A Clinical Manual for Parents with Preschool Aged Children Diagnosed with ADHD

Pathways for Children and Youth
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Abstract

*Preschool ADHD Success* is a parent manual that addresses the needs for education of the general public regarding ADHD. The parent manual is primarily directed to parent/guardians and caregivers who have preschool aged children diagnosed with ADHD and live in Kingston, Ontario. It was created based on empirical research, multiple published books on ADHD, and from the CADDRA website. The information collected was presented as a five chapter manual called *Preschool ADHD Success*, that included information about Pathways as an organization and other resources in the community to help improve the parent and child’s quality of life. The manual is an educational resource that addresses what ADHD is and the causes of the disorder. It informs parents about ADHD evaluation and addresses how families can cope with the disorder. Inclusion of topics such as stigma gives readers skills to enhance self care through physical wellness, mental wellness and relaxation techniques that enable them to help their children to be successful and to overcome stigma. The manual also discusses how to cope with the new diagnosis of ADHD in home setting and how to engage their child’s school to support the child. There is a chapter on the behavioural techniques and medical interventions for preschoolers with ADHD. The five chapters cover as much information as possible while remaining user friendly for parents. This manual’s goal was to provide a handy resource that promotes ADHD education for parents with preschoolers who have ADHD and to decrease stigma. The manual was not assessed empirically or used in the community. However, it was shaped by feedback collected from ratings provided by the staff at Pathways for Children and Youth. This was to ensure the utility and appropriateness for Pathways client population. The preliminary findings from the participants were positive and suggested that the manual would be very useful for the organization. While there was a high degree of satisfaction it is recommended that more data and further research be compiled from actual users of the manual.
Dedication

I would like to dedicate this lengthy document to those who kept me mentally sane during the 2015-2016 year. A huge thanks to the creators of Gotham, Scott White and founder of Netflix’s, Reed Hastings. If it weren’t for you two, this would have been done in November 2015 and not March 2016. To C.M, thank you for being my comedian, confidante, and charming boyfriend. How would I’ve gotten though this year without your Instagram mentions?…Who knows? …Literally nobody knows? Or maybe Amin Yashed knows? To J.P & J.P thank you for bleeding financially for the last four years so I could complete this degree. THE BLEEDING HAS STOPPED. We survived… now to do a masters degree across the country. Is it too early to ask for my inheritance now? To J.M, the thought of losing you brings a tear to my eye. I will love you forever (J.M is my tutor). For real, thank you so much for helping and guiding me over the past four years. To Betty Joe Degrace and Karen Vanberkle, thank you for giving me the guidance and support to create a manual to help those who I have met along this crazy journey. St. Lawrence it’s been real.
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Chapter I: Introduction

Parents of children who are diagnosed with ADHD do not always have the skills or knowledge needed to efficiently work with their children at home without the assistance of service providers. The placement students project is to create a manual for parents to use giving them the opportunity to refer to information that will continuously assist them in gaining independence when treating their children with ADHD. Attention Deficit Hyperactivity Disorder (ADHD) is one of the most commonly diagnosed childhood developmental disorders (Barkley, 2013, p. 73). ADHD is a genetic self-control disorder which affects 8-12% of children in North America (Pliska, Carlson, & Swanson, 1999). Children with ADHD experience hyper-impulsivity and difficulty retaining focus (Barkley, 2013, p.19). ADHD increases the likelihood of developing other behavioural disorders such as conduct disorder and impaired social skills (Seiji, 2002). Parents of children who have ADHD have no choice but to be exceptionally involved with their children. (Barkley, 2013, p.47). Some of the difficulties that parents face when raising a child with ADHD are sleep difficulties, impulsivity, accidents and increased financial expenses (Barkley, 2013, p. 49). Studies have shown that more than 40% of children with ADHD have sleeping difficulties and frequently awaken multiple times a night (Barkley, 2013, p. 309), which causes them to be lethargic upon awakening and makes for a long day. Children who have ADHD are more prone to injuries like accidental poisoning or burns that may lead to hospital visits (Barkley, 2013, p. 310). Lastly, raising a child with ADHD can be costly. Studies have shown that it costs twice as much to raise a child who has ADHD than raising a child without a diagnosed disorder (Barkley, 2013, p. 310).

The diagnosis of ADHD can be hard for parents to hear. Barkley (2013, p. 391) states that parents often experience denial when confronted with the possibility of their child having ADHD. This is a common response from parents who may be the last to know the child has ADHD symptoms. These parents must come to this realization on their own terms and seek accurate information about ADHD. Other parents accept their child’s diagnosis, embrace it as the answer they were looking for and are open to information regarding the diagnosis (Barkley, 2013, p. 392). Once parents have accepted the diagnosis, their involvement in helping their child live with ADHD increases and they protect their child from those who do not understand the disorder (Barkley, 2013, p. 394). Parents should be wary of accepting everything they read or hear over the internet (Barkley, 2013, p. 61). They must challenge and criticize ideas until they are logically analyzed and approved by a professional in the ADHD field. The Canadian ADHD Resource Alliance (2013), states that one of the most important factors in treating ADHD long term is psycho-education regarding the disorder. One of the best approaches to helping the family and the patient is receiving continued support about ADHD and how to manage the disorder.

Medication, behavioural interventions and cognitive and empathetic strategies should also be utilized when treating the child and increasing compliance (Barkley, 2013, p.47). Manuals provided to parents help to generalize strategies for every day life so they do not have to constantly rely on outside sources (Scott & Dadds, 2009). A manual for parents will allow them to gain independence from service providers in assisting their children with daily struggles while also emphasizing the importance of self-care when caring for a child diagnosed with ADHD.

The contents of the manual will focus mainly on the parent’s involvement and how it affects the child. The manual will be categorized into six main components as follows: Section
One (Educating the Family on ADHD) will be broken down into multiple headings that will discuss topics such as What is ADHD? and What Causes ADHD?. Section Two (Being an Informed Parent) will be broken down into multiple headings that will discuss topics such as ADHD Evaluation and Dealing with the Diagnosis as a Family. Section Three (Fighting Against Stigma) will be broken down into multiple headings that will discuss topics such as Parent Stigma and Child Stigma. Parent stigma will be further looked at with emphasis on how to break down the barriers of stigma and how to seek self-compassion. Section Four (Coping With the New Diagnosis Day to Day) will be broken down into multiple headings that will discuss topics such as Taking Charge at Home and Taking Charge at School. Section Five (Treatment) will be broken down into multiple headings that will discuss topics such as Medications and Behavioural Interventions. The treatment section will also include information about supports and services located in Kingston and the surrounding area. Lastly, Section Six (Parent Self-Care) will be broken down into multiple headings that will discuss topics such as Physical and Mental Wellness and Relaxation Techniques.

Participants of the study will be the agency staff members on the intensive team at Pathways who agreed to review the parent manual. No consent is needed because they are only providing feedback on the manual. A letter will be sent to staff inviting them to participate in providing feedback (see Appendix A). The letter explains the purpose of the study and what is expected from each member of the intensive team. The potential benefits and risks are thoroughly explained in the document. The participants are assured that if anything goes wrong the placement student would contact both college and organization supervisors to ensure the issue is resolved as soon as possible. The letter will further elaborate on the seriousness of privacy and that there will be no identification factors listed on the feedback forms. If there is any indication of personal identity, the participants’ feedback form will be shredded and not used for feedback. All the feedback forms need to be completed anonymously and then placed in an opaque envelope provided in the resource room of the agency to ensure confidentiality.

The Intensive Team’s feedback form for the review of the parent manual is a written form of 16 questions based on a likert scale of 1-5 and two short answer questions. The likert scale was selected to ensure that all questions could be evaluated on the same scale. The additional short answer questions were added to give staff the opportunity to add their personal feedback. The feedback form evaluates whether or not the participant read each section thoroughly, their thoughts on the manual’s overall readability, appearance and usefulness for the parent, child and agency. The survey will provide information for improving the parent manual for future editions.

The parent manual will provide guidelines for the primary caregiver that will focus on education about ADHD and how to manage the challenges that arise with the diagnosis of preschool aged ADHD. This manual will be important for Pathways to provide to parents who frequently cancel appointments or who drop out of treatment. Parents often cancel appointments or drop out of treatment for personal reasons. Parents may also be intimidated by the intrusiveness of in-home intensive care and find the manual less intrusive.

A problem that arises for families who are too stressed to engage in treatment, is that they may be less likely to engage with print material. This manual is versatile and can be beneficial to families who are functioning well but lack specific information on ADHD management. The manual could be used once the child is diagnosed with ADHD but is not in need of intensive services at that time. Having information readily available that helps parents can be beneficial
when they are no longer being supported by Pathways. Once the manual is created, the Intensive Team is to provide feedback to ensure that the information provided in the manual is appropriate for their clients and demographic. The language used in the manual has been targeted to a Grade Six literacy level to ensure that the general population understands it. By providing Pathways Early Years Intensive Team members with the parent focused resource, they can access the documentation and give it to clients who are having difficulty dealing with the child’s challenging behaviour and its effects on the family. The results will be broken down into a table presenting each participant’s individual feedback.

The results will be displayed in a table showing the mean and mode of each answer. The desired outcome is that the manual is given to the clients of the Intensive Team. A common problem the team faces is low treatment compliance from parents due to missed or irregular appointments. Providing this additional resource may assist families with some of the difficulties of raising a child with ADHD.

Chapter II: Literature Review

There are more than 300 scientific journals published each year on Attention Deficit Hyperactivity Disorder (ADHD) (Barkley, 2013, p. 26). ADHD is beyond a person’s control and could be as involuntary as seizure disorders (Summers & Caplan, 1987). The disorder is one that commonly affects a person’s impulse control, activity level and attention span (Barkley, 2013, p.19). From a behavioural perspective, ADHD is described as having an unjustified excess of energy, impulsive behaviours, poor concentration and rapid changes in activities showing poor attention (Glozman & Shevchenko, 2014). Neurologically, children with ADHD exhibit underdeveloped cognitive functions that impair problem solving skills and spatial awareness (Glozeman, Kurdukova & Chibisova, 2007). Zametkin et al. (1990) have suggested that abnormalities or damage in the frontal lobes of the brain may be associated with the development of ADHD. Numerous studies have tried to demonstrate association with smoking or alcohol use in pregnancy and development of ADHD (Barkley, 2013, p.243). Behavioural scientists have also debated whether or not certain chemicals or foods can cause ADHD; however, these studies are based on indirect evidence (Barkley, 2013 p. 246). The disorder is usually prevalent during the first five years of life; however, most diagnoses are given between ages six and seven (Osipova & Pankratova, 1997). The majority of children with ADHD have impaired social behaviour, which arises in early childhood (Huang-Pollock, Mikami, Piffenner, & McBurnett, 2009). These problems persist into their teenage years and continue into adulthood if not treated (Bagwell, Molina, Pelham & Hoza, 2001).

Social Effects

There are several symptoms listed in the DSM-V that comprise the criteria for an ADHD diagnosis including social impairments, such as difficulties not listening to others during playtime (APA, 2015). Although children with ADHD cannot self-report such difficulties, parents and teachers are consistent in reporting the child’s social struggles (Van der Oord et al., 2005). Children with ADHD are usually judged and often rejected by peers because of their social differences (Boo & Prins, 2007). Peers report that children with ADHD are disruptive, lack social skills and are generally labeled less popular (Flicek, 1992). Flicek, (1992) conducted a study of 345 predominately white males through grades two to six. Six hundred and seventy male and female peers judged the boys who were divided into three categories. The first category
was ADHD/learning disabled (LD), non-ADHD / low achieving (LA) and non ADHD / academically competent controls (C). Students were put into the LD category if they demonstrated a 1.5 deviation discrepancy of ability and achievement. The LD boys were assigned to the category one if they scored lower than the 30th percentile on the TRAP scale. The competent children were assigned if they scored above the 30th percentile. The participants were then assigned to either an ADHD or non-ADHD behavioural category. The categories were divided by having the subjects complete the IOWA Conners Teaching Rating Scale (Pelham, Milich, Murphy & Murphy, 1989). If the boys scored less than the 1.5 cut-off, they were termed non-ADHD. The 670 student observers assessed the boys social status using peer popularity by asking the question “who would you like to play with?” on an item-by-peer-matrix. The students were then asked how much they would like to play with the boy being observed on a likert scale of 1 (I don’t like to) and 5 (I like to a lot). There were five other items associated with the boys’ social status and they were also on an item-by-peer matrix. They were: cooperative, acts shy, disruptive, leader and starts fights. The second phase was to ask the teachers from the second to the sixth grade to evaluate the children being observed by completing the IOWA, five scales of the TRAP (two reading, two mathematical, and one global scale) (Gresham, Reschly, & Carey (1987) and the Social Skills scale of the Social Skills Rating System-Teacher Forms (SSRS-T) (Gresham & Elliot, 1990). The SSRS-T breaks down 30 pro-social behaviors. The results showed that there were significantly close and consistent results from both male and female observers (teachers and children). The C group scored much lower than the LD and LA groups. Findings showed that ADHD, LD and low achievement affected social problems in unique ways. The social problems that were evident to the child and teacher observers were identified in the LD category but not in the LA category. Teachers and peers saw ADHD males as disruptive but not groups C or LA. They also classified ADHD males as oppositional and having poor cooperation skills. Children in the ADHD LD and ADHD LA groups were rejected significantly more than the boys in the C group. The findings of the Flicek(1992) study showed the children with ADHD and learning disabilities were at a higher risk of being ostracized by peers than children who were classified as academically competent. Unfortunately, this puts children that have ADHD at a higher risk for bullying (Bagwell, Molina, Philham & Hoza, 2001). Bagwell et al., (2001) investigated whether or not childhood ADHD and symptoms of that disorder could later cause difficulty in peer relationships in adolescents. The researchers interviewed 111 ADHD adolescents and compared their answers to 100 non-ADHD adolescents between the ages of 13-18. They interviewed parents and close friends about peer rejection associated with ADHD and non-ADHD children. Peer relations for children with ADHD are known to be a common issue due to the behaviors associated with the diagnosis of ADHD. Bagwell et al., suggests that treatment be implemented to help adolescent youths with ADHD to improve their poor social functioning.

