ADHD: Medications and Behavioral Interventions

PAL Conference
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Disclosures

• Financial: No relevant financial relationships to disclose.
• Unlabeled/unapproved uses of medication: Off-label medication use is discussed and when it occurs will be highlighted.
Overview

• Research on Treatments: MTA/PATS
• Principles of Parent Behavior Management Training, Resources
• Medication Options
• Practice Behavioral Interventions!
Multimodal Treatment of Attention-Deficit/Hyperactivity Disorder Study (MTA)

- 579 children, 7-9 y/o
- Dx: ADHD-Combined Type
- 20% female, 80% Caucasian
- Treatment modes:
  - Intensive medication management (methylphenidate TID, other drugs as needed; algorithm for adjustments; advice and readings)
  - Intensive behavioral treatment alone (parent training; structured teacher consult; full time summer treatment program; half time classroom behavioral specialist)
  - Combination of above
  - Routine community care (control)

The MTA Cooperative Group. A 14-month Randomized Clinical Trial of Treatment Strategies for Attention-Deficit/Hyperactivity Disorder. Arch Gen Psychiatry 1999; 56: 1073-1086.
MTA at 14 months

- Combination and Medication Alone>>> Behavior Management and Control
- Combination superior for: oppositional/aggression, anxiety, reading achievement, parent-child relations, families with stress and social skills
- 4% stopped medications due to side effects
- Optimal dosing 1 mg/kg/day
- Combination allowed for lower dose of medication:
  - Medication only: 32.3 mg/day
  - Combination: 28.7 mg/day

The MTA Cooperative Group. A 14-month Randomized Clinical Trial of Treatment Strategies for Attention-Deficit/Hyperactivity Disorder. Arch Gen Psychiatry 1999; 56: 1073-1086.
MTA at 8 years

- After 14 months of treatment, returned to community
- At 8 years, all four groups MAINTAINED improvement
  - No differences between treatment groups
  - MTA group still functioned less well than non-ADHD sample

Preschool ADHD Treatment Study (PATS)

- 3 to 5.5 year old with severe ADHD, unresponsive to 10 week psychosocial intervention
- 37/279 patient parents said behavioral treatment resulted in satisfactory improvement
- Treated with IR methylphenidate
- Outcomes:
  - Stimulant effective for core ADHD symptoms
  - Mean optimal dose 0.7 mg/kg (LOWER END DOSES)
  - Lower effect size and higher rate of side effects
    - Irritability, prone to tears, crabby

Sequencing Treatment

- 8 weeks of behavioral OR med tx, then the other
  - 1 year randomized study (ages 5-12 with ADHD)
  - Second intervention offered only “if needed” at 8 weeks
- Behavioral 1st group had better classroom behavior
- Adding meds 2nd improved classroom behavior and parent/teacher-rated oppositional behavior compared to meds 1st.
- Parent engagement higher if offered group first

- Overall: Better to start with behavioral first, especially in very young

(Pelham et al., 2016, JCCAP)
Efficacious Psychosocial Treatments

- **Level 1: Well-Established**
  - **Behavioral Parent Training**
  - Behavioral Classroom Management
  - Behavioral Peer Intervention (Summer Treatment Program)
  - Combined Behavior Management Intervention
  - Organization Training

- **Level 2: Probably Efficacious**
  - Combined Training Interventions
  - Exercise
  - Improved sleep

