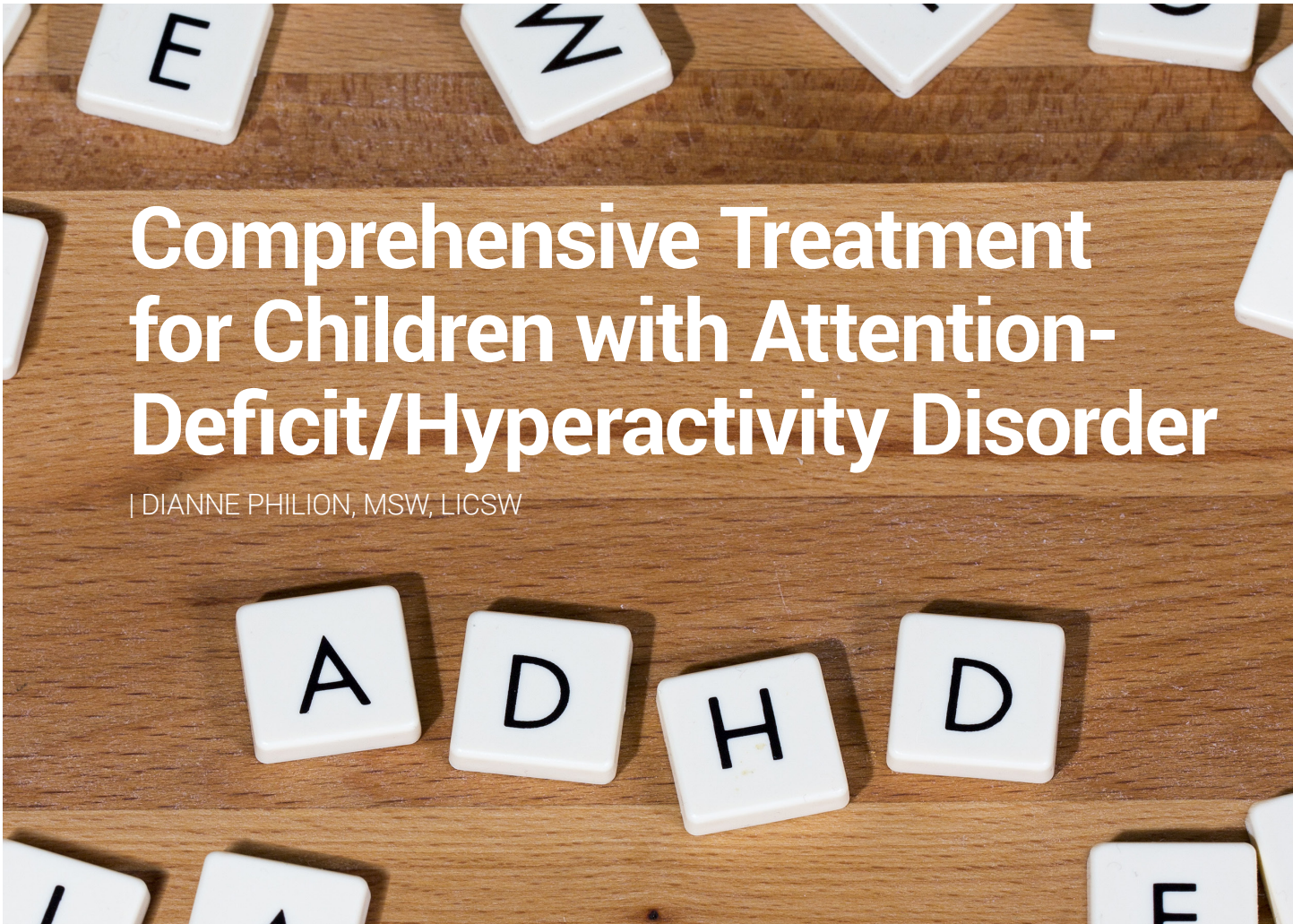




Comprehensive Treatment for Children with Attention-Deficit/Hyperactivity Disorder

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Attention-deficit/hyperactivity disorder (ADHD) is a neurological disorder that has been diagnosed in 6.4 million children aged four to 17 years in the US; boys are three times more likely to be diagnosed, and the average age of diagnosis is seven years old (Holland & Riley, 2014). With the prevalence of this diagnosis in American society, clinicians should create a comprehensive and methodical framework for working with children diagnosed with ADHD. The present framework incorporates a child-centered approach based on Rogers's (1959) client-centered personality theory.

