

# **ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)**

## **DSM-IV**

314.00 ADHD predominantly inattentive type

314.01 ADHD predominantly hyperactive-impulsive type

314.01 ADHD combined type

314.9 ADHD NOS

This disorder is associated with inattentive, impulsive, and hyperactive behavior that is maladaptive and inconsistent with developmental level. This behavior creates clinically significant impairment in social/academic functioning. Accurate diagnosis is difficult, as symptoms resemble depression, learning disabilities, or emotional problems. The diagnosis is made through extensive observation of the child's behavior; however, contact with health professionals is limited and the child's activity may be misleading during short office visits. Reports from parents and teachers are often used to make the diagnosis, and their observations may be distorted, as they assume a problem exists and often predetermine the diagnosis themselves.

## **ETIOLOGICAL THEORIES**

### **Psychodynamics**

The child with this disorder has impaired ego development. Ego development is retarded and manifested impulsive behavior represents unchecked id impulses, as in severe temper tantrums. Repeated performance failure, failure to attend to social cues, and limited impulse control reinforce low self-esteem. Some theories suggest that the child is fixed in the symbiotic phase of development and has not differentiated self from mother.

### **Genetic/Biological**

The disorder may be gender-linked as the incidence is higher in boys than in girls (3:1). ADHD is also more prevalent among children whose siblings have been diagnosed with the same disorder. Recent studies have established that the fathers of hyperactive children are more likely to be alcoholic or to have antisocial personality disorders. Affected children have shown the presence of subtle chromosomal changes and mild neurological deficits with irregular brain function including too little activity in the area that inhibits impulsiveness. Hyperactivity may result from fetal alcohol syndrome, congenital infections, and brain damage resulting from birth trauma or hypoxia. Cognitive distractibility and impulsivity are associated with other disorders involving brain damage or dysfunction, such as mental retardation, seizure disorder, and brain lesions.

Physiological conditions that can mimic the symptoms include constipation, hypoglycemia, lead toxicity, and thyroid and other metabolic diseases.

### **Family Dynamics**

This theory suggests that disruptive behavior is learned as a means for a child to gain adult attention. It is likely that whether or not the impulsive irritability seen in individuals with ADHD was present from birth, some parental reactions tend to reinforce and thus maintain or increase its intensity. Anxiety generated by a dysfunctional family system, marital problems, and so forth, could also contribute to symptoms of this disorder. Parents become frustrated with the child's poor response to limit-setting. Parents may become overly sensitive or may give up and provide no external structure.

## **CLIENT ASSESSMENT DATA BASE**

### **Activity/Rest**

Very active, "always on the move," does not slow down when should/must  
Difficulty playing or engaging in leisure activities quietly

### **Ego Integrity**

Emotional lability, hot temper, mood changes

### **Hygiene**

Forgetful in daily activities

### **Neurosensory**

Reports from parents and teachers of:

- Being easily distracted, unable to sustain attention to remain on task or complete projects
- Having difficulty sitting still, sometimes physically overactive, fidgets with hands/feet, may engage in disruptive behavior or dangerous activities without considering the consequences
- Difficulty following instructions, organizing tasks/activities

### **Social Interactions**

Does not seem to listen/attend to what is being said  
Significant distress or impairment in social, academic, or occupational functioning

### **Teaching/Learning**

Onset before age 7  
Family history of alcohol abuse

## **DIAGNOSTIC STUDIES**

(ADHD is a diagnosis by exclusion, and studies are done to rule out other conditions having similar symptoms.)

**Thyroid Studies:** May reveal hyperthyroid/hypothyroid conditions contributing to problems.

**Neurological Testing (e.g., EEG, CT Scan):** Determines presence of organic brain disorders.

**Psychological Testing as Indicated:** Rules out anxiety disorders; identifies gifted, borderline-retarded, or learning-disabled child; and assesses social responsiveness and language development.