- **Level 3: Possibly Efficacious**
  - Neurofeedback

(Evans, Owens & Bunford, 2013; Pelham & Fabiano, 2008)
ADHD Parent-Child Cycle

Neurocognitive Deficits

Behavioral Difficulties
- Off-task
- Disruptive
- Lack compensatory skills

Parenting Problems
- Coercive cycle
- Negative expectations
- Withdraw

Externalizing
- Attention-seeking
- Defiance
- Anger

Internalizing
- Low self-efficacy
- Withdrawn

Parent Stress
- Frequent correction
- Fewer pleasant interactions

Functional Impairments
ADHD Parent-Child Cycle

**Neurocognitive Deficits**
- Behavioral Difficulties
  - Off-task
  - Disruptive
  - Lack compensatory skills

**Parenting Problems**
- Coercive cycle
- Negative expectations
- Withdraw

**Parenting Skills**
- Positive attention
- Increase structure
- Consistent consequences

**Child Skills Training**
- Organizational skills
- Mindfulness
- Coping skills

**Child Engagement**
- Success experiences
- Self-efficacy
- Positive relationships
- School effort
- Withdraw

**Effective Parenting**
- Realistic expectations
- Positive relationship
- Less stress

**Functional Impairments**
The Incredible Years
Parenting Pyramid
Special Time

- 5-15 min per day (timed)
- Scheduled!
- Child chooses and leads activity
- Parent pays special attention!
  - Praise
  - Reflect
  - Imitate
  - Describe
  - Enjoy
- Roleplay
  p. 70 in PAL guide
Antecedent: Giving Instructions

“I have to tell her 12 times to do anything”
“He never listens when I ask him to do something”
“He has no idea what the teacher told him to do”

What guidance do you give parents?
Antecedent: Giving Instructions

Effective Instructions:
- Direct and specific
- Only one or two instructions at a time
- Instruction is followed by 10 seconds of silence

<table>
<thead>
<tr>
<th>Ineffective Instructions:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Buried:</strong></td>
<td>Too much talking or explaining after a command makes it difficult for children to figure out what they are being asked to do</td>
</tr>
<tr>
<td><strong>Chain:</strong></td>
<td>Too many instructions one after the other makes it difficult for children to remember each step</td>
</tr>
<tr>
<td><strong>Question:</strong></td>
<td>Stating the instruction in the form of a question technically allows the child to say no</td>
</tr>
<tr>
<td><strong>Vague:</strong></td>
<td>Nonspecific commands that don’t state exactly what you want makes it difficult for child to comply</td>
</tr>
<tr>
<td><strong>Let’s:</strong></td>
<td>Gives the child the impression that you are going to help him/her</td>
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<tr>
<td><strong>Distance:</strong></td>
<td>Instructions are yelled from a distance which makes it more difficult for child to pay attention well</td>
</tr>
<tr>
<td><strong>Repeated:</strong></td>
<td>Repeating same instruction without reaching a limit</td>
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</tbody>
</table>
Consequences

- To increase behaviors
  - “Catch ‘Em Being Good”
  - Attending to desired behaviors
  - Incentives
    - Immediate, consistent feedback (tokens)
    - Premack Principle (If-Then)

- To decrease behaviors
  - Planned ignoring
  - Time Out
  - Response Cost (losing privileges)
Planned Ignoring

**Extinction Graph**

- **Initial Behavior**
- **Response Frequency**
- **Extinction Burst**
- **Extinction Occurs**
- **Reinforcement Removed**
- **Spontaneous Recovery**
## Token System

<table>
<thead>
<tr>
<th>Target Behavior</th>
<th>When Checked?</th>
<th>Tokens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of bed with 1 reminder</td>
<td>After 1&lt;sup&gt;st&lt;/sup&gt; reminder</td>
<td>1</td>
</tr>
<tr>
<td>Dressed and teeth brushed in 10 min</td>
<td>Timer goes off</td>
<td>1</td>
</tr>
<tr>
<td>End on “green” at school</td>
<td>Arriving home</td>
<td>1</td>
</tr>
<tr>
<td>Put away shoes and backpack</td>
<td>Arriving home</td>
<td>1</td>
</tr>
<tr>
<td>Pajamas on with 1 reminder</td>
<td>Bedtime</td>
<td>1</td>
</tr>
<tr>
<td>Kind words to brother all day</td>
<td>Bedtime</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>
Time Out

What pitfalls have you seen?

• “We’ve tried everything and nothing works”
• “She is happy to be in her room”

How have you seen the child undermine the time out?