Phillips, Tunstall and Channon (2007) investigated nonverbal social cues in children with ADHD. Non-verbal social cues took into account the child’s nonverbal emotions and relationships. Social decoding is often associated with working memory and attention. The researchers conducted two experiments to investigate working memory in social decoding situations. The first experiment involved the Interpersonal Perception Task (IPT) (Archer & Costanzo, 1988) and the Profile of Non-Verbal Sensitivity (PONS). The IPT and PONS require the participant to go beyond social perception and emotion recognition. The tests require the participant to observe and assess social cues such as intimacy and relationships. IPT is comprised of multiple videos that show examples of social situations. The participant is to observe and
portray the social interactions and behaviours of the multiple actors seen in the clip. The social interactions that the participant must decode are as follows: family interactions or relationships, relationship status, deception, determining who has won in a game or competition and spontaneous actions. These are good, yet small representations of every day behaviors amongst people. The question was whether the clients have issues decoding the social cues themselves, or if it is a cognitive processing issue in memory. The PONS test is also used to detect poor social skills but usually used with patients diagnosed with schizophrenia. The test consists of shorter clips than the IPT with a single actor. The participant is to determine the emotional and social status of the actor and does not mention the relationships amongst the actors. Less information is provided and less information is needed from the participant to complete the PONS test. The PONS test shows through neuroimaging that there are two areas in the frontal lobes affected with working memory.

The results from the IPT and the PONS showed that working memory was not required in the IPT task; however, the second experiment (PONS) relied heavily on working memory. It is evident when considering the two studies that children with ADHD struggle with social cues, which sets them apart from other children. The difference can be attributed to the lag in accessing working memory without social cues. Parents and peers were quick to pick up on such differences but children and youth with ADHD cannot recognize these cues so easily. It is evident that children with ADHD struggle with social relationships and there is a need for treatment to improve their social functioning.

Cognitive functioning and memory issues can become a predictor of future negative events including delinquent behaviour, drug and alcohol abuse and educational failure (Mikami & Hinshaw 2006). Children who have ADHD often show early signs of Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) (Loeber, Keenan, Lahey, Green, & Thomas, 1993). Children often exhibit symptoms of ODD but usually outgrow symptoms due to cognitive development and maturity. However, clinical samples show that almost all youth who have conduct disorder before the gestation of puberty also meet the requirements to be diagnosed with ODD. As this cohort ages, the symptoms of ODD are not usually outgrown. They are consistently entangled amongst one another. It is important to understand that ODD symptoms differ from CD symptoms. For children with ADHD the severity and the risks for CD and ODD are increased due to the relationship between impulse control and memory, which increases the symptoms of CD and ODD significantly.

Loeber, Keenan, Lahey, Green and Thomas (1993), conducted a meta-analysis by studying 177 participants aged 7 to 12 years old from 3 outpatient clinics in order to validate the symptoms of ODD and CD. They selected two groups of participants: the first was referred for their disruptive behaviors by teachers, guardians or counselors, while the second group was referred for internalizing their problems. Seventy-one boys had the diagnosis of ODD and 68 had the diagnosis of CD. 62.2% of the ODD boys and 70.6% of the CD boys had been diagnosed with ADHD. The results of the Lober, Keenan, Lahey, Green and Thomas study showed a significant relationship between ODD, CD and ADHD. These relations should not be ignored, as they are very serious symptoms and can be increased if one has ADHD.

Other co-morbidities such as depression, drug use and learning disabilities are common in children who are not properly treated for their ADHD (Bailey, & Owens, 2005). Several
studies have shown that children with ADHD are mindful of how to behave in regards to social interactions but struggle to control and implement their behaviour in an acceptable way when around peers (Boo & Prins, 2007). However, children who receive stimulant medication for their ADHD model appropriate social interactions with peers better than children who do not take medication (Boo & Prins, 2007).

The social issues that children with ADHD face could be rooted in their working memory (Martinuseen, Hayden, Hogg-Johnson, & Tannock, 2005). When looking at the causes of ADHD, theses authors state that most of the research is focused on brain damage that affects the frontal lobes. Due to ethical considerations, research is limited to investigating such brain differences in children with ADHD and without. Without invasive investigation, there is no means at this time to explain differences in the brain but there is confirmation that memory is impaired by ADHD from neuroimaging. With ADHD causing impairment of memory, children have a hard time storing and recalling information about social interactions from the past, causing social issues amongst peers (Phillips, Tunstallm & Channon, 2007).

**Sleep Difficulties**

Children who have ADHD often have difficulties with Chronic Sleep Onset Insomnia (CSOI) (Corkum, Moldofsky, Hogg-Johnson, Humphries & Tannock, 1999). Parents frequently report sleep disturbances in their children with ADHD (American Psychatric Association, 1994). Onset insomnia, in which the child wakes several times during the night, causes him or her to fall asleep during the day (Lecendreux, Konofal, Bouvard, Falissard, & Mouren-Siméoni, 2000). Parents and teachers have reported that children with ADHD may become agitated and uneasy due to their difficulty sleeping or staying asleep (Kaplan, McNicol, Conte, & Moghadam, 1987). Children that have CSOI and do not take stimulant medication for their ADHD exhibit irregular sleep-wake patterns on a regular basis (Van der Heijden, Smits, Someren, & Gunning, 2005). Research has also shown that the untreated ADHD children displayed hampered levels of endogenous melatonin at night (Van der Heijden et al., 2005). There are behavioural interventions that can help extend sleep times, including eliminating sugary snack intake before bed and using blue light electronics and participating in regular sleep hygiene (Weiss, Wasdell, Bomden, Rea, & Freeman, 2006). Burkart and Phelps (2009), state that blue light is one of the most visible lights that affect the circadian rhythm. The timing and duration that blue wavelengths are used for can lessen the quality of sleep and lower the duration of sleep. Mood is greatly affected by these two factors and if one were to limit his or her use of blue light to zero three hours before bed sleep quality would improve. Burkart and Phelps (2009) had 20 adult volunteers wear blocking goggles before bed. One group was to wear blue wavelength goggles and was the other to wear amber tinted goggles three hours before sleeping. They were to complete a sleep diary for the duration of one week to establish baseline and then for two weeks with blocking goggles. Significant results were found, as those who wore amber coloured wavelength blocking glasses had a much better quality of sleep versus those who wore the blue coloured glasses. Mood changes were also significantly related to the participant’s self reported sleep due to the glasses.

Pharmaceutical intervention with endogenous melatonin properly dispensed at night could lead to the child sleeping at a more appropriate bedtime with fewer sleep interruptions (Lewy, Emens, Bernert, & Leffler, 2004). Giving melatonin over a short time span of several weeks is safe and an appropriate sleep aid for children with ADHD and CSOI (Tjon, Broeren,
Melatonin is not something that should be utilized as a long-term treatment approach without direction from a doctor (Hoebert, Van der Heijden, Van Geijlswijk, & Smits, 2009). It is recommended that there be breaks in melatonin use although there are minimal reports of adverse effects such as withdrawal symptoms (Lecendreux, Konofal, Bouvard, Falissard, & Mouren-Siméoni, 2000). There are, however, reported adverse effects such as dizziness, urinating the bed and sleep maintenance insomnia caused from long term melatonin (Lecendreux et al., 2000). These authors point out that each of these events are not only aversive for the child but for the parents as well. There are alternatives to using melatonin such as ensuring that the child has the opportunity to utilize their excess energy before their earlier bedtimes (Weinberg, & Harper, 1993). Sleep is an issue that most children with ADHD face but with the practice of appropriate sleep hygiene and melatonin, use there can be an improvement in both the child’s and the parent’s life.

**Effects on Parents**

In a study by Hinton and Wolpert (1998), parents of children with ADHD felt that they were not understood by other parents and were blamed for their child’s ADHD behaviour; however, results showed that was not the case. Mothers of children without ADHD felt similar blame due to their child’s behaviours (Hinton & Wolpert, 1998). Alternatively, mothers who had children diagnosed with ADHD revealed that they received more criticism from family, friends and co-workers than strangers (Norvilitis, Scime, & Lee, 2002). The authors also report that comments made by family and friends were internalized and played a role in the well being of mothers who faced the difficulties of raising a child with ADHD. Parents feared that they would receive scrutiny for receiving treatment for their child (Bailey & Owens, 2005), including being afraid that diagnosis and treatment for their child could jeopardize the child’s future employment.

Raising a child with ADHD can cause fatigue and isolation (Baker, 1994). The impact of stress these parents experience has been reported as being more stressful than socioeconomic status worry (Brown & Pacini, 1989). Studies have also shown these parents receive less social support than parents whose children do not have ADHD (Brown & Pacini, 1989). The consequences of isolation and lack of support can lead parents to problematic behaviours such as alcohol abuse as a poor outlet to reduce stress (Pelham & Lang, 1999).

**Stigma**

Link, Struening, Dohrenwend, Cullen, & Shrout (1989), define stigma as a mark of disgrace associated with a particular circumstance, quality, or person. They state that stigma is a complex phenomenon that includes labeling lowered status individuals, stereotyping, exclusion and discrimination and that while stigma has been associated with various diagnoses, it has been strongly associated with mental illnesses. There is a culture of suspicion about child mental health treatments (Link, Struening, Dohrenwend, Cullen, & Shrout, 1989). North American researchers have shown that there is a strong belief that children who receive treatment for mental health are stigmatized and over medicated (Pescosolido, Perry, Martin, McLeod, & Jensen, 2007). Pescosolido, Perry, Martin, McLeod, and Jensen (2007) used a widely diverse sample representative of the United States population in their study. Over 1,293 non-institutionalized adults were interviewed about stigma regarding children. The results showed
that people who experienced a loss of a relationship due to mental health issues believed that stigma was a direct result of receiving treatment for a mental health concern. Almost half of the interviewed adults believed that these children would likely be rejected at school and over half were concerned about confidentiality of such services. A third of participants believed that the parents of these children would face stigma associated to their child’s mental health diagnosis. Over half of the participants believed that medications should be avoided until the child is fully developed and almost all participants believed that almost all children with mental illness were overmedicated for common childhood problems. This negative view placed on receiving assistance for mental health concerns causes serious barriers for parents in getting appropriate help that is crucial for their child’s future (Schomerus & Angermeyer, 2008).

In a study by DosReis et al. (2010), parents often reported a fear about their child’s well-being for the future, due to issues and risks that arise with ADHD. For these reasons, ADHD therapy focuses on minimizing disruptive behaviours, improving educational supports for success, improving self confidence and building strong relationships with family and friends (Bailey, & Owens, 2005). Treatments such as parent training programs, help the parents adapt to the diagnosis and implement interventions to cause behaviour changes in both the child and the parent (Anastopoulous & Farley, 2003).

**Treatment**

By the time children diagnosed with ADHD enter school, their lack of organization and poor imitation skills are observed and the child is then referred to a specialist for intensive behavioural therapies and medications (Osipova & Pankratova, 1997). Behavioural interventions such as Behavioural Parent Training (BPT) help parents learn behavioural modification techniques through social learning principles (Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004).

Pharmacological interventions have side effects; however, the benefits usually outweigh the minor side effects (Greenhill, Halperin,& Abikoff, 1999). Pharmacological treatment most commonly involves the use of stimulants like Ritalin (Singh et al., 2009). Stimulants are widely prescribed, but have a stigma associated with them (Singh et al., 2009). Ritalin is now a commonly used word in the American household and is known as the drug that troubled kids are prescribed (Widener 1998). Stimulants have been proven to be successful 50-95% of the time in improving behaviour, academic work and social skills (Barkley, 2013, p. 843).

The perception parents have about ADHD is a very important factor when they seek treatment (DosReis, Barksdale, Sherman, Maloney, & Charach, 2010). There has been a lack of research on overcoming parental stigma regarding ADHD but the hope is that there will be increased awareness and education to lessen public stigma associated with mental health (Wassel, 2008). There is a lack of motivation from organizations such as schools to challenge mental health stigma (Wassel, 2008). Sciutto, Terjensen, & Bender Frank (2000), found that teachers that have worked in the school board for several years believed that ADHD could be controlled by diet. Newly graduated teachers have similar ideologies, showing that there is a lack of adequate training (Jerome, Washington, Laine & Segal, 1999). Research conducted by Cornett-Ruiz and Hendricks (1993), found that negative first impressions were conceived in under five minutes when the child was being observed by teachers and peers. Both teachers and peers even made negative predictions about the child’s future success when observing them for the first time. Norvilitis, Scime, and Lee (2002) found that peers and teachers judge the child
based on observed behaviours and not the labels that have been placed on them. The results of this study showed that mothers who had children with ADHD and mothers who had children without ADHD felt similarly about negative thoughts of stigmatization. There was only one significant difference, which was mothers with children without ADHD thought “Most children with ADHD just need more discipline”. The study concluded that mothers with children who have ADHD felt that there is more blame placed on them because of their child’s irate behaviors. These negative self reports are correlated to depression and low support. DosReis, Barksdale, Sherman, Maloney, and Charach (2010) state that there is a need for stronger policies and procedures to address such issues to further decrease isolation of these at risk children and families in the community. Although society has been more accepting of mental health issues, there is still a need for improvement around preventing isolation of the individual and family. Norvilitis, Scime, and Lee (2002) discuss the relationship between social supports and depression for parents of ADHD diagnosed children. They advise that it would be beneficial for parents to partake in therapies as a family to alleviate some of their negative thoughts. In addition, if they learn that their thoughts may be cognitive distortions that can be changed, it may reduce their stress and therefore increase their overall wellbeing. Using cognitive behavioural models can improve individual functioning and reduce the stress parents face.

Research has shown that the stigma associated with ADHD can affect how parents seek help for their children (Charch, Volpe, Boydell, & Gearing, 2008). Charch et al. (2008) studied how parents go through their own personal journeys. This trans-theoretical model helped change the parent’s attitudes about their children partaking in medication treatments. Parents felt that making such decisions about their child’s medication were not easy. They needed to weigh the pros and cons before medication use. Although awareness for mental health issues such as stigma has increased, education on mental health has not (Mojtabai, 2007). Studies conducted by McLeod, Fettes, Jensen, Pescosolido, and Martin (2007) revealed that people do not have sufficient education about ADHD or its appropriate treatments. Stigma is something that a lot of parents face when having a child with ADHD but those who found medication ineffective were most likely to encounter stigma through personal experiences (DosReis et al., 2010). They reported a feeling of isolation due to their child’s behaviour. The isolation that is felt could be a result from the parents feeling blamed for the child’s illness (Hinshaw, 2005).

