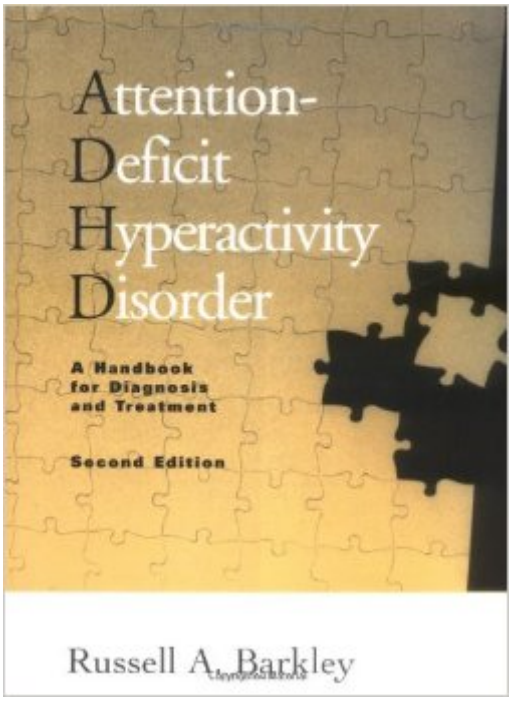
Attention-Deficit Hyperactivity Disorder: A Handbook For Diagnosis And Treatment, Second Edition



Synopsis

Updating and expanding Russell Barkley’s acclaimed Handbook, this new second edition incorporates the latest findings on the nature, diagnosis, assessment, and treatment of Attention-Deficit/Hyperactivity Disorder (ADHD). As in the previous edition, Dr. Barkley includes contributions from other leading scientist-practitioners, who report on their respective areas of expertise. Readers will find current, practical information on nearly every aspect of the disorder. In-depth assessment and treatment guidelines are supported by updated outcomes documentation, and three new chapters focus specifically on adults.Practitioners wishing to implement the assessment and treatment recommendations delineated in this edition are advised to purchase the companion Workbook, which contains a full set of forms, questionnaires, and handouts, in a large-size format, with permission to photocopy.

Book Information

Hardcover: 628 pages
Publisher: The Guilford Press; 2 edition (July 3, 1998)
Language: English
ISBN-10: 1572302755
ISBN-13: 978-1572302754
Product Dimensions: 10.2 x 7.3 x 1.4 inches
Shipping Weight: 2.8 pounds
Average Customer Review: 4.9 out of 5 starsÂ Â See all reviewsÂ (13 customer reviews)
Best Sellers Rank: #2,905,655 in Books (See Top 100 in Books) #84 inÂ Books > Parenting & Relationships > Special Needs > Hyperactivity #424 inÂ Books > Health, Fitness & Dieting > Children’s Health > Learning Disorders #1371 inÂ Books > Education & Teaching > Schools & Teaching > Special Education > Learning Disabled

Customer Reviews

The first edition of "Attention-Deficit Hyperactivity Disorder : A Handbook for Diagnosis and Treatment" was generally considered a must-read for all Clinical Child Psychologists and other practitioners who worked or planned to work with children with behavior disorders. The second edition is even better, as it should be. This edition clarifies how we have learned much about ADHD in the past decade. The book’s coverage of relevant literature, findings, and data-based theories and treatments makes it one of the very best books on ADHD available on the market. I recommend it to all who plan to work with behavior-disordered children. Also, this text should be in most public

libraries to allow parents the opportunity to read accurate writings about ADHD.

I’m a patient. Self-help books written for a general audience can be great, but if you find yourself on the last page with too many unanswered questions about details or causes or evidence - if you want the final word (insofar as there can be one) - and you can deal with college-level material and some jargon, then this book is what you need. At least it’s the best such book. You may find yourself reading several "textbooks" after this, as I did, but this is the best. Barkley is probably the single most respected and cited expert in the field. He wrote more than a third of the book and selected the best people in the field to write the other chapters. This is a summary and overview of all that was known scientifically as of 2006, and there’s nothing newer that’s nearly as comprehensive. As an academic work should, it has all the citations of peer-reviewed journal articles etc. that you’d need to get even further into the subject.For an adult patient or the parent of an affected child, the knowledge you can gain here will allow you to better understand the particular form/nature of the disorder you’re facing. It’s said that every case of ADD is different - really different. No self-help book can address the nuances and peculiarities of an individual case. But armed with the scientific data in this book you can both get a more clinical look at your own case and be better able to read those self-help books with insight and a critical eye.For primary care practitioners, mental health and social work professionals, educators, caregivers in specialized fields related to ADD, and any other professionals who might run into ADHD kids or the 4% to 8% (or so) of adults who have some form of the disorder: a plea from a patient who wasn’t diagnosed until age 54. Please read this book. Please. Had anyone suggested to me that I might have ADHD just a year earlier, not to mention ten or thirty years earlier, I might have saved myself (and others) much pain and many difficulties. This book can help you make that difference for someone. And of course if you’re routinely dealing with ADHD this book is a must-read.Lots of researchers disagree with Barkley, though usually just in part. There’s still much that’s mysterious about this disorder. I don’t want to imply that this book is the beginning and end of the subject. Only that it’s a great overview and starting point for the scientifically-minded.

