



## Changing Academic Support in the Home for Adolescents With Attention-Deficit/Hyperactivity Disorder: A Family-Based Clinical Protocol for Improving School Performance

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*Attention-deficit/hyperactivity disorder (ADHD) is highly prevalent among adolescent clinical populations and associated with myriad deficits in school functioning. Yet, behavior therapists have few developmentally appropriate tools for addressing school problems in this group. This article introduces a behavioral protocol designed to fill the gap: Changing Academic Support in the Home for Adolescents With ADHD (CASH-AA). CASH-AA is a family-based intervention that targets home environment, adolescent skills, and family-school partnership characteristics in order to improve school performance. Protocol components are derived from three evidence-based approaches for adolescent behavior problems: family psychoeducation, clinical family interventions to heighten adolescent and caregiver motivation to change, and training interventions for homework planning and organization skills. CASH-AA contains four treatment modules: (1) Psychoeducation: ADHD and Academic Functioning; (2) Motivation and Preparation: Home Academic Environment; (3) Behavior Change: School Attendance and Homework Plan; (4) Collaboration: Therapist-Family-School Partnership. The protocol can be implemented as a stand-alone intervention for ADHD or an adjunct to other behavioral interventions for co-occurring disorders. Two case examples with markedly different treatment profiles are presented to illustrate the utility and flexibility of the protocol.*

**A**TENTION-DEFICIT/HYPERACTIVITY disorder (ADHD) is highly prevalent among adolescent clinical populations as both a primary reason for referral and a co-occurring disorder among teenagers presenting with conduct, anxiety and depression, and substance use problems. Adolescents with ADHD often present with myriad school problems in the domains of school achievement, learning difficulties, and behavioral infractions, all of which complicate treatment planning efforts. The most common treatment option, pharmacological intervention, has proven generally effective in reducing ADHD behavioral symptoms. However, medications have not demonstrated strong or consistent outcomes related to improved academic functioning. Moreover, most behavioral interventions<sup>1</sup> that strengthen school outcomes in younger children with ADHD are either developmentally inappropriate or unproven for adolescents. Thus, behavior

therapists have few viable options for treating ADHD-related school problems in their teenage clients.

This paper addresses the need for academic interventions for adolescents with ADHD by introducing a behavioral treatment protocol designed to be implemented in clinical settings: Changing Academic Support in the Home for Adolescents With ADHD (CASH-AA). CASH-AA is a family-based protocol that is intended to improve school performance by targeting home environment, adolescent skills, and family-school partnership characteristics that directly support academic success. CASH-AA contains intervention components derived from three evidence-based approaches for adolescents with ADHD and co-occurring disorders: ADHD psychoeducation, family-based treatment engagement and motivational techniques, and training interventions for homework planning and organizational skills. These three approaches are integrated into the four CASH-AA treatment modules presented below. Two case studies are presented to illustrate the utility of the protocol in routine clinical settings.

### Rationale for Developing a Family-Based Clinical Protocol to Improve School Functioning in Adolescents With ADHD

#### ADHD Prevalence in General and Clinical Adolescent Populations

Knowledge about the prevalence of ADHD in adolescent populations has grown enormously over the past decade.

<sup>1</sup> This article uses the terms “behavioral intervention” and “behavior therapist” generically to reference psychosocial treatments of all kinds (behavioral, cognitive-behavioral, relational, etc.) and to contrast with pharmacological interventions.

**Keywords:** adolescent ADHD; family-based treatment; psychoeducation; training interventions

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There is now consensus that ADHD is a chronic childhood mental health condition that persists across the developmental span of adolescence and into young adulthood (Taylor, 2009). The newest national prevalence data on ADHD in adolescents gathered by the National Survey of Children's Health (Visser et al., 2014) indicate that 14% of children aged 11 to 17 have received an ADHD diagnosis at some point in their lives. Based on these and similar data (e.g., Merikangas et al., 2011; Schwarz & Cohen, 2013), ADHD affects almost 1 in 5 teen boys and 1 in 10 teen girls. These rates confirm its status as the most prevalent behavioral disorder among teenagers (Merikangas et al.).