**Early Intervention**

In a study conducted by Keenan and Wakschlag (2002), results showed that mental health services for preschoolers are poorly attended compared to older age groups although the results of this study did not expand on why the help is not sought. This is troublesome for medical professionals as many of the symptoms of ADHD continue to escalate once the child starts school due to the demands that come with the educational system. When children are not properly treated, they are denied the opportunity to strengthen social skills and to experience valuable pre-academic structure thus making school a challenge (Blackman, Westervelt, & Welch, 1991). There is a need for acknowledging the child’s problem behaviour at a preschool age, recognizing the need for services before school begins, and knowing where to access supports (Mantadakim, Sonuga-Barke, Kokourost, & Karaba, 2006).
Relationship of the Literature to the Present Project

Being a parent to a child who has ADHD can be very challenging due to the child’s inattentiveness, impulsivity and over-reactive behaviors (Barkley, 2013, p.47). These problems put a strain on families, relationships and the parent’s emotional wellbeing. The parents are exhausted at times due to the excessive amounts of guidance, love, and behavioural correction required by these children on a daily basis. Parents of children who have ADHD need to find help for themselves as much as they do their children (Singh et al., 2010). Donelan, Falik, and DesRoches (2001) state that there is little information available on self care for parents of children with ADHD; however, it is known that children who have ADHD have a significant impact on shaping the family’s daily activities and family dynamic in a positive or negative way. As a result, parents’ emotional well-being is jeopardized due to an uncertain amount of time to meet their personal needs daily (Klassen, Miller & Fine, 2004).

Most children who have ADHD have a main caregiver that focuses on implementing interventions, booking appointments and communicating with teachers and doctors (Donelan, Falik, & DesRoches, 2001). In most reported cases, the mother plays the primary caregiver for children with ADHD (Norvilitis, Scime, & Lee, 2002). It has been reported that these mothers have role specific stress and global psychological distress (Johnston, 1996). If parents do not participate in self-care, there is a risk for a negative parent-child connection that could lead to child abuse if not resolved (Bishop & Leadbeater, 1999). Reaching out into the community is a usual coping mechanism used by parents of ADHD children; however, only when the behaviour escalates into a more problematic level are supports sought (Podolski & Nigg, 2001). There is a need for social supports that share an understanding of these parents’ daily struggle. (Podolski & Nigg, 2001).

Manuals can provide a useful adjunct to treatment and social supports. Manuals provided to parents help to generalize the information from therapy into everyday life (Scott & Dadds, 2009). Manuals should provide information that will help parents’ problem solve, promote positive family engagement, minimize child/parent resistance and provide education on problems that arise in children with ADHD. Bauermeister, Jensen, & Krispin, (2006) state that manuals can be used to help caregivers assist children in internalizing and externalizing problems. They also state that manuals should be developed from the appropriate literature to be effective. Professionals and parents have stressed the lack of resources available to help parents prepare their preschool-aged child with ADHD to enter the world of academia (Eckert, McGoey, & DuPaul, 1996). There is a need to focus on providing education for parents and creating interventions to improve behaviour management (Eckert, McGoey, & DuPaul, 1996). Creating a manual for parents of preschool children with ADHD will help the family deal with the new diagnosis, find the best treatment, reduce stigma, find support in the community and develop their new roles as parents while practicing self compassion.

Chapter III: Method

Setting

Pathways for Children and Youth is an agency supporting children and families through a family centered approach to improving children’s mental health. Pathways for Children and
CLINICAL MANUAL FOR PARENTS

Youth offers a wide variety of services including counseling, education, Intensive Behavioural Intervention (IBI), Applied Behavioural Analysis (ABA) and in-home intensive services. The manual was administered by the Pathways workers and discussed by the staff member and client at a Pathways location or the client’s home. The manual was implemented by participants in their various environments to assist in the care of their children diagnosed with ADHD.

Selection

There are seven members of the intensive team, with each member having approximately six clients. Each member of the intensive team has access to multiple copies of the manual for his or her clients. Each team member can provide the manual to all of his or her clients to give a total of 42 clients using the manual. Although many of the families are working with a Pathways in-home worker to incorporate some of the techniques that were discussed in the manual, it will be important to provide the organization with a manual for multiple reasons. The manual can be given to parents as an alternative if they frequently canceled appointments or abruptly decided to stop the services being provided. The manual may also be used to provide information for parents who share custody of their children but are not involved in home visits, thus promoting consistency across the child’s living environments.

Participants

The manual was designed for primary caregivers of the preschool aged child with ADHD. Primary caregivers included, but are not limited to, biological parents, adopted parents, foster parents and other family members. The manual was given to the primary caregiver by staff of Pathways for Children and Youth to be used in the home on a voluntary basis. Use of the manual is not intended to be restricted but is aimed for caregivers who have the confidence and ambition to use the manual without additional supports from in home workers or case managers. Caregivers can use the manual daily or intermittently, as needed. They may share it with other providers such as babysitters and teachers.

Manual and Procedure

The contents of the manual focused on the parent’s involvement and how it affects the child diagnosed with ADHD. The manual has an introduction discussing the writer and her educational role and the purpose for creating such a manual, followed by a description of the Pathways agency. The contents of the manual is broken down into six main components as follows: Section One (Educating the Family on ADHD) will be broken down into multiple headings that will discuss topics such as What is ADHD?, and What Causes ADHD?. Section Two (Being an Informed Parent) is broken down into multiple headings that will discuss topics such as ADHD Evaluation and Dealing with the Diagnosis as a Family. Section Three (Fighting Against Stigma) is broken down into multiple headings that discusses topics such as Parent Stigma, and Child Stigma. Parent stigma is looked at further with emphasis on how to seek self-compassion. Section Four (Coping With the New Diagnosis Day- to- Day) is broken down into multiple headings that discusses topics such as Taking Charge at Home, and Taking Charge at School. Section Five (Treatment) is broken down into multiple headings discusses topics such as Medications, and Behavioural Interventions. The treatment section discusses supports and
services located in Kingston and the surrounding area. Lastly, Section Six (Parent Self-Care), is broken down into multiple headings that discusses topics such as Physical and Mental Wellness, and Relaxation Techniques. To ensure that the information in the manual was easily understood, some of the language used was included in a glossary at the back of the manual. After the glossary there is a list of resources in the Kingston community that encompasses food, shelter and housing, counseling services, hospital based services, community mental health and outpatient services, addiction services, mental health organizations and societies, long term care and related services, patient rights and legal services, developmental disabilities and children and adolescent services.

Table 1: Breakdown of Preschool ADHD Successes.

<table>
<thead>
<tr>
<th>Sections of the Guide</th>
<th>Parts Within Each Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>- Purpose of manual</td>
</tr>
<tr>
<td>About Pathways Organization</td>
<td>- Pathways Mission Statement</td>
</tr>
<tr>
<td>1. Educating the Family on ADHD</td>
<td>- What is ADHD?</td>
</tr>
<tr>
<td>2. Being an Informed Active Parent</td>
<td>- What Causes ADHD?</td>
</tr>
<tr>
<td>3. Fighting Against Stigma</td>
<td>- ADHD Evaluation</td>
</tr>
<tr>
<td>4. Coping With The New Diagnosis Day-to-Day</td>
<td>- Dealing With the Diagnosis as a Family</td>
</tr>
<tr>
<td>5. Treatment</td>
<td>- Parent Stigma</td>
</tr>
<tr>
<td>6. Parent Self Care</td>
<td>- - Barriers of Stigma</td>
</tr>
<tr>
<td></td>
<td>- - How to Seek Self Compassion</td>
</tr>
<tr>
<td></td>
<td>- Child Stigma.</td>
</tr>
<tr>
<td></td>
<td>- Taking Charge at Home</td>
</tr>
<tr>
<td></td>
<td>- Taking Charge at School</td>
</tr>
<tr>
<td>Glossary</td>
<td></td>
</tr>
<tr>
<td>Resources Guide</td>
<td></td>
</tr>
</tbody>
</table>

Evaluation of the Guide

Participants

Participants in the study were the agency staff members on the intensive team at Pathways for Children and Youth who agreed to review the parent manual. No consent was needed because they were only providing feedback on the manual. A letter was sent to staff inviting them to participate in providing feedback (see Appendix A). The letter explained the purpose of the study and what was expected from each member of the intensive team. The potential benefits and risks were thoroughly explained throughout the document. The participants were assured that if something were to go wrong the placement student would contact both college and organization supervisors to ensure the issue was resolved as soon as possible. The
letter further emphasized that privacy would be maintained and that no identifying information was to be on the feedback forms. If there were any indication of personal identity, the participants’ feedback form would be shredded and not used for feedback. The letter requested that all the feedback forms be completed anonymously and placed in an opaque envelope provided in the resource room.

Measure

The Intensive Team’s feedback form for the review of the manual was a written form of 16 questions based on a likert scale of 1-5 and two short answer questions (see appendix A). The likert scale was selected to ensure that all questions could be evaluated equally. The additional short answer questions were added to give staff the opportunity to add their personal feedback. The feedback form evaluated whether or not the participant read each section thoroughly, his or her thoughts on the manual’s overall readability, appearance, and usefulness for the parent, child, and agency. Collecting qualitative data was used to assess how the participants thought or felt about the manual on a personal level. The survey was intended to provide information for improving the parent manual for future editions in the 2016 year.

Chapter IV: Results

The parent manual Preschool ADHD Success can be found in Appendix C. The manual was created for parents who have children with ADHD. The information in the manual was taken from peer reviewed journals, multiple published books on ADHD and general ADHD websites available to the public such as the CADDRA website. The information collected was amalgamated and presented in a five chapter manual that covered as much information as possible while remaining user friendly for parents. The manual was developed as an additional resource for parents when first learning about ADHD and to share amongst other guardians. The staff from Pathways for Children and Youth evaluated the manual. Evaluation forms were used to measure the staff’s satisfaction and usefulness of the manual.

A total of 16 questions were asked to evaluate the content based on a number of variables. The raw data of the participant’s feedback can be found in Appendix D and the tabled data can be found in Appendix E. A total of fourteen questions were asked on two Likert scales. The first scale of five questions asked how much each participant read of each chapter. This set of data measures the quality of the participant’s quality of engagement rather than satisfaction. The question could be answered with any of the following answers; 1: not at all, 2: not really, 3: undecided, 4: somewhat and 5: all of it. This was asked to ensure that all five participants read the manual before answering the following questions. The results from all five participants showed that they read all of the five chapters, while 1 participant only read somewhat of all five chapters. The participant’s quality of engagement can be seen in figure 2.
The next set of nine questions could be answered as follows; 1: strongly disagree, 2: disagree, 3: neutral, 4: agree and 5: strongly agree. The first four questions assessed the participant’s ease of reading. These questions addressed the manual’s clarity, organization, and appeal, as well as the clinician’s comfort about giving this information to clients. The participant’s results can be found in Appendix D. Out of all five participants, four participants believed that *Preschool ADHD Success* was easy to read and understand, while one participant felt neutral about this question. When asked if they would feel comfortable about giving a copy of *Preschool ADHD Success* to a client, every participant agreed. Overall, the results show that the participant’s ease of reading *Preschool ADHD Success* was positive. The participant’s ease of reading results can be seen in Figure 3.
The following five questions assessed the participants thoughts on the helpfulness of the manual. The five questions asked the participant their thoughts on each section of the manual and assessed the helpfulness of each chapter in regards to the child’s guardian or agency. The results showed that all participants agreed or strongly agreed that every section in the manual would be helpful for the child’s guardian or agency. The participant’s helpfulness of the manual results can be seen in figure 4.
Figure 4. Participant’s results on the helpfulness of Preschool ADHD Success.

The last two questions asked the participants to give their opinion of the manual. The comments of five participants were used to assess usefulness for other organizations as well as gain their general feedback on the Preschool ADHD Success manual. Out of the five participants, four gave a list of additional agencies in the area that would benefit from having a copy of the manual. Some of the agencies listed included: Limestone District School Board, Ontario Early Years Centre, Better Beginnings, medical doctors and health clinics. In the last question, participants were to give their general feedback on the manual. The participants provided some recommendations for the writer to consider, as well as positive comments such as, “I love that this manual focus on the positives and covers self care as we all know this is so important”. The answers provided great advice on improving the manual for the final copy. This information can be found in Appendix D.

Chapter V: Discussion

Main findings

The Preschool ADHD Success manual was created for parents who have children with ADHD. The manual is to be used as an additional resource for parents when first learning about ADHD and to share amongst other guardians. The information in the manual was created from peer reviewed journals, multiple published books on ADHD, and general ADHD websites available to the public such as the CADDRA website. The intention was that the language used in the manual would be user friendly for a wide range of people, while still containing the most current published information. The evaluation of the manual provided data on the judgements of Pathways staff members regarding the predicted satisfaction and usefulness for their clients. The results from the Evaluations forms showed that the manual was a success. The results showed that four out of the five participants read the entire manual, while one participant read only “somewhat” all of it. One participant reading only “somewhat” all of the manual could be the cause outliers in the data. All participants “agreed” or “strongly agreed” that Preschool ADHD Success was visually appealing and that the contents was organized and flowed. There was, however, one outlier in the data that showed that the participant was not entirely satisfied with the readability and accessibility of the manual, but still agreed with the rest of the participants that he or she would feel comfortable providing a copy of the manual to clients. All participants agreed or strongly agreed that all of the sections in the manual would be beneficial for the child’s parents, guardian, or agency. The results showed that four out of the five participants thought that many organizations in the Kingston community would benefit from having copies of the manual. The participants mentioned in the additional comments how important self-care skills are and how they enjoyed this piece of it. The preliminary findings from participants are good, but more data would need to be compiled from actual users of the manual to emphasize findings.

It can be concluded that providing this manual to clients will educate them about the basics of ADHD, parenting a child with ADHD, managing the stigma associated with ADHD, the accommodations needed at home and school, ADHD treatment, and parent self care.
Strengths

The staff at Pathways for Children and Youth believed that the manual would be a positive resource for parents and other agencies in the community. The Parent Manual provided an easy to read, educational resource which amalgamated various information from articles, books and websites to incorporate the most important aspects of how to care for a child diagnosed with ADHD, while maintaining self-care for parents. As mentioned before the manual is an additional piece of literature that parents can share with those who may not be knowledgeable about preschool ADHD. A second strength of the manual is that it addresses the topics of stigma associated with ADHD, and of parent self-care. These topics are less commonly included in psycho educational materials on ADHD. Parents would also benefit by feeling less stigma by not having to ask for information on ADHD if it was available in waiting rooms, libraries, and additional areas associated with every day living. A third strength of the manual is that parents don’t have to struggle to attend appointments or have invasive home visits because the education is available in an easy to read manual.

By providing parents with the educational resources that address a broader range of ADHD information such as, stigma and parent self care, parents can be more informed and aware the way in which affects other family members and relationships.

Limitations

While the manual was deemed to be useful by the Intensive Team staff at Pathways for Children and Youth, it has limitations that must be considered. First, about half of the Intensive Team’s members did not get a chance to read the manual or give their evaluation of the manual in the allotted time because most of them are often out of the office for in home visits or groups and can not check e-mails frequently. Second, the allotted time for feedback from the staff was shortened by approximately one week due to the manual’s completion being one week behind schedule. If there had been a longer time period for responding, there may have been more feedback with which to improve the final draft of the manual for the target population.

