with A.D.D.. It can be learned and applied at any time in the process of discovering what your child, or even your partner, needs to succeed.

Good luck in your efforts!

Part Three

Riding the Wave - Behavior Management for Parents of Children with A.D.D.

Part Three: "Riding the Wave"
Behaviour Management for Parents of Children with A.D.D.

Introduction

It takes a lot of energy and skill to parent children with A.D.D. With all the ups and downs, it sometimes seems like surfing! Being a good parent involves many different skills - and most of the time we do very well - except in managing our child with A.D.D. We don't really understand why what seemed to work so nicely for our other children, just doesn't seem to work for the one with A.D.D.

We feel like remote control car drivers who are constantly on duty. We don't understand why s/he can't get ready for school in the morning. Why doesn't the homework get done? Why can't the completed homework get to school? "Be sure to do this ... do that ... don't forget this ...where did you put that?" We don't like behaving this way and our children don't like it either. But what are the options?

How about an approach specifically developed for parents of kids with A.D.D.? That's why *Riding the Wave* was developed.[34]

If you want to understand more about HOW this process works, please read on…
If you want to get right to the program, please turn to page 163 and begin!

What is ***Riding the Wave?***

It is an approach to behaviour management for people:

- who have children with A.D.D.
- whose children are 4 - 34 years of age
- who want to teach self-control, responsibility and build self-esteem
- who want quick results
- who want to have a positive parent-child relationship

Parenting a child with A.D.D. sometimes seems like surfing!
It takes a lot of skill!

[34] For more detailed instructions, see Scholten (2018b) for *Riding the Wave: A Handbook for Parenting a Child with ADD*

How does *Riding the Wave* work?

Some people with A.D.D. have problems with **self-control**. By following the steps taught in this handbook, you will learn how to:

- identify a **single behaviour of concern** to focus on first
- specify what behaviour you expect
- formulate an appropriate **RULE**
- generate both a positive and negative **CONSEQUENCE** for the child's choice as to whether or not to follow the rule.

The consequences are as immediate, natural and non-punitive as possible. They are simply designed to teach the child that there are consequences to his/her choices. This is how the child begins to develop self-control.

What good can it do to start with only one behaviour?

The secret is the *Ripple Effect*.

By **starting off with only one behaviour**, it is remarkable how quickly you will see results. Often, just focusing on one behaviour has the *Ripple Effect* of resulting in other behaviors just taking care of themselves!

When this program has been taught in three one-hour sessions for an individual family or offered to groups over a five-week period, the **results have been astounding**! BOTH parents and children seem to feel better within a couple of weeks.

As the child develops greater self-control and self-esteem, you may still want to use the principles of ***Riding the Wave*** for addressing ongoing issues that come with additional maturity.

Focusing on one behaviour has a *Ripple Effect*!
Many other problem behaviors just take care of themselves, once self-control is learned.

The *Riding the Wave* Method

If you are learning this method on your own, begin Step ONE now and proceed through the remaining steps in accordance with the instructions. If you and your partner are learning this method together, you will each complete Steps ONE, TWO and part of THREE independently. Then you combine your results at the second part of Step THREE, work independently again for Steps FOUR and FIVE, then work together again for Steps SIX through TEN.

☑ Step One

Write down all the behaviours that concern you.

Each person learning the technique makes up their own separate list. Fill in the left column with behaviors you wish would disappear or change. Be descriptive, specific and objective. Do not generalize or be judgmental. For instance, use "interrupts conversations" instead of saying "he is rude". Say "rips up papers when angry" instead of "is destructive". Describe the behavior in such a way that someone else could picture exactly what your child is doing.

Behaviours of Concern[35]

Behaviors of Concern	**Situation** (when or where the behavior occurs)

Use more paper if necessary. List ALL the behaviors which bother you.

[35] Originally developed by Blakemore, Shindler, & Conte (1993)

☑ Step Two

Once you have your COMPLETE list of your concerns, record the situation in which these behaviors occur. Add this information to the chart you have started in Step ONE.

Example

Behaviors of Concern	**Situation**
Does not initiate school work on his own	*After school, when it's homework time*
Interrupts conversations	*When anyone else is talking and he thinks of something to say*
Rips up belongings of others	*When angry that he can't have or do something he wants*
Doesn't take out the garbage on his own	*Garbage days*
Doesn't finish homework	*School days*
Arrives late for school	*Every school day*
Doesn't bring homework home	*School days*
Says he has no homework when he actually does	*Most school days*
Resists taking a daily bath	*Every day*
Yells at me when I am talking to him	*When I am reprimanding him for misbehavior*

You may discover that certain problems occur at specific times, such as when you are tired or when your child is angry or frustrated. This may be new information that you can use in understanding you or your child better and in future problem-solving.

Now cross off any behaviors that are strong habits (such as thumb sucking) as these can be dealt with later, when the method has been learned. Also cross off anything that is a problem to YOU, but not detrimental to your child's health or well-being (such as wearing socks that don't match or not eating everything on his or her plate).

☑ Step Three

Cut up your list of behaviors of concern and arrange them in order.

NOTE. If you are learning the method with a partner, you are still working on your own list, at this point. Take all of the behaviors you have just written down in STEP TWO (make sure that you have at least ten behaviors) and arrange them from MOST to LEAST bothersome. (I find it easiest to cut up the paper I have written on and arrange each behavior on a sheet of plain white paper.) Once they are arranged from MOST to LEAST bothersome, scotch tape them onto the page.

