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MANAGEMENT OF ADHD (Attention-Deficit/Hyperactivity Disorder) IN CHILDREN

The most effective approach is multimodal—combining **behavioral strategies**, **school support**, and sometimes **medication**. The approach depends on the child's age, severity, and functional impairment.



1 BEHAVIORAL & PSYCHOSOCIAL INTERVENTIONS

(First-line, especially <6 years)



Parent Training in Behavior Management

Parents are taught structured techniques to shape behavior:

- Positive reinforcement (reward charts, praise)
- Consistent consequences (time-out, loss of privileges)
- Clear rules and routines



Classroom Interventions

- Preferential seating (front of class)
- Short, structured tasks with breaks
- Reward systems (token economy)
- Individualized Education Plan (IEP) or 504 plan if needed



Behavioral Therapy for the Child

- Social skills training
- Emotional regulation techniques
- Problem-solving skills

2 EDUCATIONAL SUPPORT



Adjust workload and instructions (simplified, stepwise)



Extra time for assignments/tests



Use of visual aids and structured schedules



Collaboration between parents, teachers, and counselors

3 PHARMACOLOGICAL TREATMENT

Medication is considered when:

- Symptoms are moderate to severe
- Behavioral therapy alone is insufficient
- Significant impairment at school/home

STIMULANTS (First-line)

Most effective medications:

- Methylphenidate (e.g., Ritalin)
- Amphetamines (e.g., Adderall)



Effects:

- Improve attention, impulse control, and hyperactivity
- Work quickly (within hours)



Common side effects:



Decreased appetite



Insomnia



Irritability



Mild growth delay (monitor height/weight)

NON-STIMULANTS (Second-line or alternatives)

- Atomoxetine
- Guanfacine / Clonidine (alpha-2 agonists)

Used when:

- Poor response or intolerance to stimulants
- Coexisting conditions (e.g., tics, anxiety)

4 LIFESTYLE & SUPPORTIVE MEASURES



Regular sleep schedule



Healthy diet (no strong evidence for restrictive diets, but balanced nutrition helps)



Physical activity (improves attention and behavior)



Limit screen time

5 MONITORING & FOLLOW-UP



Regular assessment of:

- ✓ Symptom control
- ✓ Side effects
- ✓ Academic and social functioning

Adjust treatment as child grows.

6 MANAGEMENT BY AGE GROUP



Preschool Children (4–5 years)

- Behavioral therapy first
- Medication only if severe and persistent



School-Age Children (6–12 years)

- Behavioral therapy + medication (often combined)



Adolescents

- Medication + behavioral strategies
- Include child in decision-making

KEY TAKEAWAY

There's no single "cure," but with the right combination of:

- ✓ Structured environment
- ✓ Behavioral strategies
- ✓ School support
- ✓ And, if needed, medication

children with ADHD can function very well academically and socially.



QUICK COMPARISON OF ADHD MEDICATIONS

CLASS	EXAMPLES	DURATION	MAIN BENEFITS	COMMON SIDE EFFECTS	NOTES
Stimulants (Methylphenidate)	Ritalin, Concerta, Focalin	Short to long acting	Most effective for attention and hyperactivity	Appetite loss, insomnia, irritability	First-line therapy in most children
Stimulants (Amphetamine)	Adderall, Vyvanse	Intermediate to long acting	Strong symptom control	Appetite suppression, sleep issues, mood changes	Vyvanse has smoother long-acting effect
Non-stimulant	Atomoxetine (Strattera)	All-day effect	Helpful for ADHD + anxiety	Nausea, fatigue, mood changes	Takes several weeks to work
Alpha-2 agonists	Guanfacine, Clonidine	Long acting	Helpful for impulsivity, aggression, tics, sleep	Sedation, low blood pressure	Often used as add-on therapy

IMPORTANT: SCREER FOR COMORBIDITIES

Anxiety Disorders	Depression	Oppositional Defiant Disorder (ODD)	Learning Disabilities	Autism Spectrum Disorder	Sleep Disorders
Treating coexisting conditions improves outcomes.					
RED FLAGS – REFER TO SPECIALIST IF:					
• Severe aggression	• Seizures	• Medication failure after multiple trials	• Significant cardiac history before stimulant use	• Suicidal thoughts	• Complex learning problems