See p. 69 of PAL guide for handout for families
Summary

- Behavioral treatments improve functioning beyond ADHD symptoms
- Work alone and together with meds
- Most benefit from working with parents/teachers
ADHD Medication Management

- Stimulants
- Alpha agonists
- Atomoxetine
- Bupropion
- Omega 3
- Dietary
- Physical Exercise
- Sleep
Stimulants

• Start with either methylphenidate or an amphetamine product (similar efficacy)
• Push dose to maximize effect
  • Monitor for SE (may be more noted with amphetamine products)
  • Avoid unsafe doses
• If not effective with first family, move on to second
  • If stimulants not effective, revisit diagnosis
• Evidence protective effects for comorbid symptoms:
  • Depressive and anxiety disorders
  • Disruptive behavior
  • Family quality of life
  • Repeating a grade

## Short-Acting Stimulants

<table>
<thead>
<tr>
<th>Name</th>
<th>Duration</th>
<th>Starting Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methylphenidate (Ritalin, Methylphenidate Chewable~, Methylin*)~)</td>
<td>3-5 h</td>
<td>5 mg Qd-BID (2.5 mg if 3-5 yo)</td>
</tr>
<tr>
<td>Dexmethylphenidate (Focalin)</td>
<td>5-6 h</td>
<td>2.5 mg BID</td>
</tr>
<tr>
<td>Amphetamine Salts (Adderall, Evekeo)</td>
<td>4-6 h</td>
<td>5 mg Qd-BID (2.5 mg if 3-5 yo)</td>
</tr>
<tr>
<td>Dextroamphetamine (Dexedrine, Zenzedi, ProCentra*)</td>
<td>4-5 h</td>
<td>5 mg Qd-BID (2.5 mg if 3-5 yo)</td>
</tr>
</tbody>
</table>

*liquid formulation for non-pill swallowers
~chewable tablets available

UpToDate accessed 7/24/17, [adhdmedicationguide.com](http://adhdmedicationguide.com)
### Long-Acting Stimulants (methylphenidate)

<table>
<thead>
<tr>
<th>Name</th>
<th>Mode</th>
<th>Duration</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quillivant XR (liquid), ER (chew)</td>
<td>20% IR, 80% gradual</td>
<td>10-12 hours</td>
<td>25 mg/5 mL 20-60 mg</td>
</tr>
<tr>
<td>Concerta*</td>
<td>22% IR, pump</td>
<td>10-12 hours</td>
<td>18-72 mg</td>
</tr>
<tr>
<td>Metadate CD</td>
<td>30% IR 70% in 3 h</td>
<td>8-12 hours</td>
<td>10-60 mg</td>
</tr>
<tr>
<td>Aptensio XR</td>
<td>40% IR 60% in 3 h</td>
<td>8-12 hours</td>
<td>10-60 mg</td>
</tr>
<tr>
<td>Ritalin LA</td>
<td>50% IR, 50% in 4 h</td>
<td>8-12 hours</td>
<td>10-60 mg</td>
</tr>
<tr>
<td>Ritalin SR/Metadate ER</td>
<td>Gradual release</td>
<td>3-8 hours</td>
<td>10-60 mg</td>
</tr>
<tr>
<td>Daytrana Patch</td>
<td>Gradual Release</td>
<td>Slow onset in 2 hours, lasts 9-12, stops 3 h after removal</td>
<td>10-30 mg</td>
</tr>
<tr>
<td>Focalin XR**</td>
<td>50% IR, 50% in 4 h</td>
<td>10-12 hours</td>
<td>5-30 mg</td>
</tr>
</tbody>
</table>

* must be swallowed whole  
** dexamethylphenidate 5 mg ~ methylphenidate 10 mg

UpToDate accessed 7/24/17, [adhdmedicationguide.com](http://adhdmedicationguide.com)
### Long-Acting Stimulants (amphetamines)