↑

MOST BOTHERSOME

Rips up belongings of others	*When angry that he can't have or do something he wants*
Yells at me when I am talking to him	*When I am reprimanding him for misbehavior*
Interrupts conversations	*When anyone else is talking and he thinks of something to say*
Says he has no homework when he actually does	*Most school days*
Doesn't bring homework home	*School days*
Doesn't finish homework	*School days*
Does not initiate school work on his own	*After school, when it's homework time*
Arrives late for school	*Every school day*
Resists taking a daily bath	*Every day*
Doesn't take out the garbage on his own	*Garbage days*

LEAST BOTHERSOME

↓

If you are learning the method with your partner, you now share your lists with each other. Make up a new, combined list which has all of the behaviors of concern, listed in order of priority from MOST to LEAST bothersome. Some compromise may be necessary at this point. (Once again, I find this easiest to do by again cutting up the list you each have, leaving them in the order YOU had and taking another piece of paper on which to create your new, combined list in the order on which you can both agree.) Once you have both decided on where a particular behavior belongs, then put it on the new page. When you have finished, tape them onto this page.

☑ Step Four

Once you have completed the previous Steps, take time during the week to complete the following exercises: "What I like about ..." and "Attending to Your Child's Behavior".

Do NOT proceed to Step FIVE until you have completed these two exercises. They may not seem especially important, but they are basic building blocks that will be necessary to the success of the approach. If you and your partner are learning this method together, be sure to fill out your own lists.

What I like about[36] ...

List several things you like about your child:

_____

_____

_____

List several ways that you are a good parent:

_____

_____

_____

[36] Originally developed by Blakemore, Shindler, and Conte (1993)

Attending to your Child's Behaviour

The purpose of this exercise is to give YOU practice identifying behaviors (both positive and negative) and monitoring how YOU respond to your child.

Take an hour this week (all at once or in several chunks of time) and write down what your child does and how you respond. If your child does something you would like to see repeated, write this down in the Positive Behaviors - What's Working Now column of the chart below. If your child does something that you would NOT like to see repeated, write this down in the Negative Behaviors - What's Not Working Yet column of the chart below. Make sure you record your response to your child's behaviors.

POSITIVE BEHAVIORS **What's working now**		**NEGATIVE BEHAVIORS** **What's not working yet**	
What did my child do?	How did I respond?	What did my child do?	How did I respond?

Is this a typical sample of your and your child's behavior? _____

_____

For example, your sheet might look like this….

POSITIVE BEHAVIORS What's working now		NEGATIVE BEHAVIORS What's not working yet	
What did my child do?	**How did I respond?**	**What did my child do?**	**How did I respond?**
Played nicely with his brother	*Smiled at him*	*Interrupted me when I was talking to my husband*	*I frowned at him*
Took out the garbage when I asked him to	*Said "Thank you"*	*Lied about having any homework*	*I told him that I was fed up with his behavior*
		Threw his brother's baseball mitt when I told him I wouldn't take him to the Mall	*I grabbed the mitt and sent him to his room*

Is this a typical sample of your and your child's behavior?
Yes - I seem to spend a lot of time lecturing him and sending him to his room. But I also try to notice the positives.

☑ Step Five

Reflect upon the results of ATTENDING TO YOUR CHILD'S BEHAVIOR.

After you have completed the chart, take some time to think about the results. Is this a typical sample of your interactions with your child? If yes, good. If no, what is usually different? Did you see any patterns? For instance, does your child seem to get angry more often just before meals or when tired or when it's time to do school work? Do you seem to *lose your cool* more often when you are tired or stressed? Do you actually notice the positives? Do you comment upon these at all? How? What have you learned about yourself during this exercise?

☑ Step Six

Now, it's time to choose a behavior to work on with your child.

You do this by using the list you created in Step THREE. For partners, use your combined list. Then count all the behaviors and draw a line across the page that divides the list into halves. For example, if you have ten behaviors of concern, draw a line under the fifth behavior on the list. Now choose a behavior to work on which is on the BOTTOM half of the list!

↑
MOST BOTHERSOME

Rips up belongings of others	*When angry that he can't have or do something he wants*
Yells at me when I am talking to him	*When I am reprimanding him for misbehaving*
Interrupts conversations	*When anyone else is talking and he thinks of something to say*
Says he has no homework when he does	*Most school days*
Doesn't bring homework home	*School days*
Doesn't finish homework	*School days*
Does not initiate school work on his own	*After school, when it's homework time*
Arrives late for school	*Every school day*
Resists taking a daily bath	*Every day*
Doesn't take out the garbage on his own	*Garbage days*

LEAST BOTHERSOME
↓

Here are some commonly asked questions and answers about Step SIX:

Why do you choose something from the bottom half of the list when my MAJOR concerns are on the top?
Because you first need to learn the technique. You and your child are more likely to see changes when you choose a behavior that is less of a problem. It also helps you to be as objective and detached as possible.

What if I'd really like to see a change in a certain behavior, but I don't believe that it can realistically be changed?
Choose ANY behavior you wish from the bottom half of the list - even if you don't feel hopeful that you can do anything about it! If you follow the steps, figure out a rule and appropriate consequences, it just MIGHT work!

What if my child is too young to understand the word "consequence"?
Many parents have found that when they explain the concept of *cause and effect*, even small children are able to understand what a consequence is.

 NOW WRITE DOWN...the behavior you have selected.

_____

Now we proceed to the next step. This step is the *nuts and bolts* of the ***Riding the Wave*** method.

Filling out the Behavior Management Worksheet
in Step SEVEN is ESSENTIAL
to the success of
the *Riding the Wave* method

If you choose to fill out the Behavior Management Worksheet, the consequence is that you will maximize your chances of learning ***Riding the Wave***. If you choose NOT to fill it out, you will NOT have learned this method and will most likely continue to be frustrated by your child's behavior.

☑ Step Seven

Fill out the Behaviour Management Worksheet.

This is the most difficult and time-consuming step in the whole *Riding the Wave* method. It is also the most important one yet. The more thoroughly you do this part, the easier the rest of the method will be. Sometimes it takes more than a hour to sit down and think carefully of what IS expected of your child, what natural and logical consequences there might be for his/her choices and what might go wrong in the process.

This is the most difficult and time-consuming step in the whole method.

In terms of choosing *consequences*, I find the concept of *freedom* useful when considering consequences. For example, "you will have the freedom to get ready on your own, to do your chores independently," etc. (depending on what your rule is). You may wish to refer to the examples on pages 179-183 to give you an idea of the types of rules and consequences that could be used.