Thsi revision of Barkley’s book is outstanding. The book is easier to read than past revisions, yet like the previous ones provides up-to-date research findings on ADHD. The chapters on school supports are matchless compared to other books by ADHD researchers/writers. Parents will probably find the book "heady", but no clinician should practice without having read this book.

Dr. Barkley has contributed an extremely beneficial companion to his handbook for diagnosis and treatment of ADHD. The rating forms are very useful for the clinician assessing ADHD and comorbid features. Dr. Barkley's discussion offers extremely helpful guidelines for assessment and treatment of ADHD and various emotional-behavioral issues which may accompany or mimic ADHD. This volume is a must for any practicing health or educational professional involved in the assessment and treatment of ADHD.

One of the most frequent and important topics of concern is medication for ADHD. Barkley stresses the efficacy of pharmacotherapy among three chapters under the following headings: 1) stimulants, 2) antidepressants, modafinil, and anti-hypertensives, and 3) others.Although psycho-social interventions are invariably recommended to accompany pharmacotherapy, treatment with stimulants alone results in reported behavioral improvement in 70% to 90% of students diagnosed with ADHD, and all three subtypes (Inattentive, Hyperactive-Impulsive, and Combined) respond well. Barkley stresses that stimulants should be used first before other medications. In fact, he recommends prescribing various stimulant medications before trying other forms of medication. What is very important is that the variability of outcome is largely due to the presence of co-morbid disorders. For example, among children with major depressive disorder (15% to 30% of children with ADHD), a favorable response to stimulants may be reduced. The same is indicated with children with co-morbid anxiety disorders (25% to 30% of children with ADHD). However, stimulant medication should be administered first because it generally does not exacerbate the anxiety, and its efficacy can be assessed very quickly.It appears that the fear of a student developing tics or Tourette's Syndrome is unfounded. Even if tics appear or increase, they almost always return to the pre-medication level in a couple of months, even when medication is continued. In addition, the author believes that the scare from 12 deaths of children who were taking Addreall XR is also unfounded. Among these children, five already had serious heart problems, and the death rate from similar problems is the same as that among children not taking medications. Based on meta-analyses of large numbers of studies, the author concluded that among healthy children, routine blood work and monitoring of the heart is not needed. However, monitoring of the child's height and weight should be done twice a year.With a number of students taking stimulant medication, a "rebound" phenomenon is sometimes noticed in the afternoon or evening when the medication wears off. With this, the increase of ADHD types of behaviors may exceed what was observed before pharmacotherapy began. This has important implications for parents; it may appear that medication has no effect, or is even making things worse. Barkley recommends a longer-acting

preparation, or the administration of a small dose of stimulant medication about one hour before the rebound symptoms are usually noticed.During 1990-2000, stimulant use for ADHD children two to four years of age increased threefold. The efficacy of pharmacotherapy is more variable with this young population, and side effects are more often reported. The majority of the side effects seem to center on changes in their emotions - sadness, irritability, outbursts, and clinging behaviors. When pharmacotherapy is being used with this young population, it is imperative that the parents, teachers and physicians keep monitoring the children for emotional as well as physical changes.Although Barkley wrote that stimulants should be the first drugs tried, he also considers Strattera to be a first-line medication, and he seems to favor it. Strattera is a new class of drug that has been developed, and it is the first non-stimulant drug to be FDA approved. (No others have been approved since.) It takes several weeks for the effects to be seen, but, compared to stimulants, fewer problems were observed with appetite suppression, growth and weight, and parents reported fewer emotional difficulties and greater self-esteem in their children.The second-line agents for ADHD are to be considered for the up to 30% of those who do not respond to stimulants and/or suffer from severe side effects. The most frequently used and recommended are antidepressants, specifically tricyclic antidepressants (Imipramine, Nortriptyline, and Desipremine), Bupropion, Venlafaxine, and Fluoxetine. The tricyclics seem to show improvement to approximately the same extent as stimulants, and they often have positive effects on mood, anxiety, sleep, oppositionality, and tics. However, the author still emphasizes that they should be used as a second-line drug. It is recommended when there is co-morbid anxiety, depression, or tic disorders. Bupropion, Venlafaxine, and Fluoxetine are not recommended because of little research to date and/or a high incidence of serious side effects.The third-line drugs are Modafinil, antihypertensive agents, and an anticonvulsant (Tegretol). These are to be considered if there is an unsatisfactory response to the first- and second-line drugs, if there are severe side effects with them, or if there is concern about tics or heart problems. Modafinil was originally prescribed to improve wakefulness by activating parts of the hypothalamus. However, it should not be used with children, and there are numerous side effects. Research has shown that the antihypertensive agents are clearly not as effective as stimulants, but they can be beneficial in reducing aggressiveness, explosive outbursts and conduct problems. It takes up to three months to determine efficacy, and the drugs need to be administered two to three times a day. Among the antihypertensive drugs, Clonidine is probably the most effective and fewer side effects are noted. Finally, Tegretol is used for treating ADHD in Europe, but it is felt that much more research is needed and there is more potential for side effects than with other drugs.Antihistamines, benzodiazepines, and lithium have not proved to be effective for the treatment