**Individual Diagnostic Studies** dependent on presence of physical symptoms (e.g., rashes, upper respiratory illness, or other allergic symptoms, CNS infection [cerebritis]).

## **NURSING PRIORITIES**

1. Facilitate child's achievement of more consistent behavioral self-control and improvement in self-esteem.
2. Promote parents' development of effective means of coping with and interventions for their child's behavioral symptoms.
3. Participate in the development of a comprehensive, ongoing treatment approach using family and community resources.

## DISCHARGE GOALS

1. Disruptive and/or dangerous behavior minimized or eliminated.
2. Able to function in a structured learning environment.
3. Parents have gained or regained the ability to cope with internal feelings and to intervene effectively in their child's behavioral problems.
4. Plan in place to meet needs after discharge.

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### NURSING DIAGNOSIS

### **COPING, INDIVIDUAL, ineffective/ COPING, defensive**

#### **May Be Related to:**

Situational or maturational crisis; denial of obvious problems

Mild neurological deficits/retardation

Retarded ego development; low self-esteem

Projection of blame/responsibility; rationalization of failure

Dysfunctional family system, negative role models;  
abuse/neglect

#### **Possibly Evidenced by:**

Easy distraction by extraneous stimuli; shifting from one uncompleted activity to another; difficulty reality-testing perceptions

Inability to meet age-appropriate role expectations

Excessive motor activity; cannot sit still

Inability to delay gratification; manipulation of others in environment to fulfill own desires

#### **Desired Outcomes/Evaluation Criteria— Client Will:**

Demonstrate a decrease in disruptive behaviors, expressing anger in socially acceptable manner.

Show improvements in attention span, concentration, and appropriate activity level.

Delay gratification without resorting to manipulation of others.

## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

### **Independent**

Provide quiet atmosphere; decrease amount of external stimuli. Maintain atmosphere of calm.

Reduction in environmental stimulation may decrease distractibility. Calm approach helps prevent transmission of anxiety between individuals.

Provide area and activities for gross motor movement (e.g., gym and/or outdoor area for running, large balls, climbing equipment).

Appropriate outlets are necessary to discharge motor activity.

Reinforce attending, concentrating, and completing tasks.

Desired behaviors will increase with positive reinforcement.

Set limits on disruptive behaviors (e.g., talking incessantly); suggest alternative competing behaviors such as playing quietly.

Child needs to know expectations and to learn competing acceptable behaviors (e.g., raising hand vs. shouting out, keeping hands to self vs. pushing others).

Encourage discussion of angry feelings and identity of true object of the hostility.

Dealing with the feelings honestly and directly helps discourage displacement of the anger onto others.

Explore alternative ways for handling frustration with client.

Promotes learning how to interact in society with others in more productive ways.

Provide positive feedback for trying new coping strategies.

Supports efforts and encourages use of acceptable behaviors.

Evaluate with client the effectiveness of new behaviors. Discuss modifications for improvement.

As client has limited problem-solving skills, assistance may be required to reassess and develop strategies.

Assist client to recognize signs of escalating anxiety. Explore ways client can intervene before behavior becomes disabling.

Helps client recognize ineffective behaviors and develop new coping skills to effect positive change.

Provide information and assist parents in learning positive ways of handling problem behaviors.

Behaviors can often be minimized and/or averted by consistent, positive approaches.

Involve in individual counseling.

Medication alone or in combination with a behavior modification program is insufficient. Children with ADHD do not outgrow their problems and many continue to have difficulties into adulthood. Research suggests about 25% of children with ADHD have or will soon develop bipolar disorder with a volatile mix of symptoms (e.g., distractibility, anxiety, depression, irritability, and violent outbursts), often requiring hospitalization. Counseling helps the individual modify their behavior, works to improve social skills and self-esteem, and addresses depression or other emotional issues.