Rogers's theory focuses on three domains: the person, the phenomenal field, and the self (Landreth, 2012). The phenomenal field encompasses all internal, external, sensory, and visceral experiences the child has that have become reality for him or her (Rogers, 1959). The self is the entirety or whole of all incidents or events experienced by the child and the perception that the child has of each encounter. Landreth (2012) defined the person as "all that a child is: the child's thoughts, behaviors, feelings and physical being" (p. 55). The child-centered approach is the most widely used approach among play therapists (Ray, 2011), and it has shown its efficacy for treating symptoms of ADHD (e.g., Naderi, Heidarie, Bouron, & Asgari, 2010; Ray, Schottelkorb, & Tsai, 2007; Robinson, Simpson, & Hott, 2017; Schottelkorb & Ray, 2009).

One of the most widespread childhood diagnoses (Ray et al. 2007; Robinson et al., 2017), ADHD is a neurological disorder that affects executive functioning skills (e.g., organization, planning, sequencing, emotion regulation, attention, initiating, and awareness). However, ADHD is often a co-morbid diagnosis, with more than two-thirds of children diagnosed with ADHD having at least one other co-occurring condition (Children and Adults with Attention Deficit/Hyperactivity Disorder, CHADD, 2019a). Additional co-occurring anxiety, depression, learning and processing disabilities or weaknesses, language needs, sensory processing disorders, behavioral and emotional dysregulation, and Level 1 autistic spectrum disorders are common (Ray et al., 2007). The therapist must investigate these clinically important features to attend to the whole child. The child-centered approach is a framework from which play therapists can structure multi-layered work in an interdisciplinary team, which includes completing a comprehensive psychosocial assessment, networking with other school- and community-based professionals, and providing multi-layered care.

Comprehensive Psychosocial Assessment

Therapists should complete a comprehensive psychosocial assessment with caregivers at intake. Clinicians should employ careful and compassionate scrutiny during this process. Additionally, discussing different aspects of the child's life helps clinicians to gather clues about

family strengths and vulnerabilities, child health and wellbeing, and any events or ongoing issues that may present stressors to the child or the family system. In so doing, the presenting problem and the child's psychosocial stressors can be understood within a broader family context.

Psychosocial stressors affect everyone, especially children, and the child's perceived stress from all areas of his or her life likely will manifest in his or her behavior. The parents' educational background, family dynamics, the child's personal resources (e.g., talents, accomplishments, hobbies), and other events over which the child has no control (e.g., parental separation or divorce, frequent family moves), may influence how the child engages in school and attempts to find his or her place socially.

Developmental history and current information about the child's habits may give clinicians a better idea of the child's general wellbeing. Historical information about developmental milestones, eating and sleeping patterns or changes (including sleep disturbances and nightmares), and medical history (including head injury) may offer ideas about the child's baseline characteristics and dispositions. Therapists also should ask about different emotions and behaviors that manifest regularly or occasionally, such as fears or anxiety; tearfulness, sadness, or depression; irritability, anger, or explosiveness; and any sensory hypersensitivities the child may have to hearing, touch, taste, smell, and sight.

Additionally, screening for the family's history of psychiatric illness, suicide and suicidality by the child, trauma or abuse, recent or past deaths (including pets), alcohol/drug use, and domestic violence within the family system will give clinicians a better idea of what stressors the family has endured and potential vulnerabilities the child may have. Asking about domains that may affect concentration and social engagement, such as caffeine intake, compulsive behaviors, socialization, play behavior (e.g., sharing, winning/losing at games and sports, aggressive or edgy play, etc.), school achievements or difficulties, ability to tolerate homework and concentrate on tasks, in general, will help clinicians understand how the child interacts with others and invests in different settings.

Once this anamnesis has been explored, play therapists can work closely with parents during this initial stage to formulate therapeutic objectives for their child's care. Treatment planning together raises the potential to achieve the best possible result for the child.

Multidisciplinary Approach to Assessment, Diagnosis, and Treatment Planning

Caring for and treating a child with ADHD involves interdisciplinary cooperation and alliance. Obtaining signed parental consent and releases of information allows the clinician to interface with schools, pediatricians, neuropsychologists, occupational therapists, psychiatrists, and other professionals who may have insight into the child and his or her level of functioning. This enables the clinician to gather additional information about the child, further enhancing a clinically holistic, thoughtful treatment plan centered on an understanding of the child and his or her world.