of ADHD.Although the number of students taking medication for ADHD has doubled and even tripled in the past decade, Barkley appears to advocate increased applications, both throughout the lifespan and throughout the day. ADHD continues throughout one's life among about half of the individuals with this disorder, so the author concludes that stimulant medication should probably continue throughout their lifespan. He also "emphasizes extended treatment of symptoms throughout the day." This seems to contradict other realities; namely, the increasing ability, as one matures, to control one's behaviors and/or environment. For example, as a group, symptoms of ADHD-HI tend to decrease with age, more often than symptoms of ADHD-I do. Barkley himself speculates that adolescents may have developed more ability to inhibit motor responses, while other adolescents may be continuing the behavior in a "disguised" fashion (moving their legs or tapping their fingers while otherwise seated quietly). Should not we be advocating this self-control, hopefully without the use of medication, as much as possible? Of course, among many people with ADHD, many areas of their lives will be significantly affected, and they will need medication. However, with counseling many will also be able to choose and structure environments in which ADHD will not significantly impair their functioning. In addition, Barkley does not comment on the "reinforcement contingencies" with those who are affected by a student's ADHD. It is quite obvious that it makes life much easier for teachers, parents, and administrators if the symptoms can be reduced in a simple and effortless fashion. This is not to say that pharmacotherapy should not be used; rather, only that it should not be encouraged. Finally, since there are still not many long-term studies, it seems almost dangerous to encourage not only the lifetime ingestion of the drugs, but also the round-the-clock use of it.Sometimes it may be helpful to inform parents and teachers of the "associated problems" that are thought to often accompany ADHD, such as learning disabilities, oppositional defiant disorder, conduct disorder, anxiety, and depression. However, caution is needed. Barkley cites extensive research about these problems related to ADHD, and most of it is conflicting. Moreover, these "associated problems" are often observed among non-ADHD children, so their existence should not indicate a diagnosis of ADHD. It is important to inform people that although there is a higher incidence of these problems among ADHD students, there is no evidence of causal connections, and many non-ADHD students have these problems.However, Barkley specifies cognitive problems that invariably accompany ADHD; these are the ones that are most helpful in understanding and treating the disorder. The most obvious is that the ADHD student is observed by most people to have a lack of self-control. Self-control manifests itself in inhibiting one's responses when needed (staying in one's seat or not blurting out an answer or opinion), sustaining effort (completing assignments), and attending. The main factors that lie at the heart of