Additional limitations include the actual manual itself such as the cost of printing it. This could be costly if there is a need for numerous copies. Another possibility is that it is unknown how often the information in the manual will need to be updated with new information and how much the re-print processes will cost. If the organization cannot afford to print additional copies for waiting rooms and libraries, it is unknown how parents will gain access to the manual without feeling ashamed. Lastly, The staff may not have the additional time to go over the chapters if needed with clients.

Contribution to Behavioural Psychology Field

The Preschool ADHD Success manual contributes to the behavioural psychology field by adding an additional resource on preschool aged ADHD for guardians and organizations in the Kingston community. Evaluation of the manual suggested that it would be helpful for many parents, guardians or care providing organizations in the Kingston area when first learning about ADHD and the stressors behind it. ADHD is one of the most common childhood disorders and can continue throughout a lifetime; however, many people do not know much about it unless it
affects them in some capacity. This manual increases awareness of the disorder and helps those affected understand basic information about it while waiting for treatment or during treatment.

**Multilevel Challenges**

Several challenges were involved in developing a parent manual on preschool ADHD. At a client level, the challenge was to create a manual that would be at an appropriate reading level for the demographic of people targeted. It was especially difficult to present the empirical information in simple terms while keeping it as concise as possible. It was challenging to include all the information without it being overwhelming for a potential reader. At the organizational level, the agency was very concerned that if the manual did not meet the needs of their clients and would not be used, resources would be wasted. At a societal level, there were problems with gathering information on what parents needed as a resource. In an open parent group when asked about what they were looking for in a resource, no one provided information due to the fear of others’ judgment. It was only after the group ended that parents provided information on a one-to-one basis. They often expressed feelings of judgment or blame around their child’s ADHD and/or their child’s impulsive behaviours. Most parents requested that there should be more information about ADHD given to the public.

**Recommendations**

Preschool ADHD Success leaves an opportunity for future behavioural psychology students to continue research for the manual. The first recommendation is that more research should be done on what the parents need included in a manual such as Preschool ADHD Success. This information should be obtained through clients that are working with the Pathways for Children and Youth organization rather than what is found online. At this time there is a noticeable gap in the research on the effects of child ADHD on parent stigma and parent mental health. The second recommendation is that a more detailed evaluation form should be created to address the limitations mentioned in the results section. In the evaluation form, the future student should ask more questions on the content versus the visual aspects. The future student should arrange an interview with the participants to gain more information about the positives and negatives about the manual. If possible have actual users of the manual give feedback, so the parents and caregivers of the child who has ADHD. This could be a good opportunity to make sure their needs are being met in the literature. The third recommendation is to find out a list of agencies in the community using the manual and ask them to provide feedback on how many copies were provided and if there was any additional feedback from their clients. With these two sets of data the future student could make comparison data between how agencies and their clients see it being useful verses pathways and their clients. The fourth recommendation is to give the staff a week or more to review the manual and complete their evaluation forms. The last recommendation is that if anyone were to take over this Preschool ADHD as an applied thesis project, they must make sure that all the information in the manual is current and addresses the needs of the target demographic.
References


Hello Pathways Intensive Team!

As many of you know, my name is Jessica Preiss from the Behavioural Psychology program at St. Lawrence College and I have been working under Karen Vanberkle, supervisor for my 4th year placement. As part of this placement I am obligated to write an applied thesis. I am asking each and every member of this amazing team for assistance completing my task. The information in this form will help you understand my project so you can determine whether or not you would like to be a part of the process.

I have created a parent manual called *Preschool ADHD Success*. This manual is to help the Intensive Team’s clients who have difficulty following through with appointments or clients who drop Pathways services. This guide is not limited to those options and can be used as an additional resource to ongoing clients. I have created a feedback based on *Preschool ADHD Success*, which I am asking you to complete. The feedback form will help determine if the manual is useful for your team and if it is appropriate for the demographic. Your subjective feedback will be a valuable contribution to further development of the manual.

In order to provide feedback, you will need to read *Preschool ADHD Success*. Every member of the Intensive Team will receive an electronic copy of the parent manual as well as the feedback form on Monday, November 16th. When you are finished reading the manual and have completed the feedback form, print off your copy of the form and place in the designated envelope in the resource room by Friday, November 20th. **The results must be in by week November 20th at 2:30pm** or else they will not be included in the study. Please do not provide any identifying information. Each feedback form is to be anonymous. There are multiple benefits to being involved in the feedback process. Many of you have extensive experience and understanding of family based treatment for ADHD. By providing constructive feedback you are giving me the opportunity to improve the information being provided in order to make the guide a useful tool for Pathways and yourselves. Other people may also benefit from the feedback on *Preschool ADHD Success*. With your feedback, parents who receive this resource will benefit by learning the basic education on ADHD, potential treatments, how to overcome stigma for themselves and their children, and they will be informed on the additional resources available in the area.

There could also be disadvantages to participating in the study but they are minimal. You may feel that this was not enough time to read the manual and give your feedback during a busy work week. You may also be out of the office at a client’s house and forget to put your form in the resource room. The results must be placed in the envelope before 2:30 on Friday or else they will not be included. You may also grow bored from reading “Preschool Success ADHD” and finishing the questionnaire. These risks are minimal and hopefully they will not interfere with your participation in giving feedback.

If something goes wrong or if you have questions while taking part in the project, you can contact me at jppreiss@live.ca. I will try to solve any arising problems, but if you are not satisfied with my solution you may also contact my agency supervisor Karen Vanberkle at
kvanberkel@pathwayschildrenyouth.org or my college supervisor Elizabeth de Grace at degracee@hdh.kari.net.

Once again, participation is voluntary. I look forward to seeing the feedback from *Preschool ADHD Success* and I hope you enjoy the read.

Thank you very much,
Jessica Preiss
Appendix B
Agency Staff Feedback Form for Review of “Preschool ADHD Success”

1. I read all of “Educating the Family on ADHD”
   - Not At All
   - Not Really
   - Undecided
   - Some What
   - All Of It

   Not At All Not Really Undecided Some What All Of It
   1 2 3 4 5

2. I read all of “Being an Informed Active Parent”
   - Not At All
   - Not Really
   - Undecided
   - Some What
   - All Of It

   Not At All Not Really Undecided Some What All Of It
   1 2 3 4 5

3. I read all of “Fighting Against Stigma”
   - Not At All
   - Not Really
   - Undecided
   - Some What
   - All Of It

   Not At All Not Really Undecided Some What All Of It
   1 2 3 4 5

4. I read all of “Coping With the New Diagnosis Day to Day”
   - Not At All
   - Not Really
   - Undecided
   - Some What
   - All Of It

   Not At All Not Really Undecided Some What All Of It
   1 2 3 4 5

5. I read all of “Treatment”
   - Not At All
   - Not Really
   - Undecided
   - Some What
   - All Of It

   Not At All Not Really Undecided Some What All Of It
   1 2 3 4 5

6. I read all of “Parent Self Care”
   - Not At All
   - Not Really
   - Undecided
   - Some What
   - All Of It

   Not At All Not Really Undecided Some What All Of It
   1 2 3 4 5

1. I found “Preschool ADHD Success” was easy to read and understand
   - Strongly disagree
   - disagree
   - neutral
   - agree
   - strongly agree

   Strongly disagree disagree neutral agree strongly agree
   1 2 3 4 5

2. I found “Preschool ADHD Success” was organized and flowed
   - Strongly disagree
   - disagree
   - neutral
   - agree
   - strongly agree

   Strongly disagree disagree neutral agree strongly agree
   1 2 3 4 5

3. I found that “Preschool ADHD Success” was visually appealing
   - Strongly disagree
   - disagree
   - neutral
   - agree
   - strongly agree

   Strongly disagree disagree neutral agree strongly agree
   1 2 3 4 5

4. I would feel comfortable giving a copy of “Preschool ADHD Success” to a client
   - Strongly disagree
   - disagree
   - neutral
   - agree
   - strongly agree

   Strongly disagree disagree neutral agree strongly agree
   1 2 3 4 5

1. The information in section 1 would be helpful to the child’s guardian or agency.
   - Strongly disagree
   - disagree
   - neutral
   - agree
   - strongly agree

   Strongly disagree disagree neutral agree strongly agree
   1 2 3 4 5

2. The information in section 2 would be helpful to the child’s guardian or agency.
   - Strongly disagree
   - disagree
   - neutral
   - agree
   - strongly agree

   Strongly disagree disagree neutral agree strongly agree
   1 2 3 4 5

3. The information in section 3 would be helpful to the child’s guardian or agency.
4. **The information in section 4 would be helpful to the child’s guardian or agency.**

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>disagree</th>
<th>neutral</th>
<th>agree</th>
<th>strongly agree</th>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

5. **The information in section 5 would be helpful to the child’s guardian or agency.**

<table>
<thead>
<tr>
<th>Strongly disagree</th>
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<th>neutral</th>
<th>agree</th>
<th>strongly agree</th>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

6. **The information in section 6 would be helpful to the child’s guardian or agency.**

<table>
<thead>
<tr>
<th>Strongly disagree</th>
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<th>neutral</th>
<th>agree</th>
<th>strongly agree</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Do you think that this parent manual would be beneficial at other agencies and if so what ones?

**General feedback:**
Appendix C
Preschool ADHD Success

Developed by Jessica Pebbles Preiss
Bachelor of Applied Art in Behavioural Psychology
2016
Preschool ADHD Success

Developed by Jessica Pebbles Preiss
Bachelor of Applied Art in Behavioural Psychology
2016
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  ● Dealing With the Diagnosis as a Family

Chapter III. Fighting Against Stigma
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  ● Child Stigma.

Chapter IV. Coping With The New Diagnosis Day to Day
  ● Taking Charge at Home
  ● Taking Charge at School

Chapter V. Treatment
  ● Medication Interventions
  ● Behavioural Interventions
  ● Parent Self Care

Glossary
Resources
Acknowledgment

St. Lawrence Behavioural Psychology Student, Jessica Preiss, created this manual to help parents who have children with ADHD to help their child be as successful as they can be. This manual is dedicated to the parents at Pathways for Children and Youth for all their positivity and devotion to helping their children in every way they can.
Introduction to Pathways for Children and Youth

Pathways provides services to children from birth to 18 years of age in Frontenac and Lennox & Addington counties. We respond to more than 1,000 referrals each year and provide services within a goal-focused and client and family-oriented framework.

Some of our children and youth clients have difficulties with behaviour or emotions, while others have experienced mental health problems such as depression, withdrawal, or aggression. Some of our clients have been impacted by family violence, abuse, family distress, trauma, substance abuse, or parent-child conflict.

Pathways has a central intake system that allows direct contact with a staff member who can explain our services and schedule appointments. Our intake counselors work with families to determine the best services to address each child's individual needs. The case management process allows for continuity of service, and we work with parents to ensure they have the tools to assist their child at home and in the community.

Community Site Services include assessment and consultations, individual, family, and group counseling, as well as parenting programs. Intensive Services include Intensive Child and Family, Early Years, and Nexus (Day Treatment) services. Resource Services include behavioural pediatric, psychiatric, and psychological assessment and consultation services. All of the services can be accessed through Community Site counselors.

For more information about our individual services, please call our central intake number at 613.546.1422 ext. 1

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Pathways Mission Statement

- We make positive change possible in the lives of children, youth and families, in our community and the province.
- We advance thinking and action in mental health and autism through collaborative leadership.
- We offer services that give each child, youth and family the opportunity to thrive and reach their full potential.\(^3\)

Pathways Value Statement

- We believe in possibilities
- We build healthy communities
- We believe people can change and grow
- We are accessible, collaborative and engaging
- We respect and invest in people
- We support excellence\(^4\)

Chapter I Educating the Family on ADHD

What is ADHD?

Attention Deficit Hyperactivity Disorder (ADHD) is a complex mental health disorder and one of the most common psychiatric conditions diagnosed in children. The disorder affects 5-12% of children in school. Children with ADHD have no outward signs that there is something different about them. There are three core symptoms of this condition: inattention, hyperactivity, and impulsivity. Symptoms must be severe enough to impair daily life. Children with ADHD have difficulty regulating their emotions. The symptoms of ADHD impair functioning in the child and the child at higher risk for negative outcomes socially and educationally. Hyperactivity and impulsivity symptoms may decline as the child gets older but often the ability to pay attention remains a continuing concern.  

Types of ADHD

ADHD has three core symptoms. Children can show predominately one, two or all three symptoms as follows:

Inattentive Type
Children with inattentive ADHD have a very hard time paying attention and completing tasks.

Hyperactive-Impulsive Type
Children with hyperactive-impulsive ADHD display behaviours such as restlessness, interrupting and self-control problems.

Combined Type
Children with Combined type ADHD have difficulties with both hyperactive-impulsive and inattentive behaviours. This type of ADHD is the most common.

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Symptoms of ADHD

Indicators of ADHD in preschool aged children are impulsive behaviours, fighting with peers and siblings, difficulties with school work and lack of participation in school, family, and group activities. Parents may see comorbid disorders begin to arise with ADHD, including anxiety. Parents often confuse a lot of behaviours and symptoms for anxiety. Anxiety is not a symptom of ADHD, but is frequently co-morbid. Anxiety can be a protective factor in ADHD. Anxiety is somewhat normative in this age group. These include phobias, generalized anxiety disorder, obsessive-compulsive disorder, and separation anxiety. Common anxiety triggers for this age group are often related to school. If this is an issue morning routines may be a huge task for both child and parent.  


Symptoms of Inattention

- Child struggles to pay attention when needed
- Child is easily distracted by noises, others, or things in the environment
- Appears to be in another world
- Gets bored easily
- Struggles to keep track of things
- Child has difficulty following directions

Not every child with ADHD has the same symptoms or struggles at the same severity level. Some children have no problems paying attention to something that sparks their interest but the problem persists when it is something they find less interesting. Children with ADHD often like to jump from task to task rapidly often without completing anything. To help these children stay focused their environment should be calm and relaxed with minimal distractions.

Figure 2. Picture of child showing inattention in class adapted from “In Case You Missed it: How to Sucessfully

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Address Client’s Inattention, Impulsivity, and Hyperactivity in Therapy Sessions”, by T., Elleseff, n.d.

**Hyperactivity Symptoms**

- Child must always be moving
- Has difficulty staying seated during activities such as school work
- Often plays inappropriately, such as climbing things he or she shouldn’t
- Talks unnecessarily
- Has trouble relaxing
- Has excessive anger

The most outward symptom of ADHD is usually hyperactivity. Children at a preschool age are usually quite active but ADHD children are constantly moving. These children often have several things on the go. Sitting still is difficult for them.