CLINICAL EDITOR'S COMMENTS:

The author provides comprehensive suggestions for treating ADHD through a multi-layered, child-centered, and interdisciplinary team approach.

Occupational Therapy Evaluation

An occupational therapy (OT) evaluation may be warranted due to pronounced sensitivities in all or some sensory domains, such as touch, sight, smell, hearing, and taste. The OT evaluation is needed if the child dysregulates emotionally or behaviorally in the presence of or after exposure to a particular sensory domain. For example, some children may be acutely sensitive to various fabrics, or their behavior may become difficult to manage in the classroom if the fire alarm sounds. Other children cannot tolerate certain tastes or food textures, so they may eat the same restricted food repertoire and/or small quantities.

Occupational therapists are specially trained to work with children to help them desensitize these overactive sensory areas. Although OT may be supported at school as time and availability allow, parents should also consider OT from a private agency because children often are embarrassed about being pulled out of their classroom, the child may miss a segment of learning that is integral, or he or she may not want to miss classroom activities. Additionally, private OT may be more comprehensive because sessions are often longer. School-based occupational therapists have limited time to see each child. In some cases, both school-based and private OT is needed. OT at school for some children helps them regulate their body during the school day, which enhances their concentration capacity and ability to learn and retain information.

Neuropsychological Evaluation

If parents report incongruities in academics, such as increased anxiety and poor grades in math, yet excellent grades and facility in English, this may be an indicator that a neuropsychological evaluation is needed. Some children exhibit high anxiety and dysregulation when receiving information from the teacher and trying to take handwritten notes. Other children display social awkwardness, have trouble maintaining eye contact, or have a very high IQ but have trouble spelling words. A neuropsychological evaluation will help diagnose possible autism spectrum disorders, learning disabilities or weaknesses, and clarify diagnoses of anxiety and depression, any of which may co-exist with ADHD (Ray et al., 2007). A therapist's introductory letter to the neuropsychologist with referral question(s) may be provided as a professional courtesy that initiates this process, but the parents should make an appointment with the neuropsychologist to set up the evaluation.

Educational Evaluation and Accommodations

Once diagnosed, protecting students' rights and ensuring their access to free and appropriate education in the school setting is important (U.S. Department of Education, USDE, 2010). Therefore, it is critical to send school personnel a copy of the recommendations section from the

evaluation(s) so they can develop an effective individualized education program (IEP, for special education concerns and delivery) or a 504 plan (for other accommodations) for the child. An IEP notes the child's current levels of educational performance, states annual goals and how they will be measured, and provides specific modifications and services to be provided to the child (Gartland, 2000; Office of Special Education and Rehabilitative Services, 2000). For ADHD concerns, very specific recommendations would be tailored to the child's individual circumstances.

For example, to help students regulate their bodies and minds, schools may provide a stand-up desk and movement breaks, such as sending the child to the office with a note as a favor to the teacher, which is a discreet way to allow the child to leave the classroom without feeling embarrassed. Implementing accommodations that promote concentration include allowing the student to sit at the front of the class, chewing gum, using a bean bag chair for reading, keeping assignments up-to-date in a weekly planner, and providing a squeeze ball for body-mind regulation. Adding additional supports may boost student self-esteem and reduce feeling alone in their discomfort, such as providing access to the school counselor for individual or group lunches with other students with ADHD or support from an educational paraprofessional. Parent or school counselor consultation can also help the teacher learn more about the child's particular situation and how to best accommodate him or her in the classroom to improve the child's focus and reduce any potential disturbances for the rest of the class.

Section 504 of the Rehabilitation Act of 1973 grants access to accommodations to the learning environment or physical space to prevent disability-based discrimination (USDE, 2010). Typical 504 accommodations may include, but not be limited to, reducing the amount of homework without changing the level or content; providing quiet places to work or to take tests; breaking assignments or tests into smaller sections, changing the format, or giving more time to complete them; and having the school counselor work with the student on academic or behavioral concerns (CHADD, 2019b).

When recommendations from evaluations have been implemented, the child's behavior often improves. The holistic and child-centered combination of individualized accommodations for school, play therapy, and occupational therapy, coupled with parents' efforts to implement behavior modification strategies at home, offer the child a platform for constructing successful attitudes and behaviors.