Once you have chosen a behavior of concern, whatever rules or consequences you choose in Step SEVEN, be sure that:

- the rule is stated in a positive manner and applies to the whole family
- the consequences are natural, logical, short-term, and immediate
- that these are consequences that YOU (not your friend or neighbour) CAN apply
- you have a back-up plan in case your child chooses NOT to co-operate with the consequences on the Behaviour Management Worksheet
- when applying the method, you notice the times that your child has chosen TO follow the rule (at least as often as the times you notice that s/he has chosen NOT to follow the rule!)
- that you use the words "you have chosen" and "the consequence" - this is the *nuts and bolts* of the approach and it WILL make a difference if you use these words or their equivalents consistently

Behaviour Management Worksheet[37]

Plan the Rule and the Consequences

Behaviour of concern: _____
(What is the unacceptable behavior?)

Expected behaviour: _____
(What is it you expect?)

Rule: (Stated in a positive manner - what is expected, rather than what is NOT expected. If possible, the rule should apply to the whole family.)

_____

_____

Consequences: (As immediate, short-term, and as *natural* a consequence as possible.)

(+) **POSITIVE**: "**If you choose TO … (insert the rule), the consequence is that you will ..."**

_____

(-) **NEGATIVE**: **"If you choose NOT to (insert the rule), the consequence is that you'll ..."**

_____

What else can you do to assist the situation? Sometimes making up charts of daily schedules or checklists can help to make your expectations clear. It saves you from having to remind your child and provides a ready reference guide for him or her. Is there anything else you can do to assist your child?_____

Include a Back-up Plan: What will you do if s/he refuses to comply with the negative consequence? This is important to have in place in order to be ready for anything. If there is a *crack* in your plan, your child will probably find it.

_____

_____

THIS FORM MAY BE REPRODUCED

[37] Originally developed by Blakemore, Shindler, & Conte (1993) and adapted by Dr. Teeya Scholten.

As an Example...

BEHAVIOR OF CONCERN*: does not finish his homework*

EXPECTED BEHAVIOR: ***I expect Mark to finish his homework before watching any TV or playing after supper.***

RULE: *Work before play.*
It is okay to play after school for a while, but, after supper I expect you to get to your homework right away and finish it. Then you can play however you like (either outdoors or indoors by watching TV, playing with your friends, being on the computer, or using your phone.)

CONSEQUENCES:

(+) **POSITIVE**: ***"If you choose TO do your work before play, the consequence is that you will be allowed to play however you like for the rest of the evening."***

(-) **NEGATIVE**: ***"If you choose NOT to do your work before play, the consequence is that you will lose the freedom to play however you like for half an hour."***
You'll have to sit where I can see you while you finish your homework and, when you are finished, you will have to stay inside and play alone (i.e., no TV, computer, phone, or friends) for half an hour.

What else can I do to assist the situation?
I could ask Mark if he would like some help remembering that it is *Homework Time*. If so, it could be announced after supper. I could also make sure that he CAN DO the work required. If it is hard for him to write, I may offer to be available to write or type his homework for him.

What is my *back-up plan*?

The usual back-up plan rule is: we carry out any negative consequences right away; if we choose to do this it's over sooner; if we choose NOT to do this, the negative consequence gets more negative. In this case, I should also think about what I will do if he chooses not to abide by the negative consequence (see above) and instead of playing alone, he turns on the TV or starts playing on the computer. In that case, I'll tell him that if he chooses to play alone, the (+) consequence will be that he will lose his freedom for only half an hour. If he chooses not to play alone (and starts watching TV, playing with friends, on the computer, etc.), the (-) consequence is that he will lose his freedom for the rest of the evening. He is told all of this when the method is explained.

☑ Step Eight

Create your own personalized script.

It is important to write out what you will actually say to your child. This gives you practice in *streamlining* your communication, while making sure that you include the important words about *choice* and *consequence*.

Our Rule: Work before play

(+) David, I notice that you have **chosen TO** do your work before play. The **consequence** is that when you are finished, you'll be allowed to play however you like for the rest of the evening.

(-) David, I notice that you have **chosen NOT to** do your work before play. The **consequence** is that when you are finished, you'll lose the freedom to play however you like. You'll need to play alone for half an hour.

It often helps to post the rule and its consequences somewhere that is easily accessible (e.g., inside a kitchen cupboard door). This helps you to get familiar with the wording and serves as a reminder to you to *catch the child being good* – when s/he makes positive choices. Being on the inside of a door protects your child's privacy when friends are over.

Our Rule _____

(+)_____

(-)_____

☑ Step Nine

Explain the method including the rule and the consequences.

Find a quiet time with your child in order to:

a) outline the **importance of rules** in society and the relationship between our choices to follow the rules and the freedom we will have. For instance, you might explain that in our society we have rules in order for life to run smoothly and for everyone's rights to be respected. If we choose to follow these rules, we usually have a lot of freedom. If we choose NOT to follow the rules, we often lose our freedom (e.g., people who choose not to pay for what they want usually go to jail).

b) explain the goal of the approach is to **teach self-control.**
Sometimes people understand that rules are important, but they don't follow the rules because they lack *self-control*. This is the goal of this behavior management approach - to teach self-control.

c) review **both positive and negative consequences** of the behaviour of concern that you have chosen. Be open to some negotiation on details of the consequences.

☑ Step Ten

Apply the method.

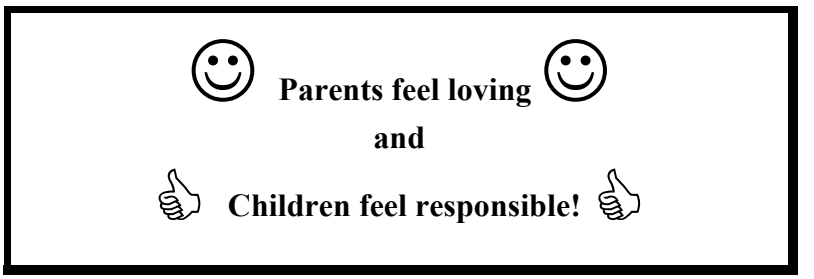
- *Catch your child* making choices. Describe what you see your child doing (i.e., the CHOICE s/he has made) and indicate the CONSEQUENCE.