<table>
<thead>
<tr>
<th>Name</th>
<th>Mode</th>
<th>Duration</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adderall XR</td>
<td>50% IR, 50% in 4h</td>
<td>8-10</td>
<td>5-30 mg</td>
</tr>
<tr>
<td>Dyanavel XR* 2.5/5mL</td>
<td>50% IR, 50% in 4h</td>
<td>10-13</td>
<td>2.5-20 mg</td>
</tr>
<tr>
<td>Adzenys XR-ODT**</td>
<td>50% IR, 50% in 4h</td>
<td>8-12</td>
<td>3.1-18.8 mg</td>
</tr>
<tr>
<td>Dextroamphetamine SR (Dexedrine Spansule)</td>
<td>50% IR, 50% gradual</td>
<td>6-8 h</td>
<td>5-40 mg (may be BID)</td>
</tr>
<tr>
<td>Lisdexamfetamine (Vyvanse)**</td>
<td>Activated in GI tract</td>
<td>10 h</td>
<td>30-70 mg</td>
</tr>
</tbody>
</table>

* Liquid formulation, 2.5 Dyanavel=4 mg Adderall XR
** Orally disintegrating tablets, 18.8 mg Adzenys = 30 mg Adderall XR
*** Capsule may be opened and dissolved in water or juice, also comes in chewable tablets

dextroamphetamine 5 mg ~ methylphenidate 10 mg
Stimulant Side Effects

- Anorexia, insomnia, emotional lability
- Slowed growth velocity: attenuates over time
  - Stopping medication leads to normalization of growth
  - Adult height not impacted
- Less common: increased HR/BP, headache, dizziness, stomachaches, Raynaud’s, priapism
  - Adrenergic effect increases HR ~5bpm in MTA
- Get baseline vitals, sleep quality and somatic symptoms
- Options: decrease dose, switch class, augment

cardiac Concerns

• AHA says obtaining ECG reasonable.
• AAP does not recommend routine ECG.
  • Consider ECG when on high dose, combining medications, BP/pulse change from a medication, or any cardiac symptoms.
• ADHD medications do not appear to increase the risk of serious cardiovascular events.
  • 1,200,438 patients with ADHD prescription matched with 2 nonusers; 2,579,104 person years: hazard ratio 0.7.
• Physical exam, review of cardiac symptoms, family history of sudden death <35
• Known cardiac issues ➔ cardiology referral

Cooper et al. ADHD Drugs and Serious Cardiovascular Events in Children and Young Adults. NEJM 2011; 365 (20): 1896-904.
ADHD and Substance Abuse

- ADHD increases the risk of substance use and nicotine dependence.
- Early stimulant treatment may reduce or delay the onset of substance use disorder.
  - 2013 follow-up to MTA: no change in adolescent substance abuse rates with stimulant treatment
- Stimulants not as effective if active substance abuse
  - If active substance use, consider atomoxetine or alpha2 agonist
- Misuse/diversion
  - Misuse rates: 5-9% under 18, 5-35% in college-age
  - Consider longer-acting formulations, lisdexamfetamine and atomoxetine

Stimulants and Tics

- High comorbidity
  - 50-60% of children with tics have ADHD
  - 20% of children with ADHD have chronic tic disorder

- Stimulants and Tics:
  - 2015 meta-analysis, 2385 participants
    - No difference in rate of children with new or worsening tics in stimulant vs. placebo groups
    - Earlier data showed some evidence that in children with both ADHD and tics, higher than recommended doses of dextroamphetamine exacerbated tics
  - If tics worsen, consider alpha agonists or atomoxetine

Uptodate accessed 7/25/2017
Atomoxetine (Strattera)

- Noradrenergic reuptake inhibitor
- Once daily or twice daily dosing, swallow whole
- Start 0.5 mg/kg/day for 2 weeks, then increase to 1.2 mg/kg/day
- Max dose is 100 mg or 1.4 mg/kg/day (whichever less)
- Approved for 6 y/o and older
- Effect size moderate (0.6) less than stimulants (0.9 high)
- Takes 4-6 weeks to work
- Can be helpful for anxiety as well
- Drug interaction with CYP2D26 inhibitors (paroxetine, fluoxetine)

Atomoxetine side effects

- GI distress, sedation (insomnia in adults), anorexia, headache, dizziness, irritability, priapism
- Possible suppression in growth velocity
- Not recommended if structural cardiac abnormalities, cardiomyopathy, or rhythm abnormalities
- Warning for liver disease (2 reports; none in 6000 patients in clinical trial)
  - Monitoring of LFTs not recommended.
- Boxed warning for suicidal thinking
  - Risk of 4/1000 in a large controlled study; no completed suicides
Alpha Agonists

