IPT-ADHD: a new option

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- Why combine interpersonal psychotherapy with an attention deficit hyperactivity disorder?

Attention deficit syndrome, especially combined with symptoms of hyperactivity, has as a consequence, heightened suffering for the patient as well as for their family and the friendship circle. They all follow a painful relationship, which encompasses more than the classical description of attention deficit and behavioural troubles. Affective disorders are often described as aggravating cognitive symptoms, making the affective symptoms worse which maintains a viscous circle within these two dimensions.

The aim of IPT, working on affective and relationship disorders, is to break this viscous circle by acting on mood and relationship quality to enable the patient to focus on his attention and behaviour.

- What is IPT?

Interpersonal Psychotherapy is a brief, well-structured codified therapy for depressive disorders and their consequences on dysfunctioning relationships.

Repercussions and causes of the depressive mood disorder are implicated in a vicious circle in which the IPT will penetrate through active work centred around the relationships (quality and number) as well as other psycho-education.

- What is ADHD?

Attention Deficit Hyperactivity Disorder is a mixed syndrome of inattentiveness, hyperactivity and impulsiveness. It often begins as early as age 5, and is diagnosable upon entering school due to the change in rhythm and background.

Inattentiveness: the patient has a (sometimes very) short attention span, and can be easily distracted by his surroundings, cannot differentiate between stimuli and doesn't differentiate between important or unimportant information, makes careless mistakes, has great difficulty in organising tasks, frequently changes activities or tasks, is unable to listen or deal with instructions, loses things or seems to be forgetful. These symptoms are sensitive to tiredness and to mood. Therefore there are various difficulties in learning and often associated with dyslexia, dyspraxia, dyscalculia, dysorthographia... that influence self-esteem.

Hyperactivity: they have the appearance of being in constant (perpetual) motion, with the inability to sit still, to keep quiet or to stay calm in quiet surroundings, that increases with tiredness (in the evening), excessive talking and arguing, talking on top of others, interrupting conversations, fidgeting, unable to concentrate on their tasks or waiting their turn, doing and acting without thinking or sensing danger, learning from consequences of their behaviour, causing other members in the relationship circle to feel uncared for or not taking care of others and therefore making them feel irritated.

Impulsiveness: this is a kind of explosive behaviour, with exaggerated reactions especially to frustrations, opposition (shooting from the hip), a high level of sensitivity increasing to mood changes, seeking sensations or feelings by acting without regard for danger, especially when frustrated, fits of temper which lead to angry outbursts with imperious expectations, verbal or physical aggression or violence, that lead to *circle* tiring and rejection. Their quest for attention and affection isn't satisfied thus leading to a new fit of hysterics.

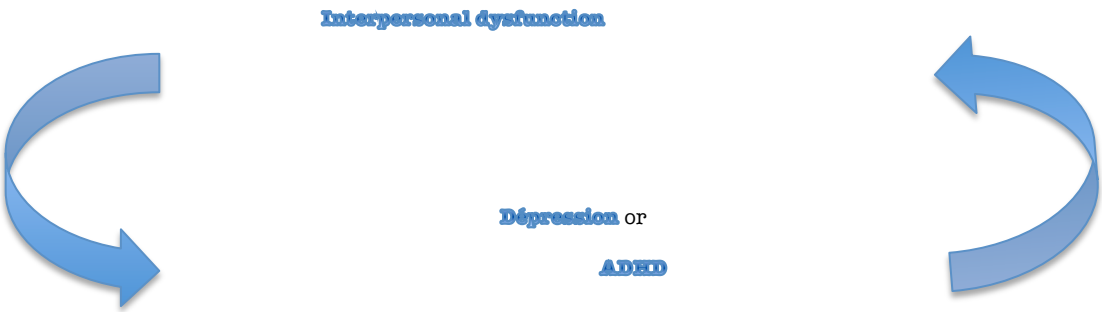
Now we can easily see the links between ADHD and its consequences on mood and relationships that we can work on with IPT.

- How IPT could interfere with ADHD?