- Try to catch your child more often when s/he is making positive choices than negative ones. If you do, you will quickly see results in terms of developing self-control, responsibility, and self-esteem. If you don't focus on the positives, s/he will most likely come to hate the word "consequence". The method will be much less effective and the relationship with your child will suffer needlessly.

- The more you choose to use the language of *choice* and *consequence*, the faster you will see results.

It may seem somewhat awkward to talk in this way, but it is a very POWERFUL technique which gives quick results. It is respectful of the child and it DOES result in changes in self-control, responsibility, and self-esteem. As you can see, this technique is non-punitive and uses consequences that are as natural and logical as possible.

The greatest joy most parents report is that they no longer feel like the *bad guy* or that they are not chasing their children all the time. Their **child has made the choices** and the parent is simply in charge of ensuring that the consequences are applied. It is very freeing. It also helps parents see the many other situations in which the child is making choices.



The children appreciate knowing what is going on. The Rules are stated ahead of time and it is clearly understood what is expected and what the consequences will be if they make certain choices. They are given an opportunity to experience the results of their choices. And they do learn quickly!!!

This technique takes a lot of prior thought
in order to make sure that all the bases are covered.
But, if used properly, it works!!!

About making exceptions ...

Sometimes we are tempted to make exceptions when the child's behaviour is close to our expectations. For instance, maybe he has almost completed his homework, or is almost dressed, or has almost finished the job to your satisfaction. Although we think it might be *nice*, or encouraging, to the child to decide that they have

successfully chosen to follow the rule and allow them the positive consequence, the truth is they have actually chosen NOT to follow it to the standard that you set.

If you choose to make an exception in this case, you will find that the next time, your child does LESS of a good job, not more. It also puts you back in the *driver's seat* and disempowers your child. If you choose to stay true to your rule and your standards, the child will most likely rise to the occasion the next time.

For instance, in our house we had the rule:
"Chores are done well."
(+) if you choose to do your chores well, the consequence is that you have the freedom to do them independently.
(-) if you choose NOT to do your chores well, you lose the freedom to do them independently. I will supervise you.

So in a situation where it is almost done properly I have found it helpful to say something like "Oh Christin, I notice that you chose to do a pretty good job in cleaning up the bathroom, but you didn't empty out the garbage. As a consequence, you've lost the freedom to have done it independently. However, the good news is that it'll only take a few minutes of supervision before it's done. I'm sure that next time you'll be completely successful and able to do it independently."

This is a slight adaptation to the technique, but it helped me acknowledge my daughter's effort while, at the same time being consistent. ☺

This takes a lot of effort and consistency
especially in the beginning ...
but it gets easier with practice!

Once you have seen some positive results from your first rule, you may wish to tackle the behaviors that were on the top half of the list you made up in STEP ONE. If your child has learned self-control, you may be able to cross off many of the original behaviors. However, there may be some left that you are now ready to tackle now that you and your child have learned the technique!!!

Consistent use of your personalized script will reinforce your child's choices and their consequences. This encourages the development of self-control.

Examples of Behavior Management Worksheets

Here are more examples of completed Behavior Management Worksheets with Rules and Consequences typical to a range of age groups.

On the following pages you will find examples of just ONE way of dealing with a variety of problems. If you are working on these issues, you will need to find what works best in your own family situation.

Example 1
Age Range: Preschool
Behavior of Concern: Hitting siblings

Example 2
Age Range: School Age
Behavior of Concern: Not getting ready for school on time

Example 3
Age Range: School Age
Behavior of Concern: Not completing homework

Example 4
Age Range: Adolescent
Behavior of Concern: Not coming home on time

Example 5
Age Range: Adolescent/Adult
Behavior of Concern: Being verbally abusive

Example 1
Age Range: Preschool
Behavior of Concern: Hitting siblings

Behaviour Management Worksheet

Plan the Rule and the Consequences

Behaviour of concern: Ryan hits his siblings.

Expected behaviour: Ryan should play nicely with his siblings by being gentle.

Rule: We use gentle touch.

Consequences:

(+) **POSITIVE**: Ryan has the freedom to continue playing with others.

(-) **NEGATIVE**: Ryan loses the freedom to continue playing with others for five minutes.

What else can you do to assist the situation? Teach the meaning of the word "consequence" when explaining the new system and also practice HOW to touch gently and HOW to ask for what he needs.

Include a Back-up Plan: A longer time-out - buzzer gets re-set for another five minutes if he chooses NOT to stay in his room for the whole time.

Personalized Script: (+) "Ryan, I notice that you chose to use gentle touch with Sally. The consequence is that you have the freedom to continue playing with her."

(-) "Ryan, I notice that you chose NOT to use gentle touch with Sally. The consequence is that you have lost the freedom to play with her for five minutes. I'll let you know when five minutes is up and you can come back and try again."

Example #2
Age Range: School Age
Behavior of Concern: Not getting ready for school on time

Behaviour Management Worksheet

Plan the Rule and the Consequences

Behaviour of concern: Charlotte plays with her toys when she should be getting ready for school.

Expected behaviour: Charlotte should get ready for school on her own (without being reminded).

Rule: We get ready for the day by 7:30 a.m.

Consequences:

(+) **POSITIVE**: Charlotte has the freedom to get ready on her own.
(-) **NEGATIVE**: Charlotte loses the freedom to ready on her own. I will have to *help her*.

What else can you do to assist the situation? Have the child choose clothes the night before, making sure you leave enough time to get her ready if necessary. Make up a chart of what is involved in *Getting Ready for the Day* and post this in the washroom and on the fridge. (Kids often like to colour or decorate their own charts.)