## Collaborative

Administer medication as indicated, e.g.:  
methylphenidate [Ritalin], imipramine [Tofranil],

pemoline [Cylert], dextroamphetamine [Dexedrine];  
diazepam [Valium], chlordiazepoxide [Librium],  
alprazolam [Xanax].

Investigate alternative treatments (e.g., diet, allergy).

Psychostimulants and antidepressants may improve attention and reduce impulsiveness in hyperactive children.

Antianxiety medications provide relief from immobilizing effects of anxiety, facilitating cooperation with therapy.

Some children seem to respond favorably to control of refined sugar, food dyes, and allergens.

**Note:** Current research has failed to show a correlation between sugar use and hyperactive behavior/cognitive problems.

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### NURSING DIAGNOSIS

**May Be Related to:**

**May Be Related to (cont.):**

**Possibly Evidenced by:**

**Desired Outcomes/Evaluation Criteria—**

Client Will:

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### SOCIAL INTERACTION, impaired

**Retarded ego development; low self-esteem**

Dysfunctional family system, negative role models;  
abuse/neglect

Neurological impairment; mental retardation

Discomfort in social situations

Difficulty waiting turn in games or group situations; interrupts  
or intrudes on others

Does not seem to listen to what is being said

Difficulty playing quietly, maintaining attention to task or play  
activity; often shifts from one activity to another

Identify feelings that lead to poor social  
interactions.

Participate appropriately in interactive play with another child  
or group of children.

Develop a mutual relationship with another child or adult.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

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### **Independent**

Develop trust relationship with child, show acceptance of child separate from unacceptable behavior.

Acceptance and trust encourage feelings of self-worth.

Encourage client to verbalize feelings of inadequacy and need for acceptance from others. Discuss how these feelings affect relationships by provoking defensive behaviors such as blaming and manipulating others.

Recognition of problem is first step toward resolution.

Offer positive reinforcement for appropriate social interaction. Ignore ineffective methods of relating to others; teach competing behaviors.

Behavior modification can be an effective method of reducing disruptive behaviors in children by encouraging repetition of desirable behaviors. Attention to unacceptable behavior may actually reinforce it.

Identify situations that provoke defensiveness and role-play more appropriate responses.

Provides confidence to deal with difficult situations when they occur.

Provide opportunities for group interaction and encourage a positive and negative peer feedback system.

Appropriate social behavior is often learned from age-mates.

### **Collaborative**

Arrange staffings with other professionals (e.g., social workers, teachers). Include parents and child when possible.

Cooperation and coordination among those working with these children enhance treatment program. Including child and parents provides them with understanding of the total problem and proposed treatment program.

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### **NURSING DIAGNOSIS**

#### **May Be Related to:**

#### **Possibly Evidenced by:**

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### **SELF ESTEEM disturbance**

Retarded ego development

Lack of positive feedback with repeated negative feedback

Dysfunctional family system; abuse/neglect; negative role models

Mild neurological deficits

Lack of eye contact

Derogatory remarks about self

Lack of self-confidence; hesitance to try new tasks

**Desired Outcomes/Evaluation Criteria—**

**Client Will:**

- Engagement in physically dangerous activity
- Distraction of others to cover up own deficits or failures (e.g., acting the clown)
- Projection of blame/responsibility for problems; rationalization of personal failure, grandiosity
- Verbalize increasingly positive self-regard.
- Demonstrate beginning awareness and control of own behavior.
- Participate in new activities without extreme fear of failure.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

- Convey acceptance and unconditional positive regard.
- Assist child to identify basic ego strengths/positive aspects of self; give immediate feedback for acceptable behavior.
- Spend time with client in 1:1 and group activities.
- Provide opportunities for success; plan activities with short time span and appropriate ability level.
- Discuss fears, encourage involvement of new activities/tasks.
- Help client set realistic, concrete goals and determine appropriate actions to meet these goals.