As we have seen, ADHD can create depressive states, relationship losses and in the same way, depression and isolation are going to aggravate the symptoms of ADHD. There is no question of cure itself for ADHD by IPT. It exists as a specific or not medicinal treatment in addition to some other counselling and time strategies. IPT can act on these symptoms' consequences, as the increase of conflicts, some failures' causes, patient or acquaintance circle suffering, particularly family and its' feelings of powerlessness or the feeling of bad towards the child, and their loss of self-confidence. Therapy is based on psycho education, on research work carried out by supporting friends and the capacity to manage conflicts and the reduction of real or unreal isolation.

The founding principle of IPT has as a base reflection :

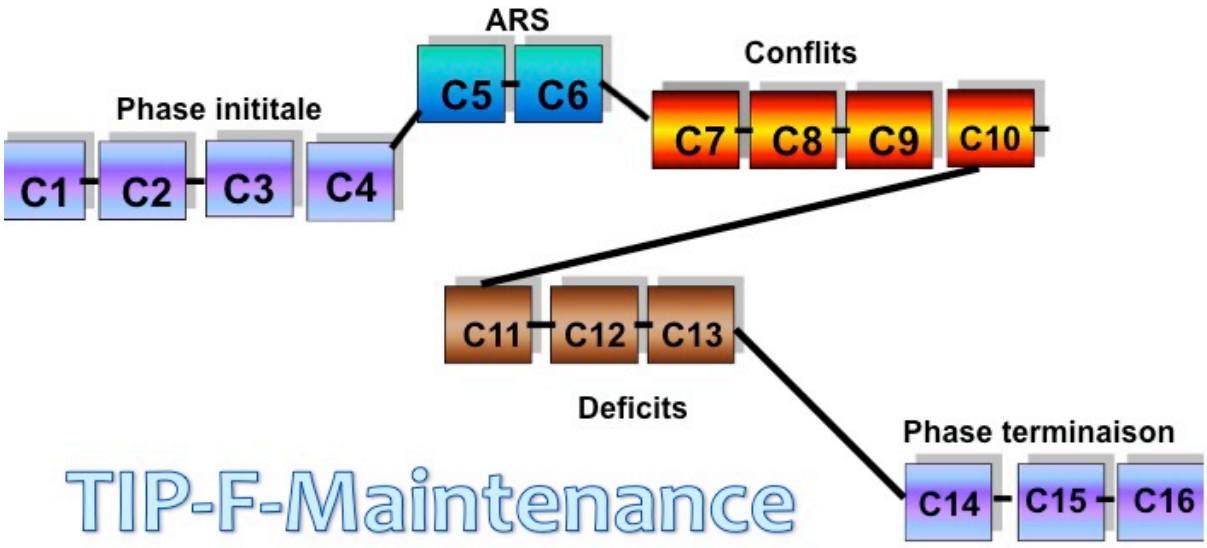
(Plan 1 : between interpersonal dysfunctions and dépression and/or ADHD)



- Organization of IPT-ADHD

> Classical » IPT takes 12 sessions. In the case of the IPT-ADHD, the initial evaluation phase as well as the patient and circles' psychoeducation requires more time. We have found that in the version adapted to long-term diseases, particularly bipolar disorders as in the IPSRT, some characteristics are near the IPT-ADHD in the therapy design. As for the question of rhythms managing for tiredness, mood and the emotional capacity to manage behavior, a suggestion is hereby shown on the following design :