Include a Back-up Plan: If she chooses to co-operate in getting ready while you are *helping*, the consequence is that she will have the freedom to get on with her day (i.e., play with toys, use their phone, internet, etc.). If she chooses NOT to co-operate, she will lose this freedom (i.e., NOT be able to use her toys, phone or internet for the rest of the day).

Personalized Script: (+) "Charlotte, I notice that you chose to get ready by 7:30 all on your own! The consequence is that you got to do this all on your own, like a big girl! "

(-) "Charlotte, I notice that you chose NOT to get ready by 7:30. The consequence is that you have lost the chance to get ready on your own. I will have to help you."

Example #3
Age Range: School Age
Behavior of Concern: Not completing homework

Behaviour Management Worksheet

Plan the Rule and the Consequences

Behaviour of concern: Peter doesn't finish his homework.

Expected behaviour: Peter starts and completes his homework on time and without being reminded.

Rule: Homework is finished by 8 p.m. (Explain that we all have work to do, and for Peter, his work is completing his homework by 8 p.m.).

Consequences:

(+) **POSITIVE**: Peter has the freedom to do his homework however he chooses (i.e., with the TV or computer on, in the kitchen or living room, with assistance from parents, etc.)

(-) **NEGATIVE**: Peter loses the freedom to do his homework however he chooses. Now, we'll do it *my way* (i.e., After 8 p.m., I decide where and how he does his homework and I will sit and watch him do it.)

What else can you do to assist the situation? Make up a daily schedule chart which includes homework time and the steps involved. Steps on a chart might be: 1. Plan homework. 2. Do homework. 3. Check homework. 4. Show parent completed homework. 5. Play. (You might also want to make sure that he is capable of doing the work. If writing or spelling is difficult for him, arrange to have him dictate his answers to you or encourage use of a computer).

Include a Back-up Plan: If he chooses to co-operate with the consequence of doing his homework *your way*, the consequence is that he will be finished sooner. If he chooses NOT to co-operate with you, the consequence is that it will take him longer to finish his homework and he will lose the freedom to use his free time as he wishes for the rest of the evening. You will need to decide and then make it very clear what is allowed and what isn't. For instance, TV, friends, phone, Internet, and videogames may not be allowed, while music, reading, and visiting with parents is still allowed.

Personalized Script: (+) "Peter, you chose to complete your homework by 8 p.m. The consequence was that you had the freedom to do it in your own way!"

(-) "Peter, you chose NOT to complete your homework by 8 p.m. The consequence is that you have lost the freedom to do it your own way. Let's go to the dining room and do it my way."

Example #4
Age Range: Adolescent
Behavior of Concern: Not coming home on time

Behaviour Management Worksheet

Plan the Rule and the Consequences

Behaviour of concern: Leila stays out past curfew.

Expected behaviour: Leila comes home by curfew.

Rule: We come home on time.

Consequences:

(+) **POSITIVE**: Leila has the freedom to go out the next evening.
(-) **NEGATIVE**: Leila loses the freedom to go out the next evening.

What else can you do to assist the situation? Negotiate a reasonable curfew - probably different for weekdays and weekends, arrangements for letting you know where she is and how much time she will have to allow in order to ensure that she makes it home by curfew. What if she is five minutes late or she misses her bus? You may want to consider some of the following options. If she comes in very close to curfew time, but still late, you might want to figure out how you will be kind and encouraging while remaining consistent with the declared consequences. Or maybe she is allowed to go out on only one weekend night until she shows that she is going to respect the family guidelines. If you talk about this ahead of time, it will prevent a lot of late night negotiating over the phone.

Include a Back-up Plan: If she chooses to respect the guidelines, the rules stay the same. If she chooses NOT to respect the guidelines, the rules tighten up. You should decide and then specify how the rules will change.

Personalized Script: (+) "Leila, I notice that you chose to come home on time. The consequence is that you have the freedom to go out tomorrow night."

(-) "Leila, I notice you chose NOT to come home on time. The consequence is that you have lost the freedom to go out tomorrow. You can try again on Thursday."

Example #5
Age Range: Adolescent/Adult
Behavior of Concern: Being verbally abusive

Behaviour Management Worksheet

Plan the Rule and the Consequences

Behaviour of concern: Steven yells and screams and calls me names when I say something he disagrees with.

Expected behaviour: Steven should be listening to me and expressing his opinion if he doesn't agree in a normal tone of voice (without name-calling).

Rule: We treat each other with respect.

Consequences:

(+) **POSITIVE**: Steven has the freedom to be with me.

(-) **NEGATIVE**: Steven loses the freedom to be with me for ten minutes.

What else can you do to assist the situation? Ensure that he knows how to give *I-messages* (such as "I feel angry when you tell me that I can't have the car".) Be sure that you know how to do *active listening* when he is expressing his feelings (e.g., "You sound really mad when I won't let you do something you really want to do.")

Include a Back-up Plan: If the child or adult will not leave the room for ten minutes, you may want to plan to leave - go to your own room or leave the house for this period of time.

Personalized Script: (+) "Steven, I notice that you are choosing to treat me with respect. The consequence is that you have the freedom to be with me and continue this conversation."

(-) "Steven, you chose NOT to treat me with respect. The consequence is that you have lost the freedom to be with me for ten minutes. Please leave the room now, or I will."

 **MORE ABOUT ...**

Riding the Wave - Behavior Management for Parents of Children with A.D.D.

I have written a little book called *Riding the Wave*[38] which gives the same ten steps to behavior management. It contains a few more case examples (including my own story about managing my daughter!), a list of 25 typical problem behaviors, possible rules and consequences for you to adapt to your own situation and some good old-fashioned parenting tips.

 **WRITE DOWN...**

the names and phone numbers of people who offer parent training in your area. Be sure to look for programs that teach techniques that have been developed specifically for children with A.D.D. or are very similar to this one.