Figure 3. Picture of child showing hyperactivity by jumping on furniture adapted from “Attention Deficit Hyperactivity Disorder - Symptoms”, by Teach Our Kids, 2012

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**Impulsivity Symptoms**

- Often acts without thinking
- Blurts out during inappropriate times
- Has difficulty waiting
- Often interrupts others or intrudes upon people's conversations
- Has difficulty handling intense emotions

Impulsivity along with inattention and hyperactivity can cause difficulties with the child's social life. Instructions, for children who have ADHD, are much harder to follow than they are for their fellow peers. Children who show impulsivity symptoms are often emotionally overactive, causing issues between peers.

ADHD symptoms and related symptoms must be at a level that causes impairment in daily living for the child, for the diagnosis to be made. The occurrence of these three symptoms determines the type of ADHD diagnosed. Children and adults who have hyperactive and impulsive symptoms are referred to as ADHD, primarily hyperactive-impulsive subtype; those who exhibit mainly inattentive are referred to as ADHD, primarily inattentive subtype (often still referred to as ADD) and those who have all three symptoms are referred to as ADHD, combined subtype.

**Causes of ADHD**

There is no one specific cause of ADHD but medical research does agree that ADHD is a neurological disorder that is often caused by environmental, biological or genetic factors.

Environmental factors such as maternal consumption of drugs or alcohol during pregnancy and the exposure to lead paint have been shown to cause ADHD. Participating in drug or alcohol consumption during pregnancy has been proven to alter brain development especially in the frontal region. Exposure to lead paint has shown weak but consistent results in many studies. It has been proven that when children are exposed to lead during the ages of 12 and 36 months, they are at a heightened risk of injuries to brain tissue because lead is poisonous. Environmental causes are less common than biological and genetic causes, but ADHD can originate from environmental factors.

Biologically, in simplest terms, the frontal regions help with executive functioning skills such as regulating attention, organization, working memory, planning (foresight) and observing the past (hindsight). In a child diagnosed with ADHD, the frontal regions functioning ability has been affected.

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Genetically, ADHD can also be passed down from parents. ADHD tends to run in families. If a child does have ADHD, the risk for other family members increases five times. Science is still researching what genetics are involved but evidence is showing that it is an assortment of genes that individually have little risk to contributing to the disorder but collectively heighten the risk of a child being diagnosed with ADHD. Often children with ADHD are at a risk for other psychological problems including depression and conduct disorder.

Figure 4. Illustration of brain with dopamine pathways and serotonin pathways adapted from “Dopamine Serotonin”, by Wikipedia, n.d.

Treatment

There are multiple methods of treating ADHD but they are most effective when combined. With the combination of medication, behavioural intervention and psycho-education, children with ADHD can achieve more positive outcomes. Being educated about ADHD is one of the most effective ways for you to help your child succeed. The more aware you and your child are about ADHD, the better the outcome will be. When your child has ADHD, it is important to seek continuous support from your child’s medical professional. The doctor may prescribe stimulant medication for children with ADHD. These medications usually have minimal side effects and help a great deal in managing behaviours, but depending upon the child the medication can have side effects. Your medical specialist will explain the side effects to you. Your medical professional will also be able to help you find the resources available to you and your child within the community. These resources can help you obtain information about ADHD and how to arrange ADHD management through behavioural intervention. It is very important that the school be aware of and involved in your child’s treatment. It is important to have communication and collaboration with the school to develop plans that best support your child.\textsuperscript{16} It is important to store all medications out of reach from your child.


\textsuperscript{17} [Untitled picture of child looking at medication]. Retrieved December 1, 2015 from http://www.cdc.gov/MedicationSafety/parents_childrenAdverseDrugEvents.html
Chapter II Being an Informed Active Parent

ADHD Evaluation

If you believe that your child has ADHD, consult your family doctor. When looking for a diagnosis just remember that you are not alone and there are others out there to help you and your child though this. As a parent, you are your child’s number one advocate and supporter. If you do not have a family doctor contact your local Academy of Medicine, which can tell you how to find one. When evaluating ADHD, a doctor will use a number of tests and scales about your child’s past and present behaviours that can determine if he or she does have ADHD. Your child must have a combination of symptoms that include impulsivity, hyperactivity or inattention. The specialist may ask about medical and family history of the child and yourself. It is important that you are honest with your medical professional to get the most accurate results. The doctor may also conduct a neurological exam and have multiple interviews with your child, your partner and the child’s teachers about ADHD symptoms. ADHD presents with many symptoms that are also seen in other disorders, so it is important to have your child properly assessed. Some of the most commonly asked questions will address how severe the symptoms are. ADHD symptoms must cause a negative impact on one’s daily functioning to be considered a disorder. The doctor may also ask when the symptoms started and how long they have been disturbing you or your child. ADHD normally occurs in childhood and the symptoms must have persisted at least six months. Sometimes children may exhibit transient ADHD symptoms in response to events like a change of school or a family stressor. If you are not confident in your doctor’s assessment, there is nothing wrong with getting a second opinion. 18

The evaluation experience can be overwhelming and at times frustrating. With the help of the information in this book and the supports in the community the process can go as smoothly as possible.

1. Make a specialist appointment for your child. There is usually a waiting list, so the sooner the better.
2. Call your child’s school and ask to schedule an appointment with the principal. In most cases your child’s school will want to be involved in the process and help assist you in any way possible.
3. Be honest about everything. Give those involved a good description of how your child behaves in home and at school.
4. Make sure to keep moving forward. You are the one who has the power to help your child get the help he or she needs and the power to get it done as fast as possible. Remember that this is a common diagnosis and that there will be a bit of a waiting period for appointments.

When you and your family get the final diagnosis, you may feel intimidation or sadness. Remember that having a diagnosis is the first step in making sure your child has access to the

supports he or she will need. The ADHD diagnosis is a label but it will be helpful in explaining some of the struggles your child has been having. There are treatments that can help manage your child’s ADHD symptoms that will help with his or her daily functioning.

Just because your child has an ADHD diagnosis does not rule out other conditions. There are sometimes co-occurring or co-morbid mental health concerns such as anxiety, depression, and learning disabilities. These are additional issues that should be discussed with your medical professional.

Figure 6. Illustration of woman being counseled adapted from “Parents: Young Children and Adverse Drug Events”, by Clipart Panda, n.d.

Dealing With the Diagnosis as a Family

The parent child relationships may need to be adjusted when raising a child with ADHD. It is important for your child to have routine, structure, and rules to set expectations; however, it is also important as a parent to be flexible and realistic. There may be limitations to your child’s capabilities due to ADHD and that you as a family unit must understand.20

Minimizing arguments over rules – Children with ADHD are usually very determined to get what they want. One of the most common debates in a household is over rules. Try to have reasonable rules. Once these rules are set, there should be no more room for discussion. Parents often make the mistake of giving long explanations when a simple, clear statement of the expectation is far more effective. Fewer words are better.22

Rewarding instead of punishing – Reward is the most effective disciplinary technique. You, as a parent, must provide positive feedback immediately after positive behaviour and provide it frequently. Rewards do not have to be a physical object. A simple “Wow, I’m so impressed Jessica” will suffice when observing positive behaviors. When you do observe negative behaviors, do your best to ignore or redirect your attention to something more appropriate and positive.

Reward strategies – Make sure to set up a reward system that is appropriate for your child. It should be designed so that it can be changed if your child gets bored. ADHD children get bored easily and respond best to novel rewards. Example: token system.

Figure 8. Illustration if token system adapted from “Amazon: Reward / Star Chart Magnetic”, by Fridgemagic, 2012. Copyright 1996-2016 by AMAZON.

[Untitled illustration of token system]. Retrieved February 8, 2016 from http://www.amazon.co.uk/Reward-Star-Chart-Magnetic/dp/B003LQXXZ4
There are positive traits that come along with ADHD that make your child who he or she is. Try to look at ADHD in a positive way and think of some things that make your child original and reasons why you love them.  

**Creativity** - Children with ADHD have very creative minds. They often have an endless ideas and notice things that are not picked up on by others. Their art is often creative and brilliant.

![Figure 9. Picture of child being creative with paint adapted from “Stop Conforming, Play Like a Kid and Unleash Your Creativity”, by B. Choat, 2012.](image)

**Enthusiasm** - Children with ADHD are usually very enthusiastic and have larger than life personalities. They are very interesting individuals and are usually a lot of fun once symptoms have been properly treated.

![Figure 10. Picture of child with plant on head.](image)

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Energy – It is no secret that children with ADHD have an excessive amount of energy. They are usually very interactive and hands-on when it comes to something they enjoy. They work hard and try to succeed to the best of their ability, just like any other kid.

Figure 10. Picture of child being enthusiastic adapted from “The Best House Plants For Kids” by, Kostolnick M., 2015.

Figure 11. Picture of child being energetic adapted from “How to Motivate Your Child to Be Enthusiastic” by, Shore, T., 2015.

Chapter III Fighting Against Stigma

Parent Stigma

Many people have strong negative views on ADHD but know little about the disorder. These negative opinions often lead to inaccurate assumptions about children and their parents. The Stigma that accompanies the neurological disorder can be damaging to relationships amongst adults as well as to the child. Understanding ADHD is not always simple and not everyone has access to accurate information about the mental health disorder. Because ADHD is a psychiatric disorder, those affected often have involvement from health professionals such as psychologists and this may lead to additional stigma that surrounds psychiatric disorder in general. Children with ADHD often have associated issues such as depression, conduct disorder and learning disabilities. There is a lot of stigma associated with ADHD medication. Often parents are judged for using medication to “control” their child. It is important to remember that people’s opinions are not necessarily based on factual information. Children with ADHD can be viewed as disruptive and difficult due to a weakness of their character. If you’ve had one incident in the store with your child having a complete meltdown you have experienced those around you are staring at you and judging that your parenting skills are not strict enough, but your child’s ADHD behaviours are not a result of faulty parenting. The cause of such behaviour is that children with ADHD do not have the biological means to self-regulate adequately.
Parent Stigma

As parents of children with ADHD, stigma is an issue that you will face. The stigma around ADHD is decreasing as knowledge of the disorder grows and educational materials are more easily accessible but it is still an issue that you should be aware of. Some parents worry that a diagnosis or disclosing their child’s diagnosis will affect the child’s future.

Parents often disclose that they feel isolated and alone because of their child’s behaviours. They often have fewer close family members or friends to help support them in raising their child. Both parents and children with ADHD claim to feel isolated and ostracized. This is important for parents to recognize and to be alert to the possibility that their ADHD child could be the target of bullying. Although it is pretty hard for parents to prevent bullying, they can help their child cope with it and work with the school if it happens.

As a parent you can fight the stigma of ADHD by;

1. Getting educated on the most recent and accurate information available on ADHD. The internet has a lot of accurate information as well as inaccurate information. Remember to check your source, dates and authors.

List of recommended online resources for parents from the Canadian ADHD Resource Alliance (Caddra.ca)30

CH.A.D.D. Canada
- www.chaddcanada.com
National Resource Centre on AD/HD (a program of CHADD)
- www.help4adhd.org
Health Canada Consumer Medication Side Effect Reporting
- www.hc-sc.gc.ca

More information on ADHD online resources for parents can be found on CADDRA’s website http://www.caddra.ca/public-information/parents/resources-and-links

List of recommended books to read for parents from the Canadian ADHD Resource Alliance (Caddra.ca)31

- Taking Charge of ADHD, The Complete Authoritative Guide for Parents Russell A. Barkley
- Making the System Work for your Child with ADHD Peter S. Jensen

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2. More information on ADHD print resources for parents can be found on CADDRA’s website [http://www.caddra.ca/public-information/parents/recommended-reading](http://www.caddra.ca/public-information/parents/recommended-reading) Get involved in your community or with an organization. There are many parents in your community who feel the same way as you do. Look for ADHD support groups and share your ideas, struggles and thoughts with one another. Most importantly, be there for one another.

3. Use your voice! When you hear misinformation about ADHD being discussed, correct them politely. An information discussion about ADHD goes a long way in raising awareness.

### Self-Compassion

Parents who have children with ADHD tend to have a lot of guilt about the child’s behaviours or even their diagnosis. It is very important that parents take time to give themselves self-compassion when facing these feelings of blame, failure, and suffering. Dr. Kristin Neff is well known for her efforts in self-compassion. Dr. Neff broke down self-compassion into three elements – self-kindness, common humanity, and mindfulness. Self-compassion is very similar to compassion for others. When you have compassion for others, you are aware that their situation is tough. When you feel compassion, you also feel their struggle and are aware of their humanness for mistakes and accept this with no judgment. Their suffering is a shared human experience and if you take a second to seek compassion instead of judge, you become aware that you’ve been in their shoes at one point. Self-compassion is feeling the same way you feel for others during times of struggle, but for yourself. Not many of us take a moment to understand our own situation and feel some empathy for ourselves during this time. Most of us try to suppress our feelings and move on. As parents there is only so much you can take and you do have your limitations. Being aware of these limitations and your humanness will help you feel less stress and intense emotions. You will that realize your experience is a shared human experience. Remember, you are allowed to give yourself some self-compassion during your time of need.32

Self-compassion is broken down into three categories

1. **Self-Kindness**
   - Self-kindness is the acceptance of and being kind to yourself when you have a feeling of being not good enough, being a failure and dealing with life’s

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difficulties. Accepting kindness from yourself and others can help alleviate stress and help you to understand that not everything or everyone can be perfect.

2. Common Humanity
   ● Experiencing frustration due to situations turning out differently than expected.

3. Mindfulness
   ● When practicing self compassion it is important to stay mindful to keep your emotions stable. The word mindful means being aware, moment-to-moment, of what’s happening from your point of view. Think of other similar circumstances friends and family have experienced. This will help put your situation into a bigger picture so that you can observe your own negative thoughts and emotions thus becoming mindful. Remember to look at your feelings about the situation and try to feel compassion without denying or suppressing your emotions and thoughts about the situation at hand. Remember that you are only human.

Child Stigma

Any stigma is obviously harmful to children. Stigma surrounding ADHD can cause social problems such being excluded from the peer group. Children with ADHD often experience self-stigmatization about their educational abilities. This affects their self-esteem and motivation a great deal. Alternatively, children may deny that there is problem. Children with ADHD tend to have problems seeing themselves realistically in situations. They are often labeled as less popular and have fewer close friends due to their poor response to social cues. Children with ADHD understand the social norms of play but have a hard time demonstrating them. It is important for any parent to be aware of bullying at school and through the Internet but this is especially important for parents who have children with ADHD. Supervision of your child and his or her friends is a good way to be aware of interaction in the peer group.

