

# “AD/HD”: What Is It, Who Has It?

by Richard Glatt and Brian Pearson

*Attention-Deficit/Hyperactivity Disorder*, or AD/HD, occurs in about five percent of the population, usually emerging in childhood and often persisting into adulthood. Its symptoms pertain to as many as three major types of problematic behaviour: *attention-deficit*, *hyperactivity*, and *impulsivity*. Formerly called *Attention Deficit Disorder*, or ADD, the contemporary name reflects mounting scientific evidence that attention-deficit and impulsivity can share common causes in the brain. Indeed, modern brain-imaging technology confirms the existence of physical differences in the brains of AD/HD sufferers, as well as unusual levels of neurological activity and concentrations of neurotransmitters, compared to persons without significant symptoms of this disorder.

AD/HD has no stereotypical face. Its component parts occur in varying proportions and combinations, and the disorder is found in both sexes and all age groups. Three basic subtypes (*Predominantly Inattentive*; *Predominantly Hyperactive-Impulsive*; and *Combined Type*) are recognized by the *American Psychiatric Association* and appear in the *Diagnostic and Statistical Manual of Mental Disorders*. Some experts in the field describe up to six distinct subtypes.

The symptoms of AD/HD consist largely of specific behaviours clearly out-of-keeping with the individual's developmental level. While nearly everyone displays some of these behaviours from time to time, such as being forgetful or speaking out of turn, AD/HD is distinguished by both a *minimum number* and *higher incidence* of designated symptoms.

Unlike their peers, individuals with AD/HD experience *many* symptoms on a daily basis. *Attention-Deficit*, for instance, is characterized by acts such as making careless mistakes in

academic or other work; losing things necessary for tasks or activities; becoming distracted by extraneous stimuli; and the like. Typically, *six* or more such symptoms, persisting for at least six months and to a degree that is plainly maladaptive, would indicate inattentive-type AD/HD. A *hyperactive* person might run about or feel excessively restless in a situation where remaining seated is expected; have difficulty engaging in leisure activities quietly; talk excessively; or fidget with their hands and feet. An *impulsive* person might frequently interrupt or intrude upon others; have difficulty awaiting his or her turn; or blurt out an answer before the question is completed. As per the attention-deficit component, hyperactivity and/or impulsivity symptoms must be present in minimum numbers, duration and severity to qualify as one or more of the AD/HD subtypes.

Because the symptoms of AD/HD often interfere with the ability to study effectively, the disorder is frequently recognized or at least suspected during the school years. This coincidence has had both good and bad consequences in the evolution of understanding and treating AD/HD. On the plus side, the need to better identify and aid children who struggle in school has spawned the specialty of *Psychoeducational Assessment*. Consisting of interviews, traditional tests of cognitive abilities, and computerized performance-testing, psychoeducational assessment can readily identify AD/HD as well as other related disorders and commonly occurring conditions.

While developments from the educational setting have been mostly positive for younger students, the heightened focus upon that age group has inadvertently created a public perception of AD/HD as a disorder affecting only children, or even as a byproduct of the school system. These misconceptions could be leading some older students and adults, and their doctors, to overlook the possibility of AD/HD. Proper diagnosis can be doubly important. Childhood AD/HD is not typically outgrown, and when combined with other factors, may even predispose

an individual to other mental health conditions such as anxiety, depression, addictive tendencies and substance abuse.

Attention-Deficit/Hyperactivity Disorder is not a disease. But the costs it can exact, particularly in terms of reduced productivity and problematic social relationships, can rival that of serious medical illnesses. Fortunately, effective therapies for AD/HD are available. Medications can partly compensate for the underlying physical basis of the disorder, and *psychotherapy* can introduce strategies aimed at facilitating academic progress and/or occupational success. In some cases, positive results are attained more rapidly when medication and psychotherapy are administered concurrently. The future for all types of AD/HD sufferers is bright. New drugs promise to work even better, research is likely to isolate the genes involved in brain developments, and AD/HD testing continues to evolve, helping individuals to better understand and overcome their disorder.

Editor's note:

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