Summary

Well, now, this is the end of **Part Three**. If you picked up this book and started with ***Riding the Wave***, good for you. I trust that it worked! But it may now be time to turn back to **Part One** and remind yourself of all of the good things about A.D.D. Or it might be time to have a look at **Part Two** in order to deepen your understanding of your child's personality type and learning strengths and challenges. What about food sensitivities? *Being the best you can be as naturally as possible* requires a combination of strategies. You don't have to do them all at once, but the more bases you've got covered, the more successful you will be.

Life is a journey that never ends.
This seems doubly true
if you are dealing with A.D.D.!!!
Be patient with yourself and thankful for the progress you are making!

[38] Scholten (2018b)

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Practical, easy to understand guidance for parents of ADDers.

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A handy reference document containing full-page descriptions of MBTI type and a list of the most commonly chosen careers for different personality types.

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A very useful book in question and answer format (available in audiotape).

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Subject and Author Index

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Teeya's Story

My earliest school memory was from Kindergarten. I was sitting cross-legged on the floor with the other children. The teacher was reading us a story and I was tracing pictures on my knee with my finger. Suddenly the teacher asked me what she had just said and I told her. She replied, "Well, next time pay attention!" I was puzzled. As far as I was concerned, I HAD told her exactly what she had said! I felt angry and ashamed.

The following year, those feelings of frustration grew and transferred to my behaviour at home. Since I had always been quiet and well-behaved, my mother decided to investigate.

My mother was forty years old when I was born. Her age and personality as well as the fact that both parents had been officers in the Canadian Army influenced the type of home in which I was raised. Our home-life was structured yet supportive. Our parents were loving, but disciplined. When I started *acting out*, my mother contacted my teacher to find out what was going on at school. The teacher told my mother that I was not reading or learning at the Grade One level and that I had been placed in a *special class* for *slow* students. The teacher said that I would likely not make it past the eighth grade and that my mother "had better accept this."

My mother knew that I was not *stupid* or *slow*. If I had difficulty understanding something, she knew that I simply needed a different explanation or another approach. It turned out that I was an auditory learner and in those days they were using a visual method to teach children to read. That summer my mother taught me to read using a phonetic method and our family moved to another school district – far from the negative and inaccurate labels that I had been assigned.

In a new school with new teachers, I did well and by the time I finished Grade Three, the teacher recommended that I be placed in an accelerated class. I was already one of the youngest in my class and now I was supposed to complete two grades in one year! It was a nightmare! While I found multiplication and division easy, adding and subtracting were difficult facts for me to memorize. My writing was messy and painstakingly slow. With strengths in some areas and challenges in others, I experienced the extremes of a child with a learning discrepancy! Was I bright or stupid? I really didn't know.

Despite my academic frustrations, I was outwardly happy. I had loving and supportive parents, I played basketball and tennis, and I had good friends. But there was a side of me that only my mother saw. At least once a week I would become overwhelmingly sad and spend hours in the basement crying while curled up with our cocker spaniel, Smokey. I was not yet nine years old and already beginning to feel suicidal.

I was not yet nine years old and already beginning to feel suicidal.

Looking back, I NOW understand where some of the sadness came from (food sensitivities were one issue) - but at the time nothing explained the DEPTH of my despair. I felt that I had no reason to be sad or depressed so I simply muddled through.

By the time I was in Grade Seven, however, I knew I needed help – if not for my depression, at least for my messy handwriting. My mother enrolled me in Business School for a summer course in typing. Even though my exams still had to be hand-written, it was such a relief to be able to type my assignments and essays.

Learning to type was my passport to academic success.

There were still classroom distractions, however. While writing a Grade Eight science exam, I couldn't concentrate because the pen nib from the student next to me was squeaking! (In those days, we still used nib pens and ink wells!) When I told my dad, he said, "You'd better get over that one, sister!"

And while I learned to get over the distractions, I couldn't get over the depression. I don't think anyone imagined I was suicidal. During the sad times, my mother would talk to me about being the best I could be and so that is what I strived for. I graduated from high school and started university. I got good grades, had lots of friends, and was on the university basketball team. I became interested in nutrition and the importance of fruits and vegetables and whole grains. I ate brown bread and bran muffins – often eating half-a-dozen muffins in one sitting. Little did I know that I was allergic to wheat and these healthy foods were making me worse! If I was concerned about my mental health before, now I was really worried. When *the blues* hit, my bad moods often resulted in real temper tantrums!

In order to deal with the stress, I started practicing yoga; I found it relaxing, calming, and therapeutic. (In everyone, but particularly individuals with ADD there is a delicate balance between body, mind, and spirit. In times of stress, they need just the right amount of stimulation to function optimally. Too little stimulation, they become

bored and unfocused; too much stimulation, they become overwhelmed. This very delicate tipping point can be illustrated by the *inverted-V* relationship between stress and performance which I discovered much later while working in private practice with adult ADDers.)

In June of 1972, I graduated with a Master's degree. Two years prior I had met Nico, my husband-to-be and we had become engaged. The day after graduation we got married; we left on a two-month honeymoon the day after that. A year later we had our first child – a beautiful baby boy!

I was now taking vitamins and Brewer's Yeast for my chronic tiredness. These supplements seemed to help my energy levels but they didn't do anything for my bad moods and depression. The *black clouds* just came and went for no apparent reason.

To add to the tiredness and black clouds, our son – still a baby – had frequent ear and bronchial infections. The pediatrician suggested that he might have allergies and recommended trying an elimination diet but I couldn't bring myself to take our baby off (what I thought was) his very healthy diet.

I didn't know what else to do, so we just suffered through it!

By the time Jeff was eighteen months old, however, I had had enough. The black clouds that hung over me felt oppressive; I felt that there were no other options but to kill myself. Our son was still getting sick but my husband was a great parent. They would be fine – perhaps even better off without me. It had been a long time since I had lived with my parents so they wouldn't blame themselves for my suicide and my husband had known that I was like this before we married so he wouldn't blame himself either. I would take an overdose of aspirin and gently, but surely, fall asleep and die.