- More effective for hyperactivity than inattention
  - Effect size again moderate (0.6)
  - May be better augmenting agent than monotherapy
- May decrease co-morbid tic disorder, anxiety, aggression
- Clonidine more sedating
  - Can be helpful for insomnia
  - Soporific effect may wane after 2-3 weeks
- Guanfacine may be better for inattention/better tolerated for daytime
  - RTC showed improvement in ADHD sx compared to placebo
- May not see full benefit for 2-4 weeks
- Side effects: Sedation, dizziness, hypotension, bradycardia, headache
- Review personal/family cardiac history and risk of rebound hypertension

Uptodate accessed 7/25/17
## Alpha agonists

<table>
<thead>
<tr>
<th>Drug</th>
<th>Start Dose</th>
<th>Max Dose</th>
<th>Half life</th>
<th>FDA Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guanfacine</td>
<td>&lt;45 kg, 0.5 mg QHS</td>
<td>27-40 kg=2 mg</td>
<td>14 h</td>
<td>Not approved</td>
</tr>
<tr>
<td></td>
<td>&gt;45 kg, 1 mg QHS</td>
<td>40-45 kg=3 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;45 kg=4 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guanfacine ER (Intuniv)</td>
<td>1 mg QHS</td>
<td>&lt;12 =4 mg</td>
<td>16 h</td>
<td>6-17 yo</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13-17 =7 mg</td>
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<td></td>
<td></td>
<td>Or</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>0.05-0.12 mg/kg/d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clonidine</td>
<td>&lt;45 kg, 0.05 mg QHS</td>
<td>27-40kg=0.2 mg</td>
<td>12 h</td>
<td>Not approved</td>
</tr>
<tr>
<td></td>
<td>&gt;45 kg, 0.1 mg QHS</td>
<td>40-45kg=0.3 mg</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>&gt;45 kg=0.4 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clonidine ER (Kapvay)</td>
<td>0.1 QHS*</td>
<td>0.4</td>
<td>12-16 h</td>
<td>6-17 yo</td>
</tr>
</tbody>
</table>

* Not per FDA
  Wait one week between dose increases
  Guanfacine 1 mg=clonidine 0.1 mg

Clonidine

Clonidine

- Sudden death in four youths receiving clonidine and methylphenidate.
  - No causality established. No other cases identified.
- High profile case of death of 4 yo girl in Massachusetts on clonidine. Parents administered doses above prescribed; convicted of murder.
  - Advise families about importance of following dosing instructions exactly.
  - Consider care-giving environment of child.
  - Monitor frequency of refills.

Bupropion (Wellbutrin)

- *Not FDA approved* for pediatric use
- Combined dopaminergic/noradrenergic mechanism
- Consider when primary treatments failed
- Consider if co-occurring mood disorder, substance abuse or smoking
- Side effects: insomnia, appetite decrease, less commonly tics, seizures
  - Risk of drug-induced seizures 10x at doses > 450 mg/day
- Starting dose: 150 mg/day or 3mg/kg/day
- Maximum dose: 300 mg/day or 6 mg/kg/day
- No single dose greater than 150 mg

Omega 3

- Not FDA approved
- Meta-analysis 699 patients--small but significant effect (effect size 0.31)
- Additional recent meta-analyses also supports benefit
- Can be used to augment traditional pharmacologic interventions or for families that decline other pharmacologic options
- Look for EPA doses between 450 mg and 600 mg

Dietary Changes

- Recent meta-analysis showed some mild benefit from elimination of food color from diet
  - effects may be limited to those with suspected food sensitivities
- Elimination diet did not demonstrate significant benefit

Physical Exercise and Sleep

• Rommel: review (16 studies)
  • Exercise may improve executive functioning and behavioral symptoms associated with ADHD.
  • May enhance neural growth and alter gene expression
  • Effect size varied from small to large. Further investigation needed. Concluding causality problematic.

