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Our monthly e-newsletter featuring the latest on our programs, services, events and mission: Building on the strengths of children, teens and young adults.

Sharing Stories: Three of a Kind?

By Meryl Lipton, M.D., Ph.D. Assistant Professor, Medical Director at RNBC

Recently I got a call from a school principal I'll call Laura who was concerned because of what she called "an epidemic" of ADHD in a first grade classroom. "There are three little girls we're all having a hard time working with," she explained. "They're sweet, they're affectionate, they want to please their teacher, but they never stop moving, and you can never get them to pay attention long enough to take in what you want them to do. How can there be so many kids with this problem in one class?"

That's exactly what I wondered, too. There were several curious features here. One was that this was a trio of little girls. Girls are much less likely than boys to show the hyperactive signs of attention deficit hyperactivity disorder. On the other hand, first grade was precisely where many problems do emerge. Generally in kindergarten less self – regulation is expected of children, so drifting around the room, acting impulsively, and failing to pay attention are not nearly so noticeable. But in first grade there are assigned seats, a schedule, and an expectation of self discipline. Behavior that doesn't conform to those expectations stands out. The real issue was, what was causing three little girls to have problems in the classroom?

The first step was to do an observation. The first little girl, Katie, was adorable, sweet, and fun-loving. She flitted around like a butterfly, talking and laughing, scarcely noticing when everyone else had taken their seats. When her hand shot up to respond to a question, the words poured out simultaneously. She just couldn't wait to be called on. And if the teacher prevented her from continuing, she blew up and could not be reasoned with. An assessment revealed that she did indeed have ADHD, exactly as the principal and the child's teacher had surmised.

The second little girl, Nicole, was similar in being unable to focus, and in drifting away to follow her own interests, oblivious of what was being asked of her. But unlike Katie, she seemed quite shy and was bothered by bursts of noise and activity, especially at the end of the day, when the room became a swirl of children finding jackets, putting on backpacks, and talking back and forth. She seemed overwhelmed by the activity around her. A desk lid slamming nearby seemed genuinely to upset Nicole, so that she whirled around put her hands over her ears and looked terribly upset. The presence of Katie's reaction to noise and increased stimuli suggested that she might have Sensory Motor Integration Disorder so we had an occupational therapist do an evaluation which confirmed our suspicion. Often children with neurobehavioral disorders of learning and regulation also have some level of difficulties with sensory motor integration. Katie started twice a week therapy with an occupational therapist and the classroom integrated ways to help her sensory needs in the learning environment (bouncy seats, thicker pencils, sensory breaks etc.) Katie improved but continued to flit around the room and had difficulty focusing. Turns out she had Attention Deficit Hyperactivity Disorder which responded well to a low dose of long acting stimulant medication.

That left the third child, Annie. Like the other two little girls, she flitted around the classroom, had trouble paying attention and didn't seem to fit in. But there was an emotional component—she seemed sad to me. When I observed her at a long table full of giggling, chattering little girls in the lunchroom, I saw that she rarely spoke. When she did try to start a conversation, no one responded, so finally she put her sweater on upside down, and looked around to see if anyone was paying attention. A few kids did glance at her, but with a look that indicated, "Gee, that's dumb.".
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In social situations Annie was impulsive, as the other little girls were, but in a way that showed a desperation to be liked. She ran up to people, she hugged them, she gave away a favorite book she'd brought to school to a child she scarcely seemed to know. Doing math she raised her hand, answered questions, and seemed confident. But she had learning problems related to language-based activities; she had a terrible time writing, and she had executive function problems —couldn't plan well or organize information. She was conscious that she couldn't do things that other children did easily, and it upset her. And her problems with language made interacting with other children more difficult.

When I spoke to Annie's parents, I found that she came from a family of 11 children, and that no one was aware that she had a problem. With recognition and treatment of her learning disabilities, and with some therapy, her mood improved greatly. So did her behavior and performance in class. Within a few months she announced that she loved school. By the end of the year she had a best friend.

For Laura, the school principal, the really valuable lesson was that behaviors that look similar, at least superficially, may have vastly different causes and may require a completely different approach. Three "cases of ADHD" were in fact, one case of ADHD, one case of learning issues and depression, and one case of ADHD and Sensory Motor Integration Disorder. "That isn't really a surprise," Laura said. "I've found that even when children do have exactly the same problem you may have to have separate solutions for each child, because they react so differently from one another." I told her that I couldn't agree more, and that kind of thinking made her one of my favorite people to work with.