Effective Teaming with Parents

The importance of working collaboratively with parents and other caregivers cannot be overstated and should be explained to parents at the beginning of the intake. Children will enjoy better results if parents are involved in their treatment. Ideally, monthly meetings with parents will suffice, unless parents wish to meet more often.

Setting realistic expectations with caregivers regarding treatment goals for their child promotes a trusting relationship with the therapist. Compassionate and active listening to the parents' worries about their child and making appropriate recommendations for managing behavior

at home advances the team approach. Additionally, treatment that incorporates psychoeducation to explain how various stressors impact the child is essential. With psychoeducation, parents may better understand why their child behaves in ways that they did not previously understand, thereby enabling them to become more effective with employing behavior modification techniques learned in the parent meetings and advocating for their child in other settings.

Filial therapy may offer another method for managing one's relationship with a child who manifests ADHD behaviors. Child-Parent Relationship Therapy (CPRT, Bratton, Landreth, Kellam, & Blackard, 2006) helps improve the relationship between a parent and child during once weekly, 30-minute, home-based play times. By focusing on the child instead of his or her emotional or behavioral dysregulation, play therapists teach parents how to establish a safe, accepting environment where the child is more inclined to communicate his or her emotions, needs, and desires. As a result, children may develop better self-esteem and increased self-confidence with a concomitant decrease in disruptive behaviors (Landreth, 2012). Furthermore, children with ADHD and emotional/behavioral dysregulation express themselves more effectively due to the accepting, trusting atmosphere established with their parents.

A Clinician's Template for Multi-layered Work

The following suggestions provide a starting point for clinicians and parents beginning multi-layered work with children diagnosed with ADHD. Choosing options that strategically, clinically, and methodically treat the child within his or her environment will promote continuity of care. However, the child's tolerance level needs to be considered when proceeding with these suggestions, because children and their parents often enter therapy overwhelmed and at a crisis point, with no understanding of why their child's behavior at school at and home is so difficult to manage. The clinician should be vigilant about the child's anxiety regarding meeting the clinician and allow time to explore the play area. This gentle style epitomizes the theoretical basis of Rogers's personality theory and Landreth's child-centered approach. It also promotes safety for the child.

- Create a comprehensive psychosocial assessment that includes a treatment plan and goals that have been developed with the parents and the child.
- Obtain signed informed consent to coordinate with professionals from other disciplines.
- Write introductory letters to the pediatrician, neuropsychologist, school counselor, and others, as needed, to solicit their cooperation in treatment.
- Compile a list of potential referrals for pertinent types of testing/evaluation with neuro- and other psychologists, occupational therapists, speech and language specialists, etc., and provide referrals to parents as needed.
- Request a neuropsychological evaluation to determine IQ, learning disabilities or weaknesses, learning style, other diagnoses, and to make informed recommendations for home and school.
- Request a school-based OT evaluation to determine if sensory integration problems exist. Provide a list of private OT providers, if needed.
- Refer to a pediatrician or to a child psychiatrist if medication is warranted.

Child-Centered Treatment Options

Within the child-centered framework, establishing a safe, positive and respectful relationship with the child is fundamental for beginning the work and following up with treatment. From the start, honoring the child's anxiety, silence, play language, need for exploration, pain, joy, confusion, etc., promotes a solid therapeutic relationship. The clinician's understanding of the child's self-directed capability can further enhance this process (Landreth, 2012). CCPT's effectiveness is based on a foundation that the therapist believes children are intrinsically self-directed, motivated, resilient, self-determined, and capable of making developmental achievements. Using this innate drive, play therapists can provide an environment conducive to helping the child move towards stabilization (Landreth, 2012).

CCPT treatments take into account the child's developmental stage, frustration tolerance, cognitive and language abilities, feelings management, confidence and self-esteem levels, and executive functioning skills. The clinician's ability to gather information about the child is greatly enhanced during game play. Games may help the clinician and child get to know one another better and give the clinician a sense of how the child's ADHD manifests; some classics are hide-and-seek; Candy Land™; The Talking, Feeling, and Doing Game; and Mountaineering: A Cooperative Adventure Game. Developmentally appropriate games also improve the child's sequencing, planning, organizing, initiating and emotionally regulating behaviors (Yorke, 2012).