There were fifty pills in the bottle. I took them all. But instead of falling peacefully asleep, I just got more alert! I finally woke my husband who drove me to the hospital. After they had pumped my stomach out, a nurse said, "What's the matter, honey? Have an argument with your husband?" Little did she know that this act had been fifteen years in the making!

I was sent to a psychiatrist who, after several visits, couldn't find anything clinically the matter with me. I thought I must have something biochemically wrong with my brain. Orthomolecular psychiatry had just come on the scene and massive doses of nutrients were being prescribed to patients. I mentioned this and he prescribed 500 mg of Niacin (B3) per day and I started to feel somewhat better.

It was Easter-time. Up until then Jeff had had a very pristine, healthy (no junk-food, no-sugar) diet. I decided to buy him a milk chocolate Easter bunny as a special treat. Within twenty-four hours he was in the hospital with croup. There must have been something in the chocolate that triggered the croup – but what? For the past two years my neighbour had been saying that she thought Jeff might have allergies! The pediatrician had already suggested it. I decided that it was finally time to listen. I booked an appointment with a specialist.

The answers were there, but I hadn't been listening!

The specialist did the usual tests on Jeff and found a dust allergy. He then told me to investigate food allergies by using an elimination process – take Jeff off milk products for a week, then put dairy back in and then do the same thing with wheat. He suggested that I follow the same diet as well!

Off milk Jeff looked healthier and more robust. Eventually, the respiratory problems and ear infections disappeared entirely. I no longer had a sore throat; and without wheat in my diet, my depression vanished.

Life finally became so much easier!

In 1983, I was back at university studying for my Ph.D. Nico and I had been married for eleven years and now had three children – two sons and a daughter. We had lived on a wheat and dairy-free diet for over a decade. Since each child had different food sensitivities, we used a five-day rotational diet. We also avoided food additives and food colouring. The bedrooms were carpet-free to minimize our exposure to dust.

After graduating, I got a position as a school psychologist. About the same time, our daughter, Christin, was diagnosed with ADHD: Predominantly Inattentive Type (that is without hyperactivity). I had seen students diagnosed with ADHD, put on medication, and then become little zombies so I was totally against medicating our daughter. Instead we made sure she avoided food allergens and helped her with her homework.

We also looked at other tools that would help our family. A friend introduced us to the Myers-Briggs personality type and this explained a lot. I am an Extraverted-iNtuiting-Thinking-Judging person. Talkative, innovative, logical … I finish what I start - no matter HOW long it takes and what the cost! It was interesting to understand how different my introverted husband was and how we could each use our strengths to make our lives better. The biggest help was learning that introverts (my

husband and our second son, Marty) need time to process information. That isn't the case for me or for our other two children!

In 1990, I was hired at an agency that specialized in the assessment and treatment of children with learning and attentional difficulties. My job was to develop a new program for adults with learning challenges. In those days, we didn't know that adults could also have ADD.

I learned so much at this agency, including a more effective behavior management strategy for kids with ADD. We used it with Christin; it was very effective in reducing how often we had to chase her to do her chores. (I eventually wrote a book about this method called *Riding the Wave*. It is so rewarding to now see Christin as a 40-year old applying those same techniques with her three-year-old son!)

I also met Dr. Geraldine Farrelly, a pediatrician and expert in treating ADD and I had an opportunity to work as part of a team in diagnosing and treating ADD. I learned how to do a medication trial in a way that pinpointed the exact dosage needed. This really opened my eyes to a responsible way to do a medication trial. We tried Christin on medication and she responded with a greater ability to focus and get her school work and her chores done!

It wasn't long after this that we discovered that
ADD could exist in adults
and that I had it too!

I could function in the outside world of work, but at home I was a "horizontal mom." I'd lie on the sofa thinking about everything that had to be done and then ten minutes before I had to leave the house, I'd try to cram in everything at once. This behaviour prompted our son Marty to remark, "Mom, I know you are very busy and have a lot to do, but do you get some kind of charge by leaving things to the last minute?" Little did he know that he was *bang-on* in his assessment! Getting a charge out of that last-minute pressure stimulated my brain and my body to kick into action!

My ADD diagnosis explained a lot about my experiences (playing with my fingers in order to stimulate my brain, being distracted by a squeaking pen, needing the house to be quiet while working on my Ph.D., cramming tasks into the last minute ...). And even though our daughter had been helped with medication, I wasn't ready for it myself just yet.

Since I had already eliminated trigger foods from my diet and was still having trouble focusing both at work and at home, perhaps it was time to try medication. For me, the

right dosage it was 1.25 tablets of Brand Name Ritalin three times per day. Life suddenly became so much easier! I didn't interrupt others like I used to and I found I could write reports with my office door open. My energy levels stabilized. I was present for my children in the evenings and a lot more patient with my husband.

Once again, life became even easier!

In the agency where I worked, I was now the Client Service Coordinator for both adults and children. At that time, the role of food sensitivities was not being investigated in the diagnosis and treatment of ADD. Because of what I had experienced, I believed that it was important to rule out food sensitivities, to understand and address learning issues, and to know personality types. If there was still a concern, I believed a medication trial was appropriate. But this was not the way things were done!

In 1995, I decided to go into private practice so that I could treat clients in a way that integrated both traditional and alternative treatment methods. I believed that there was a place for medication in the treatment of ADD, but that it belonged at the caboose of the train, not the engine! I developed the Empowerment Plus® model and trained professionals and parents how to use it. As you could see from the case studies in this book, we got great results! Strategies that had taken me forty years to learn could be used to help clients overcome learning challenges in about six hours of time over several appointments.

Over the years, I've adjusted my daily routine to strengthening my body (adding essential fatty acids, following an anti-inflammatory diet), reducing or eliminating allergic stressors (such as gluten, corn, soy, and sugar), going to the gym four times per week and meditating twice a day. My ADD medication has been slowly cut down by 1/4 of a tablet each time over the last 25 years. The correct dose for me now seems to be 1/8 of a tablet of Brand Name Ritalin taken three times per day. If I don't take any medication, it's easy to become the horizontal person again; however, if I take 1/4 of a tablet I re-engage, but feel a slight edge of irritability. So 1/8 tab is just right for me, at this point in time.