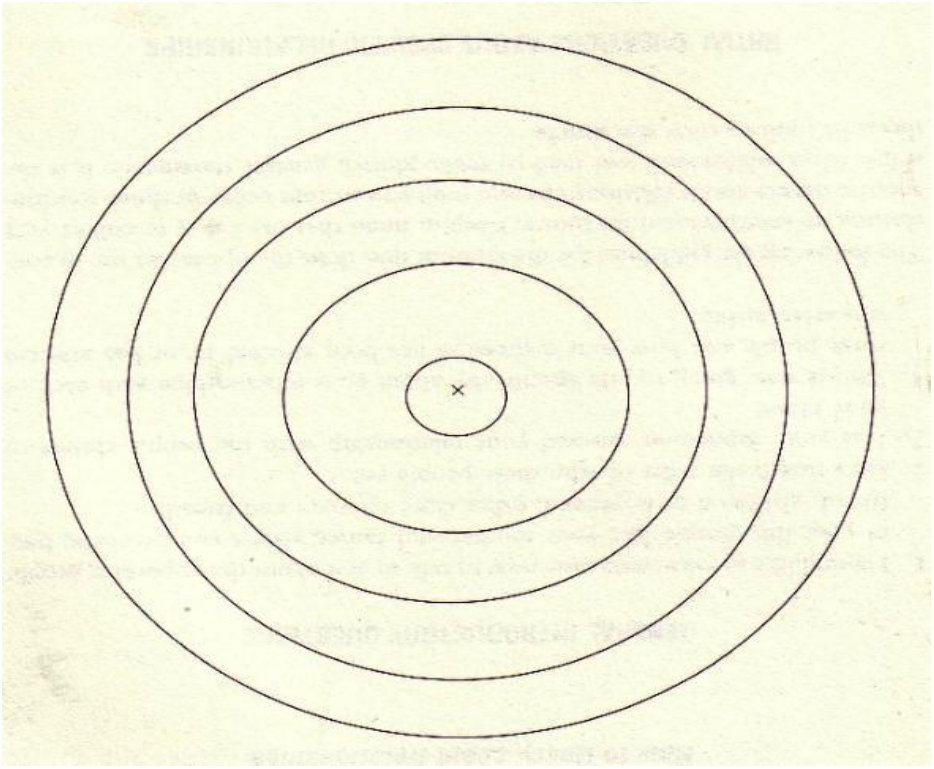
(Plan 2 : C1 to C16 with the initial , conflicts, deficit and ending phases)



> Initial phase : - diagnostic time to confirm ADHD, collection of neuropsychological tests results, the Connors scale (for family and school), information on what has already been done, in particular specific advices or councils, what treatment has been tried or set up, the story of the desease, the associated « dys », the current consequences.

- previous medical history : another member of the family presenting symptoms of the same king, recognized as such or not ;
- the relationship circle (named copinogramme in French for the teenagers), the circle of closeness for the child and the family, the interpersonal inventory which gives precious information as to the state of the intra and axtra family relationships as well as the level of isolation, and surrounding supports, the capacity of using relational strategies and a visualization of the troubles' real social consequences.

(Plan 3 : copinogramme, family, school or other links)

