



The Family Physician's Perspective on Attention Deficit/Hyperactivity Disorder: Collaborating With Parents and Teachers

Lloyd A. Darlow, M.D.

The family physician or pediatrician is usually the first professional to evaluate and treat the child with Attention Deficit/Hyperactivity Disorder (ADHD). Although educators' and parents' roles in assisting children with ADHD have been described thoroughly, many parents and teachers might not appreciate the physician's perspective. The physician is a vital and important member of the ADHD treatment team. This article can help parents, teachers, and others working with children who have ADHD better understand the physician's vantage point.

The management of children's health issues in primary care is quite complex. When dealing with adults, the physician engages in a one-on-one encounter with the patient. In pediatric settings, however, physicians always must remember that they are dealing with not one patient but two or more, namely the child's parent(s). In addition, issues that affect the child at school often bring more "patients" into the mix. Suddenly, the physician is involved with parents, teachers, school nurses, etc., all of whom have their own unique view of the child's difficulties. In order to provide the best possible service to all parties, especially the child, it is important for the physician to learn effective strategies for dealing with both parents and school personnel.

The Physician-Parent Relationship

From the first moment the parents walk into the doctor's office with a child for an "ADHD visit," the physician is presented with a unique opportunity. In very few areas of medicine does the physician have the chance to become such an important part of the child/patient's life, both immediately and for the future. But while the physician sees opportunity and promise, the child's parents might see trouble and despair. Often they feel overwhelmed with the child's difficulties at school, and they have no idea where to turn for help.

In addition, the parents might be encountering significant difficulties with their child at home. Common concerns include completing homework or other school assignments, compliance with household chores, "peace" at the dinner table, and getting to bed in a timely fashion. It is not unusual for that first physician-parent visit to include tears, frustration, desperation, and pleas for help. To make matters more complicated, the child with ADHD often will

be quite well-behaved in the office setting. Children with ADHD frequently behave differently in various situations.

Therefore, the physician should attempt to accomplish several things in the first interview with the parents. This is a prime opportunity to establish rapport and gain the parents' confidence. It is also valuable to ascertain the parents' perception of their child's disorder. Close observation of the parent-child relationship in the office can be quite revealing in this regard (Barkley, 1990). There is a certain amount of information about the child's performance and behavior, both at school and at home, that is critical to obtain during this visit. The use of parental checklists or diagnostic rating scales is an effective method of describing certain behaviors that help to classify the child's disorder (Kelly & Aylward, 1992). The presence of other comorbid disorders such as Oppositional Defiant Disorder, learning disabilities, childhood depression, and Conduct Disorder can make the diagnosis of ADHD more difficult (Searight, Nahlik, & Campbell, 1995). These questionnaires are helpful as a diagnostic aid and, when given out at the initial visit, give the parents an immediate sense that "something is being done" to help their child. A number of behavioral scales are available, perhaps the best known of which is the Conners Parent Rating Scale. The physician should select a rating scale with which he or she feels comfortable and use it consistently.

Interactions With Teachers

In many cases, the person who has the most contact with the child (in terms of hours spent) during the course of a regular day is the teacher. Therefore, excluding the teaching professional from "the loop" (i.e., the diagnostic and therapeutic plan for that child) is neither practical nor helpful. Teachers are a source of invaluable information about the child's cognitive and behavioral performance. Their input aids in making the proper diagnosis of the child's condition(s) and also helps the physician determine whether or not any prescribed medication is accomplishing the therapeutic goal.

Teacher rating scales, similar to the parental rating scales, are available (for example, there is a Conners Teacher Rating Scale comparable to the Conners Parent Rating Scale). However, it might be helpful to have parents and teachers complete the same scale. It is important to recognize that teachers and parents might provide different yet

The Family Physician's Perspective on Attention Deficit/Hyperactivity Disorder: Collaborating With Parents and Teachers

often complementary ratings of the child's behavior. Certainly there are behaviors that are apparent only in the school environment, and parents might be unaware of these patterns. Similarly, teachers should not be surprised to hear a parent say, "My child never does that at home," and the physician must be careful about "choosing sides" should this prove to be the case. The teachers need to know that their input is desired and valued, and the physician should go to great lengths to communicate this.

An "Integrated" Office Protocol for ADHD

Attention Deficit/Hyperactivity Disorder is not a condition that can be diagnosed and treated in one 10-minute office visit. Therefore, physicians and parents should plan ahead so that the process from presentation to diagnosis, treatment, and follow-up is smooth and efficient.

At the first visit, the physician takes a thorough history from the parent, reviews any communication sent by the school, and performs a basic physical examination of the child. The physician gives a behavioral rating scale to the parents, along with copies for the child's teachers to complete, and stamped envelopes with the doctor's name and address. If there are two parents in the household, they should fill out their questionnaires separately and in private, no comparing of answers. Parents and teachers should return the completed forms directly to the physician.

After receiving all of the rating scales, the physician should analyze them promptly and, in combination with the history and physical findings, make a preliminary diagnosis of the child's condition(s). The physician should meet with the parents (with or without the child present) for a second appointment to review the entire process and discuss the diagnosis. The doctor should send a letter under separate cover to the child's teachers, summarizing what has taken place to date. The physician's office obviously must inform the school of any decision to start the child on medication, because the majority of medicines used to treat ADHD require the child to take at least one dose at school. The physician and parents also must inform the teacher if they choose to defer beginning medication. The physician should perform any further educational and/or psychological testing deemed necessary at this time.

The family must come in for monthly follow-up visits until the condition stabilizes to the point where these visits can be spaced out to every 3 months. Every child on medication for ADHD and/or other disorders should see the physician no less than every third month. It is important to track changes in the child's height and weight. Certain psychostimulants initially might slow the child's physical development, although this will normalize in the long term. Other medications, such as pemoline (Cylert),

require periodic blood testing. A regular schedule for office follow-up prevents anyone's slipping through the cracks.

In preparation for the child's follow-up visit, parents will need to obtain a progress report from the teachers along with a review of the child's tests and homework assignments for the preceding period. Communication from the teachers is vital because mere paperwork does not tell the entire story of the child's progress, particularly in the social realm. Only by reviewing the work done at school can the physician determine whether the medication is producing the desired effect and whether the dose or type needs to be changed. Phone conversation with the teachers also might be appropriate before or after these regular visits.

Summary

When the question of ADHD arises, the physician often is the first, vital link between the parents, the child, and the school. There initially might be miscommunication and different opinions among these parties. The physician will need to understand these distinct points of view but also weigh information and make decisions about diagnosis and treatment. A consistent, coordinated treatment plan will help everyone keep in mind the most important thing—the health and welfare of the child.

References and Resources

- Barkley, R. A. (1990). *Attention Deficit/Hyperactivity Disorder: A handbook for diagnosis and treatment*. New York: Guilford.
- Kelly, D. P., & Aylward, G. P. (1992). Attention deficits in school-aged children and adolescents. *Pediatric Clinics of North America*, 39, 487-512.
- Searight, H. R., Nahlik, J. E., & Campbell, D. C. (1995). Attention Deficit/Hyperactivity Disorder: Assessment, diagnosis, and management. *Journal of Family Practice*, 40, 270-279.

Lloyd A. Darlow, M.D., is a family physician in private practice with the Grandel Medical Group and a member of the faculty at Deaconess Family Practice in St. Louis.