Reading aloud to children of all ages is a positive way to enhance the relational bond (Landreth, 2012). Klass (2018) summarized research that tracked more than 600 families with a reading program called the Video Interaction Project (VIP). The researchers found that when parents read aloud to their children, especially in the developmentally significant years of life (birth to 3 years of age), a substantial improvement in attentional, aggressive, and hyperactive behaviors, all of which are indicators of ADHD, were noted.

Art-based activities that include painting, drawing, working with natural or sculpting clay, and beading open clinical doors for children to express their feelings and thoughts verbally or nonverbally (Dessauer, 2016). The child's silence during the activity is important to respect, as creativity can be interpersonally private. Words do not necessarily need to be uttered for healing to take place (Landreth, 2012).

The following examples depict the therapeutically self-directed capability of children with whom I have been privileged to work. They used these activities to self-regulate and to concentrate on therapeutic tasks.

- **Relaxation sock:** made from a tube sock filled halfway with dry beans, tied off at the ribbed part, then placed in the microwave for the child's desired warmth level. Children have reported immediately feeling calmer as they place the relaxation sock around their neck or on their stomach or legs. Some children have preferred to put the relaxation sock in the freezer because a colder temperature is more calming and soothing for them.
- **Yarn stress balls:** made from very soft or baby yarn, these handmade balls serve to quiet sensory domains for emotion regulation. Children have reported the ultra-soft feel of the yarn calms their body and thoughts.
- **Balloon stress balls:** The first balloon is filled with baking flour, tied off, then encased with two more balloons (let the child choose the colors), then securely tied off so that the child can squeeze and release tension/stress without the flour spilling out of the balloon. Some children have invented mixing flour and dry beans for a greater sense of sensory regulation, peacefulness, and accomplishment.
- **Emotions puppets:** made from craft sticks and various embellishments (feathers, sequins, pompoms, googly eyes, beads, etc.) with each stick depicting an emotion the child identifies. This invites age-appropriate conversation about school, home, or social difficulties associated with emotion and helps the child to safely externalize the problem(s) through the puppet (Landreth, 2012).
- **Clay bags:** made with natural clay that is dense and thick. Using a small resealable plastic bag, have the child dig into the clay and grab several fistfuls to place into the bag. Squeeze all the air out of the bag and zip it closed. The child can then squeeze the bag of clay, which helps to calm their body and mind during times of stress.
- **Dry beans:** in a variety of shapes, colors and sizes (chosen by the child) placed into a plastic container with a top may help a child quickly self-soothe by slowly running his or her hands through the cool, dry beans. Children can achieve a relaxed feeling, which reduces the overwhelming emotional state they often experience when in distress.

Using these art/craft ideas that come from children themselves offer them a chance to allay their stressors instead of acting emotionally immature or aggressively. Implementing children's ideas, based on their own intuitive therapeutic needs, is the ultimate child-centered treatment.

Nonclinical Treatment Options

Play therapists should also recommend nonclinical treatment approaches to parents. For example, allowing the child time to play after school, encouraging him or her to ride a bike, run freely, and participate in other physical outlets may help manage some of the dysregulation children with ADHD experience. Sax (2016) touted more than 60 years of research emphasizing the importance of multisensory interaction on healthy child development. Sax (2016) found that time spent outdoors, digging and putting hands in the dirt (e.g., playing, feeling, smelling the dirt and environment) "awakens the senses" (p. 35). Such activities are part of a helpful treatment option for children diagnosed with ADHD. The importance of movement and exercise after school cannot be overstated, particularly for boys, who are more likely to be diagnosed with ADHD (Holland & Riley, 2014).

Conclusion

Given the complicated layers of ADHD and its co-existing diagnoses, children with ADHD need effective care as early as possible to avoid potential adverse, long-term consequences (e.g., Naderi. et al., 2010;

Ray et al. 2007; Robinson et al., 2017; Schottelkorb & Ray, 2009). If their care is tailored to treat the whole person of the child, they will have the greatest chance of being more grounded, self-confident, self-aware, self-assured, and socially poised in their interactions with others. Therapists can create a comprehensive framework for supporting these children through collaborative efforts with parents and other professionals. By suggesting further evaluation and testing when needed, and providing recommendations to parents and school personnel, play therapists can assist in implementing accommodations that promote children's social, academic, and career success across multiple settings.

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