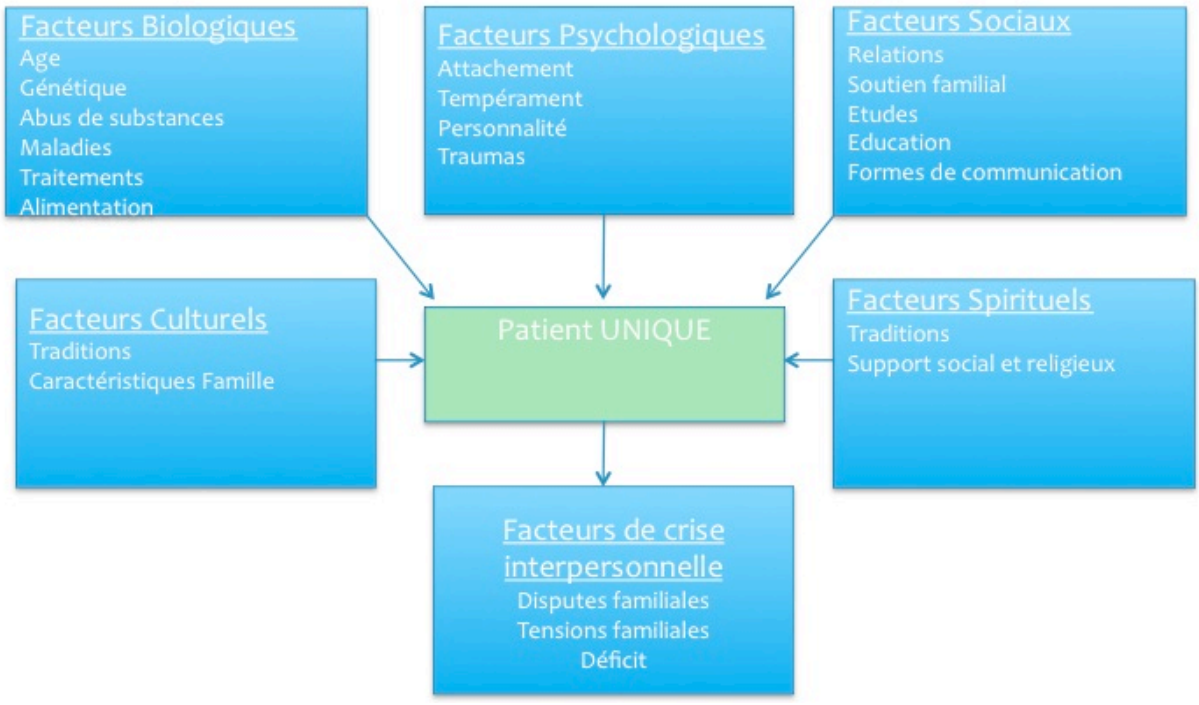


- Psychoeducation : after the explanation and having given information on ADHD, having given current knowledge on the subject, define the sick role, where necessary the need to explain what we can hope to expect or not, what we can require or not from the patient, and on the other hand, what he or she can hope to achieve. How he or she will manage the rhythm in life, in particular the influence of tiredness on the symptoms : attentional, behavioral, and on mood (we can use various supports such as Social Rhythm Metrics 5) ; advise on time management (by using a time-timer for example) to define the acceptable limits of continuous working duration with planned breaks, punctuating these periods ;

(Plan 4 : rhythms helpers or not)

- Mood evaluation : begin to introduce the Socratic link between mood and event, and event and mood, as well as placing interpersonal relationship as a cause or a way of emotional management ;
- Define problem area : in fact, it is almost systematically bi situational, which occurs between conflits and isolation. It si often interesting to manage both problems even if in classical IPT, we usually only choose one between 4 usual themes.
- Make an interpersonal proposition (by a specific formulation) to introduce a working agreement.

(Plan 5 : board of formulation IP)



IPT is centered not only around the child or the teenager (or even an adult) but equally around the familiy (siblings are welcome) or close circle of acquaintances, given the gravity of impact upon these close circle. Problems (conflicts and isolation) are clarified and we ask for work conflirmation which can be carried out together by stating the frequency and number of sessions.

> Intermediate phase :
- first focused on the conflicts and the learning of efficent relationship management . The objectives are to calm the relationships, to find support, to improve some self-confidence, and working on expectations and the bias of communication.
Expectations must be realistic and reachable ("I don't want my son to be hyperactive" cannot be taken into account due to the reality of the disease) and understandable, we'll try to improve communication using non-violent communication technics such as Feeling-Need-Demand. The expectations will be adapted for those difficult situations. The learning of the research of the others' feeling or mood to evaluate the communication mode is also necessary after a so long conflict or unsatisfying time of relationships.
This takes into account the characteristics of the trouble as irritability, impulsiveness, unflexibility, and restlessness. We then use the usual IPT techniques as clarification, communication analysis, role play (especially reversed role play). The debriefing after the trial at home or at school is of course to be given the next session.

- secondarily, centred on the deficits, and we first differentiate the difficulty for making new relationships, and the difficulty in kepping them, which is the most frequent.
Getting back to the basics with communication, going over social aspects (practicing sports, meeting friends, ...)and working on maintaining motivation. The difficulties is managing Pittbull syndrome (context, learn to postpone requirement, reintroduce communication techniques, use of relaxation) through the usual Socratic work.

> Phase of termination : the work shift towards separation while allowing the patient and his family to consider themselves capable of managing events, of being competent and not having the feeling of powerlessness that they felt before. We can therefore see the psychoeducationals elements and what ADHD still remains, the interest in Socratic links between mood and relation, and the situational risk reminders and effective use of strategies. The objective of this last phase is to allow separation by reducing fear by confirming the positive experiences and to emphasize the positive results, psychoeducation about ADHD and rhythms, communication, mark and remind of the supports.

All in all : ADHD is a common disorder, 3 to 5 %. Up to 65 % of adult patients still suffer from the disorder. Moreover, near half patients with ADHD have a bipolar comorbidity. Links between ADHD, mood disorders and difficulties with relationships are complex and underestimated.
It is very obvious that the IPT objective in the care of the ADHD is not to act on the hard core of the disorder (there is other strategies which are targetted towards it or on the comorbidity (the « dys ») but to work on the emotional and relational consequences through working on conflicts and secondary isolation. This work design, which we have been using for a few years now, might interest practitioners who treat this particular type of pathology. We would be interested in developping it or even to define a manual for its particitants, in order that other teams can, too share the same type of experience.

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