Figure 13. Photo of little boy getting called named often wrongly associated with ADHD adapted from “Niall’s ADHD Notes” by, Niall, 2015.

33 [Untitled photo in front of chalkboard]. Retrieved December 1, 2015 from https://niallsadhdnotes.files.wordpress.com/2015/05/adhd-djacak-plocom.jpg
Chapter IV: Coping With The New Diagnosis Day to Day

Taking Charge at Home

The impulsive, inattentive, and overactive behavioural patterns of ADHD affect parent-child interactions on a day-to-day basis. Daily tasks require vigorous demands, the child may have such poor sustained attention and self-restraint that the task never gets done, especially if the option of a more desirable task arises. Children with ADHD sometimes have trouble following instructions. It is beneficial to gain the child’s attention, give simple clear instructions, and be sure to follow through with reinforcement or a consequence if necessary. Children with ADHD need multiple reminders. Change is hard and transitions can be even harder, so prepare your child and give him or her structure. Make sure to utilize transitional warnings. Some children will need more than verbal warnings, such as visual prompts or a timer. All children are different. Some children will need one transitional warning in an hour where others will a count down of several prompts. For example, if you are going grocery shopping, remind them with transitional warnings two days before with a visual calendar. The day before grocery shopping, tell them you’re going to the store tomorrow and the day of your shopping trip, tell them in the morning and when they get home from school. Make sure to tell them 60, 30, 15 and 5 minutes prior to leaving. It may seem like a lot of transitional warnings at first but utilize the reminders frequently until you know just how many your child needs.34

1-2-3 Magic was created by Dr. Tom Phelan and has shown to be effective in helping parents with follow through.35 Your child is not a tiny adult so explanations and discussion will not work. Before you can change your child’s behaviours you must change your own. Less emotion, less reaction.

Counting begins when the child does not do as he or she is told or when he or she displays a behaviour that is unacceptable, such as talking back, swearing, etc. For example, Cole is an eight year old boy who will not tidy his toys before bed and the conversation may go like this:

“Cole, will you please tidy up your toys?”
“No mom, I’m busy 15 more minutes.”
“Cole, that’s one (puts 1 finger up)”. "Mom, please 10 more minutes!”
“Cole, that’s two (puts two fingers up)”.
“Ugh, Fine then.” Cole picks up his toys and gets ready for bed.

You will find that you will only have to count to three a couple times and deliver a consequence for non compliance before your child realizes you are serious. When you get to

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three, a time out is in order. The age of your child in years is the number of minutes he or she should be in time out. Time out ideally should only begin once the child is calm and quiet, but this may not be possible for your child during an episode. When a child is not cooperating with the time out then an alternative consequence such as loss of a privileged like a favorite toy, or story time. For children with ADHD, immediate consequences are preferred especially for young children. You know your child best and you know what will and will not work for him or her as a consequence.

Many parents struggle to give appropriate consequences unacceptable behaviours. There are two types of consequences that your child will experience: logical consequences and natural consequences. Logical consequences are given by you as a parent and are to enforce rules and your authority as their caregiver. For example, if a child will not clean his or her room before a play date, then the play date is cancelled. Natural consequences are occur because of the behaviour not because the parent delivered them. These consequences do not need to be enforced to show authority, instead nature will enforce the consequence itself. For example, your son won’t wear his mittens on his way to school and his hands will be cold. Do not waste your energy fighting your son or daughter about behaviour that has a natural consequence, just let nature run its course.  

As parents, it is important to be consistent. This will not work if two parents under the same roof do not support one another in enforcing the house standards. Do not let your child manipulate you. There is no fourth, fifth, sixth, chance etc. It is simple- less talking and less emotion. Simply count 1,2,3. Once the child returns from the timeout, there is no talking, discussion, or shaming the child on his or her behaviour. The child has already received the consequence.

Another great tool to take charge of your child’s ADHD in your home is “when – then” statements. Begin with giving your child a request or a direction. Then conclude your statement with what they would like. “When – then” statements make your request a priority for him or her. Instead of saying “take the garbage out”, it is less confrontational to say “when you take out the garbage, then you can watch your show” or “when you are finished your math homework, you can go for a bike ride”. These statements are not up for discussion and they are to be followed as asked or counting will take place. 

Taking charge at home requires planning ahead. This will include you and your child formulating a plan together.

1. Describe the upcoming event or situation to your child, for example, trip to Toronto over Christmas break to visit relatives
2. Formulate a plan with your child and prompt the child for their input in the plan

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3. Praise your child for coming up with an appropriate plan
4. Have your child recite and review the plan you made together up until anticipated event
5. Reward your child if he or she was successful in following through on your plan
6. Use planned ignoring for your child’s minor interruptions
7. If a major interruption happens, prompt your child to review your plan and ask what he or she should be doing to make the plan work.

Planned ignoring is an effective way to decrease negative behaviours. When parents give their children attention by correcting their undesired behaviours as they are occurring they actually reinforce and strengthen the negative behaviours unintentionally. There are some behaviours, for instance unsafe behaviours, that cannot be ignored but reevaluate what is really important to address and what can be ignored. Planned ignoring works because for children any attention is better than no attention. This intervention strategy is used to decrease undesired behaviours by ignoring the minor inappropriate behaviors exhibited by children. When the child is participating in positive behaviour make sure to give lots of praise.  

In Conclusion

Make sure that your child understands what is expected of him or her. You can do this by making a visual schedule or using visual prompts. Do not treat your child like an adult. He or she is a child and needs to be reminded of the rules in the simplest terms. Make sure that he or she understands the rules and that they are visible for the child so he or she is reminded frequently and held responsible. When giving a command, make sure that you have your child’s attention and give clear achievable tasks. Praise your child for what he or she does right and minimize criticism. Choose your battles and do not fight them all. Use counting, positive reinforcement, token economies, “when-then” statements and transitional warnings. Always praise your child’s positive behaviours and be consistent. If your plan doesn’t work instantly do not throw it away, persist and tweak it if necessary. Lastly, less emotion and less reaction from you will increase the probability of positive behaviours.

Taking Charge at School

As your child’s main advocate, it is important that you help get the support he or she needs at school. School can be a very difficult environment for children with ADHD. Open communication with the school about your child’s needs is very important to ensure that teachers can help your child learn in their own style and work through his or her daily challenges. Ask to meet your child’s teacher in person and arrange a way to communicate with one another on a regular basis. Try to remember that your son’s or daughter’s teacher has a full class and may have other children who need additional support as well. For your child to be successful, it is important that you both create goals that are realistic and achievable. Most schools will provide a behavioural plan with clear expectations and reinforcement for positive behaviour. Create a

reinforcement schedule for rewarding positive behaviours and share with the teacher. Have open communication with the teacher to make sure that the delivering of the reinforcement so they may modify the reinforcement schedule.

Most teachers have strategies that will help your child succeed. They will plan ahead and place the child in the least distracting place in the classroom to limit inattention. The teacher may also incorporate physical movement into the lesson to decrease hyperactivity and distractibility. Children with ADHD may have difficulty in social situations due to impulsivity. Impulsivity may result in aggressive behaviours that may get your child into trouble in the classroom and at recess. There should be immediate consequences for aggressive behaviours and children should be reminded of what the expectations are at school and on the field. For children who are hyperactive and have difficulty sitting in their seats, their teacher may ask them to run errands or to use fidget toys in their seats. Some children with ADHD may also have difficulty following instructions. It is important when giving directions that they are broken down into small steps. Prompts given in a calm firm voice will assist ADHD children to stay on task. These are just some of the behavioural techniques teachers may use with your child. Just remember to keep open communication and share education to ensure that your son or daughter is learning to the best of their abilities.

Figure 14. Photo of parent speaking with the teacher adapted from “How Parents and Teachers Can Work Together”, by Champion Parenting, n.d.

Helping Your Child with Peer Relations
Building Social Skills

If your child is having difficulty with social skills, it is important that to work on social interactions starting in the home.

1. Start an individual token system for teaching social skills.
2. Pick one to two skills that you would like to work on. For example, sharing or speaking quietly.
3. Post the two skills that you will be working on in a location where you and your child

can frequently see it.

4. Have a discussion with your child about the goals that you’ve set and what he or she can earn by practicing the behaviours to achieve their goal.

5. Monitor your child’s behaviour during peer interactions and notice his or her skills being put to use.

6. Make sure to praise your child for desired behaviours and give rewards when they occur.

7. Make sure that you do not reward your child in front of peers if he or she is uncomfortable with this. Calling your child over to reward them may be more suitable.

8. Remember to frequently discuss and re-visit your child’s goals and encourage your child to try these skills in other settings such as school.

An additional example:

If the problem behaviour is sharing, a chaining list will be posted for the child to read through.

Step 1: Play with toy for 5 minutes.
Step 2: Once this is complete, child can ask for another person if they would like to play with the toy and gets reinforced for doing so
Step 3: Once this step is complete, child waits 5 minutes and gets reinforcement.
Step 4: Ask if he is done with the toy again then gets reinforcement.

You can do this for any behaviour you’re trying to change that the child doesn’t do yet. Just remember after each step they get reinforced if the desired behaviour occurs.

Teasing

Teasing is a very common problem in almost all ages of childhood. How your child deals with the teasing is important. While it sometimes works to ignore the teasing, this may not always work for children and sometimes causes the problem to worsen. A different approach to teasing is to teach the child laugh at him- or herself, acknowledging it in a humorous way. Teaching your child to accept some of his or her own personality quirks and reject the teasing through humor may be more effective than ignoring in decreasing the teasing.

Positive Peer Relationships in Other Settings and Home

Children with ADHD are often less popular and have difficulty making and keeping friends. Friendship develops when people show kindness to one another and share interests. It is a mutual effort. You can help your child build friendships.

1. Have your child invite a friend over after school or during the weekend. Suggest a friend who you may already know shares common interests as your child. Make sure that you do not leave playtime unstructured but instead plan ahead and have a movie or a craft planned. Make sure that you are there or close by to give prompts and supervision.
2. When the friend is with your child make sure to monitor their behaviour and activities. Make sure to keep control over the situation and be aware of any escalating issues. If an
issue does occur, interrupt their play and provide a calmer, structured activity, or change locations.

3. Make sure to model positive interactions and make every effort to minimize negative emotions or aggressiveness from you or other family members.

4. Discourage friendships with aggressive or oppositional playmates. You want to minimize how often your child is reinforced for aggressive or antisocial behaviours. Encourage friendships with children who are positive influences and good role models. Encourage your child to be accepting of others and treat everyone how they would like to be treated.

5. Try to register your child in community activities. A lot of activities in Kingston are reasonably priced and have flexible hours. Remember that children who have ADHD often have problems in larger groups so try to keep the activities to smaller populations. Try activities with less complex rules and little unstructured time. Activities that have more structure and supervision will trigger fewer emotional outbursts and will provide more opportunities to create stronger peer relations.  

Chapter V Treatment
Medication Interventions

Stimulants are the most commonly used medications to treat ADHD symptoms. Brand names of commonly used stimulant medication include; Ritalin, Adderall, Adderal XR, Concerta, Focalin and Vyvanse. The chemicals found in stimulant medication are called methylphenidate and amphetamine.

Using medication to treat ADHD is often a big concern of parents. There is a lot of misleading information regarding ADHD medication in the media including the Internet and social media. As your child’s main advocate, you need to be aware of this and seek out the best information. Regardless people who have personal views for and against medication, sound research has proven medication to be highly effective in helping ADHD in children. The best person to consult about these medications and whether they are right for your son or daughter is your family doctor. It is important that you trust and feel comfortable with your family doctor. He or she may be very experienced in treating ADHD or may be more comfortable in referring you to a pediatrician or a child psychiatrist. The doctor involved with your child’s case should be able to give you advice about the best treatment. This will include talking to you about side effects, follow-up, and answering any questions you may have. Your child’s doctor will want to be sure that you are comfortable with the treatment plan before you agree to a medication trial. It is important that you discuss your concerns and have your questions answered. Make sure to have your questions ready for the doctor ahead of time to get the most information out of the appointment and be sure to ask about anything you are unsure about.

Stimulant medication increases the control of the brain on impulsive behaviour, it preserves attention, and it improves self-regulation. The body metabolizes stimulant medications within a few hours. New technology has created medication delivery such as slow release

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capsules and, in the case of Concerta, an extended release capsule, to allow for a longer lasting effect through the child’s day. These medications are so effective that hundreds of studies have shown that stimulant medication can change ADHD children’s behaviour and learning between 70% and 90%. Some children do not respond positively to certain stimulant medications. Often a different drug is effective. Sometimes the getting the best effect requires trying different forms of the same drug, different dosages or a different drug. Medication is not enough to address all problem behaviour so sound behaviour management and behavioural interventions are important.\(^{44}\)

![Figure 15. Photo of parent speaking with the doctor adapted from “Hearing Loss Support Groups”, by G., Jacky, n.d.](http://www.speechbuddy.com/blog/hearing-loss/hearing-loss-support-groups/)

**Behavioural Interventions**

**Verbal Reinforcement**

Behavioural interventions help ADHD children display appropriate behaviours. The most common behavioural intervention is verbal reinforcement. Verbal reinforcement is to be given when your child is beginning or completing the desired task. One example of this is, “Good job starting your homework without any help!” The key to verbal reinforcement is to provide it frequently and to give it immediately after the child is doing the desired behaviour. Remember that your comments should reflect what your child has done right and what was desired. If you are consistent and sincere with your praise, the appropriate behaviour should increase and undesired behaviours will decrease.\(^{46}\)

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Visual Cues & Prompts

Children with ADHD need to be frequently reminded of rules and their goals. Providing visuals around the house will help him or her stay on track. You can use visuals for many things such as schedules that show your child’s daily schedule. You can also put reminders about bedtime hygiene in the bathroom or your child’s bedroom. Having visual schedules, pictures and prompts around the house is a neutral way to help your child remember what is expected of him.


<table>
<thead>
<tr>
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<th>Monday</th>
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<th>Wednesday</th>
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<td>Comments</td>
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</table>

Parent Signature: __________________________________________________________

Visual Prompt

Figure 17. Illustration for visual prompt retrieved from “Weekly Behaviour Notice”, by Teacher Synergy, n.d.

Figure 17. Illustration for visual cues retrieved from “Visual Support”, by TASN, n.d.

