Social Skills Improvement with AD/HD Medication

by Edward B. Aull, M.D.

YOU HAVE just finished a phone call with Adam's social studies teacher. Adam, your 11-year-old, started middle school this autumn in the sixth grade. He was diagnosed with attention-deficit/hyperactivity disorder (AD/HD) in the third grade and has been on medication since then. You called his teacher concerned with Adam's transition to the new school. The teacher reports that while he was struggling a bit at first, there has been a big improvement since his medication was increased in October. You agree. He's been arguing less with his siblings and finishing his homework more quickly, with less prompting from you.

But he has also been complaining more about having to take his medication. He insists "I'm not as funny," and believes his better grades are due to greater effort on his part. Adam's doctor reassures you by saying that no child wants to take medication in middle school because no child wants to be perceived as different. This was especially a problem when students had to report to the school nurse at lunch to take a dose, but with newer, long-acting medications, students can now take medications at home before going to school. "In middle school, even children with asthma and diabetes think they can do fine without their medications," the doctor relates.

Note to Readers: Given the lack of empirical research on social effects of AD/HD medication, the information highlighted within this article comes from the author's experiences as a pediatrician over the past 30 years, and thus must be considered with caution when extending these practices to other individuals. It is important to discuss treatment options with your child's physician.

When determining the best treatment regimen for AD/HD, it is very important to question both the child or adolescent and the parents about how medication affects social interaction in addition to academic performance and behavior.

The medications used to treat AD/HD often have positive social effects; in fact, most children feel an improvement in the way they relate to others.

Your real concern is that Adam seems to be spending less time with his friends and more time alone in his room. Since his older brother also did this when he first became a teenager, you wonder if maybe this is just a stage Adam is going through. In his room, he reads or works with his sports cards and doesn't seem to be brooding or sad. You've always been careful to watch for signs of depression, as it runs in his father's family, and an uncle had trouble with moodiness as a teenager. You couldn't help but notice that Adam turned down an invitation to go to his cousin's home last weekend. They have always gotten along very well, and his cousin has several dirt bikes, which Adam usually loves to ride.

In most studies concerning social interaction and medications in children with AD/HD, social behaviors are scored by trained observers using standardized checklists and working with groups of children or adolescents. Therefore, outcomes are based on group rather than individual interactions, and findings that are true for the group are not necessarily true for the individual. Rarely are studies based on the subjective feelings of individuals interacting one-on-one, since such results are so difficult to standardize.

The medications used to treat AD/HD often have positive social effects; in fact, most children feel an improvement in the way they relate to others. They are better able to remember their ideas so that turn-taking in conversation is enhanced, and they interrupt less often, resulting in a less tangential and better-flowing conversation. These qualities are appreciated by the listeners.

Some children and adolescents become too quiet, less talkative, less likely to speak and more likely to stand back and observe when they are taking stimulant medications for AD/HD.

When determining the best treatment regimen for AD/HD, it is very important to question both the child or adolescent and the parents about how medication affects social interaction in addition to academic performance and behavior. One medication may work well for improving academic skills, yet have negative effects on social skills. At the college level, grades may outweigh social effects in importance, and problems may be addressed through an alternate dosing schedule. At the middle school level, however, where social relationships are paramount, the social impact may be significant enough that the medication must be changed or the dose lowered. In some cases, an additional medication must be added to overcome the negative effects of the primary medication.

In summary, it is important to see children and adolescents as social beings and to be certain that medications are not adversely affecting that aspect of their lives, as in Adam's case. Medications may still be employed, but decisions concerning which one and what dosage should be based on careful consideration of individual needs and reactions. Furthermore, psychosocial interventions may be combined with medication to address problems with social functioning. ■

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Jared by Katrina Norfleet Brown

I WALKED INTO MY OFFICE to find a voice mail message waiting for me. When I saw that the phone number on the caller I.D. was the public middle school my son attends, I wondered, "What's happened now?" With trepidation, I began listening to the message. Much to my surprise and delight, my son's seventh grade team leader/science teacher had called to share good news: my son Jared had scored 35/35 on his mid-term science assessment and as a result, he earned a B as his interim grade.

Teachers don't routinely call parents just to share a great test grade, at least not this parent. But Mr. H is as excited as I am to witness the turnaround in my son's academic performance over the past several weeks, a turnabout that happened after my 12-year-old was diagnosed with AD/HD, inattentive type, and subsequently treated with stimulant medication.

Just over a month ago, Jared brought home a report card that documented a below grade point average for two consecutive quarters. Poor grades had begun to surface for him when he started middle school in the sixth grade. At our parent-teacher conference that year, my husband and I sat in a room with six of our son's teachers. Each one repeated the same mantra, "He's not focused. It's difficult for him to get on task and stay there. He's constantly daydreaming. He's disruptive." When seventh grade began, the cycle started all over again.

But since he started taking the stimulant, teachers have been reporting that his classroom behavior and work and study skills have improved. He is paying attention. He is completing assignments. He is participating more in classroom discussions. And, he is less disruptive.

Jared's diagnosis came on the heels of discovering a little over six months ago that my 10-year-old daughter was a gifted and talented student with AD/HD, combined type. The now fifth grader, who had struggled terribly with low grades and other classroom issues the previous year, had grown as concerned as her father and I were about her inability to master the work she knew was within her capability. Within weeks of starting a stimulant, her test-taking skills improved dramatically and reading, writing and math improved to the levels they should have been all along. She made the honor roll twice in a row. The Education Management Team (EMT) at her elementary school agrees that hers is a success story.

The voice mail message from my son's team leader gave me the same hope for success his sister is already enjoying, now that his AD/HD symptoms are being properly treated with medication. As a parent, I'm thrilled by my children's academic improvement, but I'm even more elated at how much better they feel about themselves. I can hardly wait to get home to congratulate Jared on his perfect grade on the science assessment. I'm certain I'll be rewarded with that lopsided grin I love so much, beaming full of pride. ■

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