- This may help child to increase own sense of self-worth.
- Focusing on positive aspects of personality may help improve self-concept. Positive reinforcement enhances self-esteem and increases likelihood of repetition of desired behavior.
- Conveys to client that you believe he or she is worthy of time and attention.
- Repeated successes can help improve self-esteem.
- Confronting concerns and engaging in new tasks promote personal growth and new skills.
- Provides a structure to develop sense of hope for the future and framework for reaching desired goals.

**Collaborative**

- Provide learning opportunities, structured learning environment (e.g., self-contained classroom, individually planned educational program).

- Successful school performance is essential to preserve a child's positive self-image.

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**NURSING DIAGNOSIS**

**May Be Related to:**

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**FAMILY COPING, ineffective: compromised/disabling**

- Excessive guilt, anger, or blaming among family members regarding child's behavior
- Parental inconsistencies; disagreements regarding discipline, limit-setting, and approaches
- Exhaustion of parental resources due to prolonged coping with disruptive child

**Possibly Evidenced by:**

Unrealistic parental expectations

Rejection or overprotection of child

Exaggerated expressions of anger, disappointment, or despair regarding child's behavior or ability to improve or change

**Desired Outcomes/Evaluation Criteria—**

Demonstrate more consistent, effective

**Parent(s)/Family Will:**

intervention methods in response to child's behavior.  
Express and resolve negative attitudes toward child.

Identify and use support systems as needed.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

### **Independent**

Provide information and materials related to child's disorder and effective parenting techniques. (Refer to CP: Parenting.)

Appropriate knowledge and skills may increase parental effectiveness.

Encourage individuals to verbalize feelings and explore alternative methods of dealing with child.

Supportive counseling can assist family in developing coping strategies.

Provide feedback and reinforce effective parenting methods.

Positive reinforcement can increase self-esteem and encourage continued efforts.

Involve siblings in family discussions and planning for more effective family interactions.

Family problems affect all members and treatment is more effective when everyone is involved in therapy.

### **Collaborative**

Involve in family counseling.

Family therapy may help resolve global issues affecting the whole family structure. Disruption in one family member inevitably affects the rest of the family.

Refer to community resources as indicated including parent support groups, parenting classes (e.g., Parent Effectiveness).

Developing a support system can increase parental confidence and effectiveness. Provides role models/hope for the future.

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## **NURSING DIAGNOSIS**

**KNOWLEDGE deficit [LEARNING NEED] regarding condition, prognosis, self care and treatment needs**

**May Be Related to:**

Lack of knowledge; misinformation/misinterpretation

Mild neurological deficits; associated developmental learning disabilities; inability to concentrate; cognitive deficits

**Possibly Evidence by:**

Verbalization of problem/misconceptions

Poor school performance; purposefully losing necessary articles to complete schoolwork (e.g., homework assignments, pencils, books)

Shifting from one uncompleted activity to another

Unrealistic expectation of medication management

**Desired Outcomes/Evaluation Criteria—**

**Client/Parent(S) Will:**

Verbalize understanding of reasons for behavioral

problems, treatment needs within developmental ability.

Participate in learning and begin to ask questions and seek information independently.

**Client Will:**

Achieve cognitive goals consistent with level of temperament.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Provide quiet environment, self-contained classrooms, small-group activities. Avoid overstimulating places, such as school bus, busy cafeteria, crowded hallways.

Reduction in environmental stimulation may decrease distractibility. Small groups may enhance ability to stay on task and help client learn appropriate interaction with others, avoid sense of isolation.

Give instructional material in written and verbal form with step-by-step explanations.

Sequential learning skills will be enhanced. Instruct child in problem-solving skills, practice situational examples. Effective skills may increase performance levels.

Educate child and family on the use of psychostimulants and behavioral response anticipated.

Use of psychostimulants may not result in improved school grades without accompanying changes in child's study skills.

Coordinate overall treatment plan with schools, collateral personnel, the child, and the family.

Cognitive effectiveness will most likely be advanced when treatment is not fragmented, nor significant interventions missed because of lack of interdisciplinary communication.