self-control, according to Barkley, are the mechanisms used to delay reinforcement.These mechanisms are executive functioning, memory, planning, and internalized speech. They are invariably impaired or delayed in development among ADHD students. In addition, many of the associated problems seem to stem from these difficulties. For example, students with ADHD have lower adaptive functioning (as a group), relative to their intelligence, than students with average intelligence and those who are retarded. Barkley writes that "deficits in executive functions may....explain (or contribute to) the deficits found in adaptive functioning in ADHD" (p. 124). It has often been reported that ADHD students tend to talk more than non-ADHD students, but that this is with spontaneous conversation as opposed to explanatory speech. Barkley points out that "their problems are not so much in speech and language per se as in the higher-order cognitive processes.....known as `executive functions'" (p.125). The author also speculates that deficits in rule-governed behaviors (difficulty with rules and instructions) are related to similar cognitive deficits.Barkley also refers to different types of memories, and emphasizes that "working memory" is the memory that is most impaired, as opposed to simple recall, long-term storage and long-term retrieval. However, among the nonverbal working memories, studies documenting deficits or impairments are few and conflicting. This is not the case with verbal working memory; this appears to be a main factor in persistence of effort, according to Barkley. He refers to persistence of effort while engaged in an activity as "self-regulation of motivation," and internalized speech and verbal working memory play the major roles in this. This is because the working memory and internalized language bridge the temporal delays in reinforcement. That is, the student is able to remind himself of the future reinforcement. This working memory and internalized language is weaker among ADHD students, so persistence with tasks needs to come from more external reinforcement.Barkley either implies or directly states that ADHD has a physiological basis. That is, the brain function differs in a way that results in weaker behavior inhibition, working memory, internalized language, and so on. For example, studies cited have shown that there is a significant difference with brain wave patterns and cerebral blood flow between ADHD and non-ADHD groups of children. (However, Barkley himself writes that ADHD should not be diagnosed because of any specific cerebral patterns; the research is conflicting, there are many false positives and negatives.) This physiological origin appears to be the main reason that pharmacotherapy is usually effective. One possible shortcoming in this reasoning is as follows: Barkley stresses the need for immediate and consistent reinforcement to keep those with ADHD motivated to complete tasks. This is consistent with reports from parents and teachers who usually say that the student can play video games or watch TV for hours but cannot sit and do homework. The video games and TV are giving them

external reinforcement that is frequent, varied, and intense (see above). One major factor seems to be overlooked: How does something become reinforcing? Reinforcers are unique to each individual, and they are developed in one's environment. The music and sports one enjoys are obvious examples. I would like to cite a couple of personal observations that may shed light on some shortcomings with Barkley's explanation, and any teacher can cite many more. One student who was diagnosed with ADHD-PI did little school work and was almost expelled from a private school because of his over-activity in the classroom. Yet, he became an excellent violinist by ninth grade. Such proficiency requires hours and hours of concentrated and sustained practice, something with which ADHD students presumably have difficulty. Another with similar problems became skilled at painting while in high school. These students acquired most of their skill before they began medication. Barkley would probably say that these activities were highly reinforcing to the students and gave them immediate feedback with the sounds or colors that they produced. (The students actually reported exactly that.) Following that train of thought, are there not simply many students who are not attentive and on-task because they are not finding reinforcement with academic and related tasks? Most students, if required to become proficient with the violin, would be off-task and distractible. Therefore, is the literature doing a disservice by not investigating why students are not finding reinforcement from academic tasks? We have all seen the ADHD student who will read novels for hours (Harry Potter) but not read school textbooks. In many cases, should we not investigate the nature of the reinforcement contingencies? Barkley also writes that up to 40% of those diagnosed with ADHD "grow out of it" in adulthood. Is this just dismissing the possible explanation that the adult is now able to choose situations that are reinforcing? In many cases, shouldn't we be investigating why these students are not getting reinforced from a young age with academic-types of activities? Or, should we be looking into educational alternatives for many students?Barkley does not touch on why or how the tasks themselves become intrinsically motivating to some students but not to others. When students spend hours on a video game, it is concluded that they are getting immediate and intense feedback, but there is no speculation or consideration as to why some students with ADHD develop reinforcing feedback from tasks that even "non-disabled" students may find tedious and boring.

Answers About Attention Deficit Hyperactivity Disorder (ADHD) In Women And Girls Attention-Deficit Hyperactivity Disorder in Adults Organizing Solutions for People With Attention Deficit Disorder: Tips and Tools to Help You Take Charge of Your Life and Get Organized Attention Deficit Disorder: The Unfocused Mind in Children and Adults Overload: Attention Deficit Disorder and the Addictive Brain Driven To Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood Through Adulthood The Hyperactive Child, Adolescent, and Adult: Attention Deficit Disorder through the Lifespan Scattered: How Attention Deficit Disorder Originates and What You Can Do About It Delivered From Distraction: Get the Most Out of Life with Attention Deficit Disorder You Mean I'm Not Lazy, Stupid or Crazy?!: The Classic Self-Help Book for Adults with Attention Deficit Disorder Delivered From Distraction: Getting the Most Out of Life with Attention Deficit Disorder You Mean I'm Not Lazy, Stupid or Crazy?!: A Self-Help Book for Adults with Attention Deficit Disorder Give Your ADD Teen a Chance: A Guide for Parents of Teenagers With Attention Deficit Disorder All About Attention Deficit Disorder Skin Disease: Diagnosis and Treatment, 3e (Skin Disease: Diagnosis and Treatment (Habif)) Windows into the A.D.D. Mind: Understanding and Treating Attention Deficit Disorders in the Everyday Lives of Children, Adolescents and Adults