With regard to youth seeking behavioral treatment, ADHD is a leading reason for referral among children ages 3 to 12 (Yeh et al., 2002). It is also highly prevalent among adolescents, affecting between 18% to 48% of those enrolled in outpatient mental health and substance use services (Tims et al., 2002; Turner et al., 2004; Wu et al., 2011). These are conservative estimates of clinical prevalence given that ADHD has been traditionally underdiagnosed in adolescent clinical samples, due in large part to deficiencies in the developmental sensitivity of diagnostic criteria (Sibley et al., 2012; Todd, Huang, & Henderson, 2008).<sup>2</sup> Also, it is frequently undetected when co-occurring with other chronic psychiatric disorders for which teens are typically referred: oppositional defiant and conduct disorder, anxiety, depression, and substance use (see Merikangas et al., 2011). Rates of ADHD comorbidity for disruptive behavior disorders and substance use problems among teenagers enrolled in outpatient treatment typically exceed 70% (e.g., Chan, Dennis, & Funk, 2008; Thompson, Whitmore, Raymond, & Crowley, 2006). Based on these estimates, of the 2.8 million adolescents enrolled annually in outpatient mental health care (SAMHSA, 2009), combined with 125,000 in outpatient substance use treatment (SAMHSA, 2007) and tens of thousands more receiving behavioral services in nonspecialty settings (e.g., school mental health, juvenile justice, child welfare; Jones, Foster, & CPPRG, 2009), approximately 20% to 50% meet diagnostic criteria for ADHD. These data suggest that the outpatient behavioral care system contains between 750,000 and 1.5 million teenagers with ADHD on a yearly basis.

### **ADHD in Adolescents Is Linked to Impaired School Functioning**

Adolescents who meet full diagnostic criteria for ADHD present well-documented behavioral deficits in attention,

self-regulation, and social competence (Barkley, 2006). These behavioral symptoms typically precipitate school behavior problems that include inconsistent attendance, poor grades, disruptive classroom behavior, time management and planning deficits, and a disorganized approach to academics (Kent et al., 2011; Kuriyan et al., 2013). Youth with ADHD also suffer a high rate of learning difficulties of several kinds (Cutting & Denckla, 2003) that create an additional barrier to academic achievement (Bussing et al., 2012). Like ADHD, learning disabilities are considered chronic conditions that require intensive intervention and ongoing management (Fletcher, Lyon, Fuchs, & Barnes, 2007). These ADHD-related behavioral and learning problems together lead to greater incidence of grade retention and dropout and incur enormous costs in educational support services (Robb et al., 2011).

Additionally, clinical neuroscience has begun to map neurocognitive risk factors associated with childhood ADHD that routinely persist into adolescence, particularly executive functioning deficits in planning, cognitive flexibility, working memory, and processing speed (e.g., Coolidge, Thede, & Young, 2000). Executive dysfunction exacerbates, and may underlie, behavioral and learning problems experienced by youth with ADHD (Barkley, 2006), and it affects social as well as academic functioning (Langberg, Dvorsky, & Evans, 2013). Thus, the confluence of poor attention and self-regulation, learning difficulties, and, for many, executive functioning deficits creates a profile of compounded impairment that compromises school performance and complicates treatment planning for adolescents with ADHD.

### **Medication Is Not (Usually) Sufficient to Address School Problems for Adolescents With ADHD**

Stimulant medication is recommended by many as the first-line treatment option for ADHD in adolescents (Faraone & Buitelaar, 2010). There is solid evidence that rapid-acting stimulants such as methylphenidate (Ritalin) are effective in reducing ADHD symptoms and improving social functioning in teens (Sibley, Kuriyan, Evans, Waxmonsky, & Smith, 2014). Recent data suggest that extended-release stimulants such as OROS-MPH (Concerta) are also safe, well tolerated, and effective in reducing ADHD symptoms for this age group (e.g., McGough et al., 2006). Effect sizes for OROS-MPH (e.g., Wilens et al., 2006) and other once-daily medications are in the medium-to-large range for symptom reduction among teenagers, which is consistent with meta-analytic findings for immediate-release medication (Sibley, Kuriyan, et al., 2014).

However, stimulant medications are not a panacea for treating adolescents with ADHD. ADHD medication compliance declines precipitously from childhood through adolescence (Sanchez et al., 2005). This is likely due to the inconvenience, stigma, and side effects of

<sup>2</sup> A comprehensive review of national trends in ADHD diagnosis concluded that recent spikes in ADHD prevalence rates among youth are correlated with states' passage of educational accountability laws that incentivize performance on standardized testing (Hinshaw & Scheffler, 2014).

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