Our children are now adults, all have received post-graduate training, and are applying much of what they learned during their childhood to raising our six beautiful grandchildren. I have now retired. Nico's still the loving, supportive spouse he has always been. I feel very blessed.
I'm grateful to have had the freedom to create terms such as *Attention Deluxe Dimension* and the *channel-surfing brain* and to develop a cost-effective method of psychological service delivery for ADD, depression, and learning issues, to write

books, to be able to help clients and to train others in the Empowerment Plus® method. It was very helpful to realize the importance of measuring how people function when they are *interested* as well *not interested* in certain activities. Assessing how people are doing in activities which do not interest them (like chores) is particularly important when making a diagnosis and in assessing the effectiveness of treatment interventions. My hypothesis of the relationship between stress and performance being expressed in an *inverted-V curve* (not the inverted-U as expressed in the Yerkes-Dodson Law) has helped so many of my clients with ADD to understand the importance of maintaining that delicate balance in body, mind and spirit, if they want to function in an optimal way.
However, in 2018, this information is still not generally known by ADDers nor the professionals who work with them. Maybe someday soon!

I hope that my story will provide you with hope and encouragement as you discover what you, your child, or your patient/client need to be "the best they can be as naturally as possible!"

Dr. Teeya

The Good News about A.D.D. Series

by

Dr. Teeya Scholten, R. Psych.

For parents of children and adults with attentional difficulties…

"Attention Deluxe Dimension": A Wholistic Approach to A.D.D.

This book was written in an easy-to-read style for people who want to understand more about attention problems and how to deal with them in the best possible way. It doesn't go into a lot of detail, but presents a positive view of A.D.D. and lists a number of different factors which I feel should be looked at when investigating attention. In addition to a couple of checklists and questionnaires that can help you get started, there is a section on common myths about A.D.D.!

The A.D.D. Guidebook: Comprehensive, Self-Directed Guide to Addressing Attentional Concerns in Adults and Children

Part One contains an overview of "Attention Deluxe Dimension" and ways to look at A.D.D. in a more positive way. Information is given as to causes of attentional difficulties, steps in the process of diagnosis and resources which can be accessed.

Part Two is called the Toolbox and contains most of the tools which I use with my clients. The tools are accompanied by detailed instructions on how to explore this part of yourself.

Part Three contains a basic description of the steps in the use of *Riding the Wave*, a behavior management method developed specifically for parents of children with A.D.D. This part is written to be appropriate for those who like a step-by-step approach.

Part Four contains additional resources, the author's story and an annotated bibliography.

Riding the Wave: A Handbook for Parenting the Child with A.D.D.

This book was written for parents to be able to learn and apply a powerful behavior management method designed to teach children self-control. Use of this method has been shown to result in increases in self-monitoring, self-esteem, motivation. It has been used by the author with her children and taught extensively to other families.

In addition to the basic steps which are covered in The A.D.D. Guidebook, this handbook provides a lot more information to guide those who are trying to learn the method. Along with real-life personal and composite stories, there are general guidelines for parenting and lots of practical examples. Although a family would only apply one rule to begin with and work up to around five rules, there are over 25 different problem behaviors listed, with a suggested rule and possible positive and negative consequences to help parents in generating their own rules.

The use of *Riding the Wave* method has been shown to help children learn to make positive choices. It does wonders for family life, too!

For children…

Welcome to the Channel-surfers' Club! (Primary edition)

This is a small, up-beat book which summarizes information which has been learned about children who have participated in a wholistic process of being diagnosed with A.D.D. After a reminder about the advantages of having a "channel-surfing brain" and "Attention Deluxe Dimension", there is a brief summary of ways that s/he learns best according to:

- areas of information processing affected by their attention
- their personality type and
- their learning strengths and challenges

There is also a section on information about medication and other alternatives and how they help one's brain to focus.

For teachers and other helping professionals…

Turning the Tides: Teaching the Student with A.D.D.

This book is organized into three parts. **Part One** outlines the approach taken by the author in her work with both adults and children with attentional concerns. In addition to promoting a more positive view of A.D.D., it gives teachers practical information about identifying and working with learning discrepancies, personality types, and how to approach parents who are resistant to hearing about attentional difficulties in their children.

Part Two illustrates the ***Riding the Wave*** behavior management method as adapted to the school system. Examples of more than 25 different problem behaviors are given with appropriate rules and consequences from which teachers may wish to select a few to adapt to their own classroom environment.

Part Three contains an annotated bibliography of books, journals and videotapes which address the issue of A.D.D. and how to address it in the school environment.

Overcoming Depression: Wholistic Strategies that Work

If you have felt sad, hopeless, angry or just not interested in life…for 5 months or 15 years, ***Overcoming Depression*** is meant to provide you with a place to start. It contains the tools that I use most often for myself and in my work with clients of all ages. I hope they will work for you too. It will NOT help you diagnose the kind of depression you have, but it may help you begin to understand the reasons you may be feeling so sad – and do something about it.

About the Author

As a Registered Psychologist**, Dr. Teeya Scholten** worked in the fields of education and mental health for over 40 years. She had a private practice in Calgary, Alberta, Canada where she specialized in the areas of learning, attention and depression in adults, adolescents and children. She offered a variety of services, including consultation, assessment and individual counseling, behaviour management programs for teachers and parents of children with A.D.D., and in-service training in the form of workshops and consultations to other professionals. She has published in the areas of consultation, assessment and program planning for individuals with learning and attentional challenges. Dr. Teeya is committed to the empowerment of clients and professionals and believes in the importance of Body, Mind and Spirit integration in order to maximize one's potential. She developed Empowerment Plus®, a cost-effective model of psychological service delivery.