Tangible Rewards

Tangible rewards are objects that can be given (big, like going to a hockey game, or small, like stickers) to reinforce positive behaviour. Just like verbal reinforcement, tangibles must be given as immediately as possible. Privileges are also tangible rewards, for example, Ipad time. When your child picks a favourite tangible, he or she will be motivated to work for his or her reward.\(^5^2\)

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**Figure 18.** Picture of visual schedule retrieved from “Free Printable Visual Schedule”, by D. Robson, n.d.

**Figure 20.** Illustration of tangible rewards retrieved from “Class Behavioural Management”, by S. Rief, n.d.

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\(^5^1\) 2015 from [e-daily-schedule.html?m=1](http://www.andnextcomesl.com/2014/04/free-printable-daily-schedule.html?m=1)

\(^5^2\) [web log post]. Retrieved from [al-counseling-personalsocial-domain.html](http://www.elementaryschoolcounseling.org/individual-counseling-personalsocial-domain.html)

\(^5^3\) [blog post]. Retrieved from [pads/2012/09/rewards-7.jpg](http://pads/2012/09/rewards-7.jpg)
Token Economy

A token economy is a reward system that is usually a series of small rewards that eventually lead to a larger reward. These rewards are achieved once the parent and child have agreed upon a goal to work towards. Every time the child works towards that goal he or she earns a point or sticker. For example, every day the child completes his or her homework on time he or she receives a sticker to put on the sticker board. Once he or she achieves the goal five times and has received five stickers, he or she may get to have a friend over and order pizza for dinner.

Figure 20. Illustration of token economy example retrieved from “Token Economy”, by G. Cosgrave, n.d. Copyright Educate Autism, 2015.

## Seven Elements of a Token Economy
(Miltenberger, 2008)

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td><strong>Target Behaviours</strong></td>
</tr>
<tr>
<td>2</td>
<td><strong>Type of Tokens</strong></td>
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<tr>
<td>3</td>
<td><strong>Backup Reinforcers</strong></td>
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<td>4</td>
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<td><strong>Exchange Criterion</strong></td>
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<td>6</td>
<td><strong>Time/Place for Exchange</strong></td>
</tr>
<tr>
<td>7</td>
<td><strong>Response Cost</strong></td>
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</table>

* A response cost is not always used. See Cooper, Heron, and Heward (2007, p. 370)

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Figure 21. Illustration of what’s included in a token economy retrieved from “Token Economy”, by M. Miltenberger, 2008. Copyright Educate Autism, 2015.
Figure 22. Illustration of token economy cycle retrieved from “Token Economy”, by G. Cosgrave, n.d. Copyright Educate Autism, 2015.

Parent Self Care

Physical and Mental Wellness
Raising a child with ADHD can be very challenging and draining at times. These children are more demanding and require more guidance. Several studies have shown that parents of preschool aged children with ADHD have higher levels of stress, self-blame, and mental health concerns. As parents do, they put their children’s needs before their own causing themselves to be burnt out and unable to properly care for the child. This situation is a vicious cycle that helps no one.\textsuperscript{57}

![Figure 23. Picture of woman getting blamed by others retrieved from “Victim-Blaming Isn’t Just a Woman’s Issue”, by M. Gardner, 2014.](image)

Say No to Stressful Events
- Try to reduce the stress in your life by eliminating the event that is causing you stress.
- Take advantage of some quiet time and think about the times in your life when you felt stressed and then think about some of the stressors (the events that preceded the stressful response). Also, consider what about that situation caused your stress? What could the alternatives have been?
- Now, evaluate events in your life and think what could have been done or avoided to prevent the problem. Did your own actions cause the situation to worsen? Write down multiple coping mechanisms that you could utilize after the stressful events.
- After evaluating your stressful events, pick one or two and resolve the stresses for the future. If the situation is unavoidable, use one of the coping mechanisms you thought of previously. Take a minute, close your eyes and visualize the situation.
- Try and take a few minutes each day to practice the steps above.
- Once you have mastered your two stressors, move on to the next two to eliminate them. By breaking down your stress into smaller achievable goals, you will have more success and feel less stressed.\textsuperscript{59}


\textsuperscript{58} [Untitled picture of woman getting pointed it]. Retrieved December 1, 2015 from http://fromcloud.us/victim-blaming-isnt-just-womans-issue/
As parents of children with ADHD, it is crucial that you take time for yourself and replenish your mind, body and soul. If you take the additional time for yourself, you will be better equipped to handle the unexpected and have more control over your life. Most parents put themselves last but you deserve to love yourself as much as you love your child. You can do this by giving yourself a weekend away or participating in a hobby or social activity that does not involve your child. This could be a great opportunity for you to rekindle friendships with close friends which can have great therapeutic value.60


Relaxation Techniques

For many parents relaxation is something of the past and, if it does occur, it happens in front of a TV. This relaxation technique does very little in reducing stress. To relieve stress, the body’s natural relaxation response has to be activated. When our bodies are overwhelmed with stress the nervous system is overloaded with the flight or fight chemicals that wear our bodies out. It is impossible to avoid all stress, especially when raising a child with ADHD. When you activate the body’s relaxation response, your heart rate will begin to decrease, blood pressure begins to stabilize, muscles relax, breathing slows down and becomes deeper and the body finally begins to rejuvenate. Finding the right relaxation technique may take time but it is worth the investment.  

Breathing Meditation

This relaxation technique is simple and can be practiced anywhere. The focus of breathing meditation is to focus on cleansing breaths. This type of breathing incorporates deep breaths that use your abdomen rather than the upper chest. This allows the body to access more fresh oxygen that gives you a more relaxed feeling than breathing quick shallow breaths.

Figure 26. Illustration on relaxation breathing retrieved from “How to Medicate Deeply – Seven Techniques For Beginners”, by Your Inner World, 2014.

- To start, get comfortable with your posture in mind. Keep your back straight and place one hand on your stomach and the other on your chest.
- While only breathing through your nose, you should see your stomach rise. The other hand on your chest should move very little. This is to show that you are breathing deeply, though the abdomen.
- Slowly exhale through your mouth while contracting your stomach muscles. This is done to exhale as much air as possible. The other hand that rests on your stomach should move very little.
- Continue this breathing pattern, in through the nose and out through the mouth, for five minutes. If you find your pace needs to slow down, slowly count as you inhale and exhale.

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Progressive Muscle Relaxation

Muscle relaxation is a great way to relieve stress but if you have a history of injuries it is recommended that you consult your doctor before using this technique. This relaxation technique is a two-step process. Tensing and relaxing the different muscles in the body will help bring awareness to spot muscle tension that occurs naturally with stress. As you bring awareness and gain familiarity with the tension your body will begin to relax.65

Before starting, make sure you are in loose fitting clothing, take off shoes, and adjust the environment to feel comfortable. Shift all your attention to the tensed muscle and only that muscle. Begin from the bottom of your body. Right foot then left foot. Continue up to the calves until you reach the face. Squeeze the muscle for a total of 10 seconds, then relax and be mindful of the tension moving away. Stay relaxed and continue to breathe deeply and slowly. Once you are satisfied with the released tension, move on to the next muscle group. This relaxation technique will take time and practice but will be worth the benefits in the end.

Relaxation Through Yoga

Yoga is a process of stationary poses and deep breathing used to reduce stress. Yoga has the added benefit of building strength and stamina while improving flexibility and decreasing anxiety. When looking for a yoga class online or in a studio, look for one that emphasizes a slow relaxing pace to start. There are many kinds of yoga, but the traditional form is Satyananda yoga. Satyanada yoga is a series of poses that incorporate deep breathing and meditation. There are many yoga studios around Kingston that have various types of yoga. Studio 330 is a drop in yoga studio that has no set fees and has various kinds of classes and times. All classes are by donation to make yoga accessible and affordable for all. With practicing by donation, you pay what you can afford in order for 330 to teach as often as possible and provide teachers for classes. 66

Contact: 330 Princess Street Kingston Ontario
E-mail: info@studio330.ca
For schedules please check out www.studio330.ca/schedule


Kingston Resource Guide

Food

Good Food Box – 400 Elliot Ave, Kingston
E-mail: goodfoodbox@nkchc.kchc.ca
Contact: Mary Wood
Hours: Monday – Friday 9 am – 4:30 pm
Eligibly & Application: Call and leave a message with personal contact information
Fees: Service depending

Martha’s Table - 629 Princess Street, Kingston
Tel: 613-546-0320
E-mail: marthstable@bellnet.ca
Contact: Ronda Candy
Hours: Monday – Friday 9am-6pm
Meal Service: Monday – Friday 3:30pm – 5:15pm
Eligibly & Application: Drop in during meal service hours
Fees: $1 per meal $0 for children under age 10 and accompanied by an adult

Partners in Mission Food Bank – 140 Hickson Ave, Kingston
Tel: 613-544-4534
E-mail: foodbank@kingston.net
Contact: Sandy Singers
Hours Monday – Friday 8:30am-12pm and 1pm -4pm
Pickup Hours: Monday – Friday 2pm – 4pm
Eligibly & Application: based upon shelter costs, income and assistance provided once a month
about 3-5 days worth of food
Fees: none

Shelter

Ryandale Shelter for the Homeless – 23 Elm St. Kingston
Tel: 613-548-8466
Email: ryandale@istar.ca, ryandaleshelter@cogeco.net
Contact: Terrie Fleming or Connie Schwartz
Office Hours: Monday – Friday 9am – 5pm
Shelter Hours: Monday – Sunday 4pm – 8am

Description: Over night accommodations to adult men, woman and children in emergency situations Eligibility & Application: all adults 18+ or families in housing crisis. Self-referral or referral from social services
Fees: none

Salvation Army – Kingston Harbor Lights -562 Princess Kingston
Tel: 613-546-2333
Email: Kingharb@kingstonharbourlight.org or larry_montgomery@can.salvationarmy.org
Contact: Larry Montgomery or Keith Warford
Office Hours: 8am – 4pm
Intake Hours: 4pm – 11pm
Church Hours: 24 H
Description: 8 bed emergency shelter accessible for a total of 5 days. Counseling, hot meals, showers and laundry facilities are available. The center also is an addiction treatment facility, so in order to stay, individuals must sustain from using drugs.
Eligibility & Application: Men 18+, must come in person at 4pm each day to see if beds are still available. Addiction treatment applications must be made though the director with the required assessment and interview.
Fees: none

Elizabeth Fry Society of Kingston – 127 Charles St, Kingston
Tel: 613-544-1744 (24 H)
E-mail: info@efrykingston.ca
Contact: Trish Crawford
Hours Monday – Friday 8:30am – 4:30pm
Service: Woman’s Correctional Support services with a variety of services such as law & counseling. Direct services: substance abuse and relapse prevention services.
Eligibility & Application: for women who have / are at risk of conflict with the law. Must call for immediate help and e-mail for less urgent help.
Fees: none

Counseling Services

K3C Community Counseling Centers
Address: Unison Place, 417 Bagot St, Kingston
Tel: 613-544-8138
E-mail: kcc@k3c.org
Hours: Monday & Thursday 8 am – 8 pm
Tuesday & Wednesday 3:30 am – 5 pm
Friday 8:30 – 4 pm
Description: offers individual counseling services or specific services such as family, youth, woman counseling. Employee assistance programs are also offered along with other services.
Eligibility & application: Call and make an appointment
Fees: assistance available some fees may apply
Kingston Pregnancy Care Centre
Address: 120 Clarence St Suite 231, Kingston
Tel Client Line: 613-545-0425
Tel Admin Line: 613-545-9407
Email: infor@kingsotnpcc.com
Hours: Monfay 10 am – 6 pm
       Tuesday, Thursday & Friday 10 am – 4 pm
       Wednesday Closed
Description: Pregnancy related services, counseling and support
Fee: none

Telehealth Ontario
Tel: 1866-797-000 (24 H)
Hours: phone line open 24 H Monday – Friday
Description: talk to a registered nurse for general health information or advice
Eligibility and Application: Call any time
Fees: none

**Hospital Services**

Kingston General Hospital – Emergency Services
Address: 76 Stuart St, Kingston
Crisis Tel: 613-548-2333
Hours: 24/7
Description: Urgent care and emergency psychiatric services. Have valid OHIP Card
Fee: none

Hotel Dieu Hospital – Urgent Care Centre
Address: 166 Brock St, Kingston
Crisis Tel: 613-546-1240
Tel: 613-544-3310
Hours: 8 am – 10 pm daily
Referral: Drop in triage and have valid OHIP Card
Fee: none
Community Mental Health and Outpatient Services

Providence Care: Mental Health Services – Outpatient Clinics: Mood Disorders Research & Treatment
Address: 752 King St., West, Kingston
Tel: 613-548-5567 Ext 1166 or 1275
Email: Sheaa@provicencecare.ca
Description: services for adults with major mental health concerns like major depression and bipolar disorders. Services available are psychiatry, social work, CBT (cognitive behavioural therapy), ECT (Electroconvulsive therapy), & TMS (transracial magnetic stimulation).
Eligibility & Referral: 18+ with mood disorder. Family physicians, mental health agencies, and psychiatrists.
Fees: None with OHIP coverage

Hotel Dieu Hospital – Mental Health Program: Anxiety Disorder Clinic
Address: Johnson 5, 166 brock St., Kingston
Tel: 613-544-3400 Ext 3552
E-mail: roym@hdh.kari.net (Monique Dacosta)
Hours – Monday – Friday 8 am – 4 pm
Description – offers assessment, treatment and support to adults 18+ struggling with anxiety.
Referral & Application: physician referral

Frontenac Community Mental Health & Addiction Services (FCMHAS) – Crisis Services
Address: 385 Princess St., Kingston
Crisis Tel: 613-544-4229 (24/7)
Toll-Free Crisis Tel: 1866-616-6005
Contact: Rob Yeo
Walk-in Services: Monday – Friday 8:30 am – 4:30 pm
Description: Crisis support and intervention to anyone in need. Offers referrals and can respond to caller in home if needed.
Eligibility: anyone who is having a mental health or addictions crisis or referring someone who is in crisis.
Referral & Application: call or drop in
Fees: none

Mental Health Organizations

Providence Care: Mental Health Services – Outpatient Mental Health: Westwood School
Address: 752 King St., West Kingston  
Tel: 613-546-1101 ext. 5449  
Hours: September – June (four and a half days a week)  
Description – educational programs for students with mental health concerns. With learning programs tailored to their specific way of learning. Additional support is offered from the Limestone District School Board.  
Eligibility: Students and clients of Providence care mental health services  
Referral / Application: By doctor or caseworker  
Fees: none

Bereaved Families of Ontario – Kingston Region  
Address: 435 Davis Dr. Kingston (Gordon F. Tompkins Funeral Home – Township Chapel)  
Tel: 613-634-1230  
E-mail: bfo@kingsotn.net  
Contact: Davis Cupido  
Hours: Must book appointment  
Description: services to those who are experiencing grief after the death of a loved one.  
Eligibility: anyone suffering from listed above  
Referral / Application: call and arrange meeting  
Fees: None

KFL&A Public Health  
Address: 221 Portsmouth Ave, Kingston  
Tel: 613-549-1232  
Contact: Charles Simonds  
Hours: Monday – Friday 8:30 am – 4:30 pm  
Description: Variety of services for public health and information on other resources in the Kingston Community.  
Eligibility: Children and Adults  
Referral / Application: registration needed some services  
Fees: some fees may apply depending on program

Patient Rights and Legal Services

Kingston Community Legal Clinic  
Address: 345 Bagot St., Kingston  
Tel: 613-541-0777  
Contact: John Ross Done  
Hours: Monday – Thursday 8:30 am – 4:30 pm  
Friday 1 pm – 4:30 pm  
Description: Providing legal services to people who are struggling financially due to low income. The services provided are; housing, income support, human rights, health, employment and education.  
Eligibility: Must meet financial guidelines
Fees: None, but will be asked to provide medical reports which may cost money to obtain from other organizations or medical professionals.