• Vysiauske: review (10 studies)
  • Moderate to vigorous exercise → medium effect ADHD sx

• Hiscock: RCT 244 kids
  • 2 consultations about sleep with 1 f/u phone call → improved ADHD symptoms, behavioral problems, QOL and executive fxn for 6 months

Vysniauske et al. The Effects of Physical Exercise on Functional Outcomes in the Treatment of ADHD. J Atten Disord 2016
Hiscock et al. Impact of a behavioural sleep intervention on symptoms and sleep in children with ADHD and prenatal mental health. BJM 2015
Wrap-up

• Get baseline of symptoms, appetite, sleep and somatic symptom frequency
• Make only 1 change at a time to correctly attribute benefit and side effects
• Titrate dose with guidance of repeated measures
• Assess after 1 year whether on-going treatment is needed
Resources

• PAL Care Guide
http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/resources/

• CDC parenting handouts/videos
https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/

• Spanish/English parent skill handouts
http://parenting-ed.org/parenting-information-handouts/

• CBT+ parent training resources for WA providers

• APA “Dulcan’s Helping Parents and Teachers Understand Medications”
https://www.appi.org/dulcan
Erin Dillon-Naftolin, M.D.
Erin.dillon-naftolin@seattlechildrens.org
Time for some practice!
ADHD Parent-Child Cycle

Neurocognitive Deficits
- Behavioral Difficulties
  - Off-task
  - Disruptive
  - Lack compensatory skills

Parenting Problems
- Parent Stress
  - Frequent correction
  - Fewer pleasant interactions

Externalizing
- Attention-seeking
- Defiance
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- Low self-efficacy
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Functional Impairments

Seattle Children’s
Hospital • Research • Foundation
ABC Tracking Sheet

Name of child: __________________ Day/Week: __________________

Identify two target behaviors that you would like to track this week:

Target Behavior 1: _______________________________________
Target Behavior 2: _________________________________________

<table>
<thead>
<tr>
<th>ANTECEDENTS</th>
<th>TARGET BEHAVIOR</th>
<th>CONSEQUENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
• Child playing on DS told to stop and put on pajamas

• Child screams and throws toys

• Parent soothes, explains, gives 5 min warning
Antecedent: Child playing on DS told to stop and put on pajamas

Behavior: Child screams and throws toys

Consequence: Parent soothes, explains, gives 5 min warning

- Child and parent negatively reinforced (child escapes demand, parent escapes tantrum)
• Anticipate and strengthen:
  • Positive relationship
  • Daily structure
  • Clear expectations
  • Incentive systems
  • School supports

• Feedback:
  • Immediate
  • Consistent
  • Frequent
  • Meaningful
  • Balanced
Functiona l Analysis: Practice

• Ask about a recent example of the behavior.
• Ask questions to identify the antecedents and consequences.
• ANTECEDENTS:
  • What led up to [target behavior]? What else was going on right beforehand? Anything else about the situation, people, location, that might have contributed?
• BEHAVIOR
  • What exactly did he do? Get specifics (not just “tantrum”)
• CONSEQUENCES:
  • What happened next? What did you do? What did he do? What did you do? And then what?
8yo Eddie

- Problem behavior: Physically hurting 4yo sister
What reasons have parents told you not to do this treatment?
Parent Defensiveness/Not Interested in Parent Skills

CHALLENGE:

• Parent feels blamed

• Child should change

• Effort involved/inconvenience

• Therapy is for crazy people
Parent Defensiveness/Not Interested in Parent Skills

CHALLENGE:
- Parent feels blamed
- Child should change
- Effort involved/Inconvenience
- Therapy is for crazy people

STRATEGY:
- Emphasize parent isn’t at fault, but is needed to solve it. Kids with ADHD and challenging behaviors often require uncommon parental skillfulness and special strategies.
- The evidence suggests parent tx is what works, not child tx.
- Look at effort already expending. Up front investment, save effort over time.
- Corrective information
Practice responding to challenges

Pair up
Pick a couple of the challenges on previous slide
One plays the parent who doesn’t want to do parent tx
One plays the PCP
EITHER:
    sell a strategy (special time, praise)
    OR
    sell a referral to behavioral parent training