Legal Aid Ontario
Address: 507 princess St., Kingston
Tel: 613-546 1179
Contact: Peter Radley
Hours: Monday – Friday 8:30 am – 4 pm
Description: aid is given for serious cases such as criminal cases and family court. Legal Aid can provide testing for financial assistance for those in the Kingston area.
Eligibility / Referral: based on financial assessment, by appointment or business hours.

Psychiatric Patient Advocate Office
Address: 752 King St. W., Kingston
Tel: 613-548-5575
E-mail: www.ppa.gov.on.ca
Hours: Monday – Friday 8:30 am – 4:30 pm
Description: provides independent, confidential advocacy services to patients and past patients of Providence Care. Addresses any concerns that the client may have in regards to rights and entitlements.
Eligibility / Referral: biased upon financial assessment, book appointment during business hours.

Developmental Disabilities

Ontario Ministry of Community and Social Services – Kingston
Address: 362 Montreal St., Kingston
Tel: 613-546-2695
Hours: Monday – Friday 8:30 am – 4:30 pm
Description: programs run for social assistance, community development disability services, and child and spousal support.
Eligibility / Referral: varies service to service, must contact for further information.
Fees: None

Ongwanada
Address: 191 Portsmouth Ave., Kingston
Tel: 613-548-4417
E-mail: info@ongwanada.com
Description: support of individuals with developmental disabilities, for family members and information on other community supports.
Eligibility / referral: must have a developmental disability, be a family member of the person with the disability, or work with the person with the disability. Referrals accepted by any of the individuals listed above.

Queens Family Health Team – Developmental Disabilities Health Check Program
Address: 220 Bagot St., Kingston
Tel: 613-533-9303  
E-mail: info@qfht.ca  
Hours: Monday – Friday 8:30 am – 4:30 pm  
Description: health checks for patients with intellectual disabilities  
Eligibility / Referral: all ages accepted. No referrals needed  
Fees: None with OHIP card.

**Children and Adolescent Services**

**Extend- A- Family**  
Address: 361 Montreal St., Kingston  
Tel: 613-544-9569  
E-mail: maria@eafkingson.com  
Hours: Monday – Friday 8:30 am – 4:00 pm  
Description: registered charity program for those with disabilities and families with access services and or respite.  
Eligibility / Referral: people with developmental disability. Contact agency for referral.  
Fees: fees for most programs.

**Community Living Ontario**  
Address: 1412 Princess St., Kingston  
Tel: 613-546-6613  
E-mail: Psproul@kdacl.on.ca  
Hours: Monday – Friday 8:30 am – 4:30 pm  
Description: support individuals and families with developmental disabilities.  
Eligibility / Referral: for children under the age of 18. Call or e-mail to make a referral.

**Hotel Dieu Hospital – Child Development Centre**  
Address: 166 Brock St., Kingston  
Tel: 613-544-3400 ext. 3175  
E-mail: web@kingstondec.ca  
Hours: Monday – Friday 8 am – 4:30 pm  
Description: Services for children with developmental, neurological or physical disabilities. Programs include programs for infants upwards to age 18. Program list: Acquired brain injury, preschool team and school age team.  
Eligibility / Referral: infancy to 18 years. Physician referral for most programs.  
Fees: none

For more information on Mental Health Resources for Kingston and surrounding areas please visit  

Glossary

ADHD – shortened term for Attention Deficit Hyperactivity Disorder.

Advocacy – speaking on someone’s behalf.

Anxiety – the feelings or nervousness or concern that happens during an event such as putting on a presentation or when an event has an uncertain outcome such as going to a new place.

Conduct Disorder – a disorder that characterized by antisocial behaviours that often show in late adolescence.

Depression – is a mental health condition that brings on emotional feelings of self doubt, guilt, and low mood. Depression often causes a decline in energy.

Diagnosis – medical identification of an illness based on symptoms.

Dopamine - a neurotransmitter in the body that is responsible for passing on signals between cells.

Endocrine System – the endocrine system is made up of glands that secrete hormones that help regulate the circulatory system that carries hormones to the targeted organs.

Fixed Interval – positive or negative reinforcement given once a certain amount of time has passed. Example is a weekly paycheck.

Fixed Ratio – positive or negative reinforcement given once a certain amount number of responses have occurred. Example is child finishes three math questions.

Fixed Variable - positive or negative reinforcement given after an average number of responses. Example is reinforcement after 2 to 5 math questions.

Frontal Lobe – A lobe of the brain, located behind the forehead, that is responsible for regulating behaviours, personality, learning, and voluntary movement.

Generalized Anxiety Disorder – showing excessive anxiety over multiple aspects of life that results in impairment of functioning.

Hyperactivity – excessive movement. Movement may result in symptoms such high levels of physical activity, fidgeting nervousness, or excessive talking. These symptoms vary among individuals.
**Inattention** – difficulty sustaining attention

**Impulsivity** – often referred to as acting before thinking. A person who is impulsive tends to behave with little thought of consequences.

**Metabolize** – The chemical processes that occur within a living organism in order to maintain life (this is from the Oxford English dictionary)

**Negative Reinforcement** – when an unpleasant event occurs and then ceases. Removing the unpleasant experience will increase the possibility of the behaviour happening in the future. Example Cole put carrots on Jessica’s plate, Jessica screams, Cole takes away the carrots, Jessica is more likely to scream if carrots are put on her plate again.

**Neurodevelopmental Disorders** – Impairments of the brain or the central nervous system that affect development and growth. These disorders affect the brain’s ability to properly function and may cause learning disabilities, poor self-regulation of emotions and self-control.

**Obsessive-Compulsive Disorder** – having obsessive thoughts and compulsions about completing a task or achieving a certain feeling

**Ostracize** – to exclude someone from a group or a part of society.

**Phobia** – having an irrational fear of something

**Positive Reinforcement** - Rewarding someone following a desired behaviour. Example Cole does his homework, Jessica rewards him with a treat for his efforts.

**Psycho Education** – is education that makes reference to mental health and the impact on the family. It is education that informs and empowers people to deal with mental health in a positive way.

**Reinforcement Schedule** – the frequency a reinforcement is given for targeted behaviour or response.

**Regulate** – controlling or maintaining behaviours or emotions.

**Separation Anxiety** – anxiety about being separated from something or someone of comfort

**Serotonin** – is a neurotransmitter found in blood platelets and serum that is responsible for regulating mood. Insufficient levels of serotonin can cause depression.

**Stimulants** – are a class of psychoactive drug. They temporarily alter and improve mental and physical functioning.
**Stigma** – often associated with mental health. Stigma is shaming someone for their particular circumstance.

**Self-Regulate** – is monitoring oneself without external controls.

**Self-Restraint** – self control

**Token economy** – is a behavioural system that is devised to increase behaviours by providing reinforcers or tokens that can be exchanged for larger or more concrete reinforcers. A token should be given immediately after the behaviour occurs.

**Transitional Warnings** – warnings that keep someone informed that the situation will change. Instead of changing events or activities quickly this gives individuals a warning and preparation for a transition.
## Appendix D
### Manual Feedback Form Raw Data

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<tr>
<td>Disagree (2)</td>
<td>D</td>
</tr>
<tr>
<td>Strongly Disagree (1)</td>
<td>SD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scale 4</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Personalized Answers</td>
<td>All Personalized Answers</td>
</tr>
<tr>
<td>Participants</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Scale 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Question 1a “I found “Preschool ADHD Success” was easy to read and understand</td>
<td>A</td>
</tr>
<tr>
<td>Question 2a “I found “Preschool ADHD Success” was organized and flowed</td>
<td>A</td>
</tr>
<tr>
<td>Question 3a “I found that “Preschool ADHD Success” was visually appealing</td>
<td>SA</td>
</tr>
<tr>
<td>Question 4a “I would feel comfortable giving a copy of “Preschool ADHD Success” to a client</td>
<td>A</td>
</tr>
</tbody>
</table>
### Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scale 3</strong></td>
<td></td>
</tr>
<tr>
<td>Question 1b “The information in section 1 would be helpful to the child’s guardian or agency.”</td>
<td>A A A SA A</td>
</tr>
<tr>
<td>Question 2b “The information in section 2 would be helpful to the child’s guardian or agency.”</td>
<td>A A A SA A</td>
</tr>
<tr>
<td>Question 3b “The information in section 3 would be helpful to the child’s guardian or agency.”</td>
<td>A A A SA SA</td>
</tr>
<tr>
<td>Question 4b “The information in section 4 would be helpful to the child’s guardian or agency”</td>
<td>A A A SA A</td>
</tr>
<tr>
<td>Question 5b “The information in section 5 would be helpful to the child’s guardian or agency.”</td>
<td>A A A A A</td>
</tr>
</tbody>
</table>

### Scale 4

<table>
<thead>
<tr>
<th>Questions</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Question 1c</strong></td>
<td>CAS, CLK, OEYC.</td>
</tr>
</tbody>
</table>
### Question 2c

**General feedback:**

<table>
<thead>
<tr>
<th>Nice coloured pictures, focus on the positive and interventions, addresses the idea of stigma and parent self-care.</th>
<th>The information guide was detailed, it was “wordy” and may be difficult for some parents to follow due to literacy skills and also ADD/ADHD diagnosis for themselves. I would cause about distributing this to parents without taking into consideration the above barriers.</th>
<th>I can see you have put a lot of thought and hard work into the manual! The manual is visually appealing, lots of colored pictures, not too much on one page. The information is great and very detailed however I worry that it could be difficult to read for some of the parent who have weak literacy skills. Sometimes less is more. Be careful of some of the wording like “problems and punishment”. Try to use works like difficulties or struggles or consequences”. I love that this manual focus on the positives</th>
<th>Hi jess, I can tell you have put a lot of work into this manual! Good Job! Just a few things for you to think about / consider. 1. P 24. Not sure if it is measurable to give transitional warnings days ahead – this is a lot for a preschooler to keep in their head and they have limited understanding of time. P 25. Word “punishing” – should be consequence. P 27 not sure about making a reinforcing schedule for the teacher – most teachers have their own plans and might not</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not sure if this highlights preschool ADHD – it seems to be ADHD general. I was a bit confused—maybe things have changed. Is it ADD + ADHD … ADD being just attention issues + ADHD being combined attention / hyper activity. Does this need to be distinguished? Scientific info may stop them from continuing to real though? Love the pictures. Love the resource guide. Love the glossary. I am a huge advocate for medication, however, not sure if they are</td>
</tr>
</tbody>
</table>
and covers self care as we all know this is so important. You have done an excellent job and can’t wait for the final copy.

want to implement yours? P.17 example seems to be designed for older kids. Some of the other token examples might be too complex for the preschool level. A few resources missed: Food – Salvation Army has a food bank & St. Vincent De Pal has an emergency food bank. Shelters – In From The Cold (Home Based Housing).

used often for preschoolers, in fact pressure sure they’re not, unless children are “extreme”. Please make it less “wordy and easier to read”.
Appendix E

Tables of Participant Results

Table 2: Frequency of participants quality of engagement on answering questions on the Preschool ADHD Success manual.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at All</th>
<th>Not Really</th>
<th>Undecided</th>
<th>Somewhat</th>
<th>All of it</th>
</tr>
</thead>
<tbody>
<tr>
<td>I read all of Educating the Family on ADHD (section 1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>I read all of Being an Informed Active Parent (section 2)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>I read all of Fighting Against Stigma (section 3)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>I read all of Coping With the New Diagnosis Day to Day (section 4)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>I read all of Treatment (section 5)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 3: Participants Ease of Reading Preschool ADHD Success manual.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I found <em>Preschool ADHD Success</em> was easy to read and understand.</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>I found <em>Preschool ADHD Success</em> was organized and flowed.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>I found that <em>Preschool ADHD Success</em> was visually appealing.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>
I would feel comfortable giving a copy of *Preschool ADHD Success* to a client.

<table>
<thead>
<tr>
<th>骡</th>
<th>辣</th>
<th>辣</th>
<th>辣</th>
<th>辣</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

*Table 4: Participants Thoughts on the Helpfulness of the Manual*

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The information in section 1 would be helpful to the child’s guardian or agency.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>The information in section 2 would be helpful to the child’s guardian or agency.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>The information in section 3 would be helpful to the child’s guardian or agency.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>The information in section 4 would be helpful to the child’s guardian or agency.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>The information in section 5 would be helpful to the child’s guardian or agency.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

*Table 4: Comments of participants personalize answers to questions on the Preschool ADHD Success manual.*

<table>
<thead>
<tr>
<th>Question</th>
<th>Participant A</th>
<th>Participant B</th>
<th>Participant C</th>
<th>Participant D</th>
<th>Participant E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you think that this parent manual would be beneficial at other agencies and if so what ones?</td>
<td>CAS, CLK, OEYC.</td>
<td>Limestone District School Board &amp; Ontario Early Years Centre.</td>
<td>Better Beginnings, Ontario Early Years, School Board.</td>
<td>N/A</td>
<td>CDC – Better Beginnings, School, Medical Doctors, Health Clinics.</td>
</tr>
</tbody>
</table>
### General feedback:

- Nice colored pictures, focus on the positive and interventions, addresses the idea of stigma and parent self-care.

- The information guide was detailed, it was “wordy” and may be difficult for some parents to follow due to literacy skills and also ADD/ADHD diagnosis for themselves. I would cause about distributing this to parents without taking into consideration: the above barriers.

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- Love the pictures. Love the resource guide. Love the glossary. I am a huge advocate for medication, however, not sure if they are used often for preschoolers, in fact pressure sure they’re not, unless children are “extreme”.

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