by Michelle Ferrer, PhD

IT IS MY TENTH MONTH as a clinical psychology fellow in a busy, publicly funded metropolitan hospital. I look over my intake referral for the week, and similar to many referrals I have gotten thus far during my internship, I am being asked to assess a child's inattentive and noncompliant behavior. Many referrals are made by teachers, caregivers, pediatricians, or other providers; often they are looking for answers as to why a child is not getting along with others, not following directions, or not completing tasks.

Let's imagine a typical (yet imaginary) case for a young boy named Sebastian referred to our clinic by his third-grade teacher. The teacher notes that Sebastian does not listen in class, leaves the room without asking, and has threatened other students with violence. The teacher believes he might have ADHD, and hopes therapeutic services may help change some of these behaviors.

SHUTTERSTOCK/LUCKY TIME STUDIO

Now let's imagine that when I meet with the family for an intake to better understand Sebastian's symptoms, I learn he has been exposed to community violence in his neighborhood. He witnessed a shooting and has nightmares related to this experience. I also learn his mother and father often engage in heated arguments, sometimes resulting in pushing and shoving. This new information might change my understanding of Sebastian's behaviors. Given the challenging exposures he has been through, I might start to consider the effects of trauma on his behavior, potentially leading to a diagnosis of post-traumatic stress disorder.

I still need to keep in mind that children can present with both ADHD and PTSD, however. Thus, it becomes important for me to understand if Sebastian's behaviors are related to a diagnosis of ADHD, PTSD, or both. Herein lies the complex predicament I find myself in as a clinical psychology trainee evaluating symptoms reflective of inattention, hyperactivity, and trauma.

Overlap and differences

As a healthcare provider, it is important for me to consider the overlap of symptoms, as well as the defining differences, when considering if a child has PTSD and/or ADHD. As you can see in the Venn diagram, many of Sebastian's presenting concerns can be found in the intersection of both diagnoses. There are several overlapping symptoms between PTSD and ADHD, including concerns with executive functioning and restlessness. There also are some defining differences, such as intrusive memories and flashbacks.

Comorbidity estimates among ADHD and PTSD range from roughly 12% to 37% across the lifespan. However, sometimes a child with PTSD will be incorrectly perceived as experiencing ADHD. Indeed, research suggests that early adverse experiences can cause structural and chemical changes in the brain, and these changes can potentially lead children who have been through traumatic experiences to exhibit behaviors that may look like ADHD.

Given the comorbidity and similarities of ADHD and PTSD, when a child is exhibiting these features, it is important for providers to understand this child's behaviors within his/her unique context. Below are some strategies for doing just that. Having an understanding of these strategies can help caregivers and teachers know what to expect when consulting with a provider to get children with suspected ADHD and/or PTSD the help they need.

Look closely at behavior

Through my clinical training, I have learned that children often show their emotions through behavior. Although a child's behavior may appear random and "out of the blue," behavior has meaning. To uncover this meaning, healthcare providers must dig a little deeper and do some good old-fashioned detective work. Related to our imaginary referral case described above, I would wonder if Sebastian generally leaves the room when he is startled by a loud noise, for example, suggesting that this behavior might be related to a trauma response. Alternatively, if he leaves the room when he is required to sustain attention for a long time, such as a quiet seated activity, this may be more reflective of an organic attention deficit.

Next, I would want to ask, what happens after Sebastian conducts the behavior? Does his mother come to pick him up and help him feel safe, which often happens when children experience trauma? Does he get out of the activity he does not want to attend to, which often reinforces unwanted behavior in children with ADHD? Once I begin to better understand the needs Sebastian's behavior is satisfying, I can better understand what may be causing or reinforcing the behavior. This may help to prevent future challenging behaviors and will in turn assist children in feeling justifiably understood.

Explore thoughts and feelings

It is important for healthcare providers to understand patterns in Sebastian's thoughts and emotions connected to his behavior. For example, children who present with PTSD-related symptoms often have persistent thoughts and feelings related to fear, safety, and loss. Children with ADHD often have thoughts and feelings related to motivation, such as feeling overwhelmed by tasks and thus not wanting even to get started.

To best appreciate Sebastian's experience from his point of view, it would be best for him to express personal thoughts and feelings to a provider without punishment or judgement. For example, if Sebastian informs his therapist he cannot finish his work because he is afraid of the other students in his class, his therapist may begin to consider the effects of his trauma on his school performance. Understanding how Sebastian thinks and feels is essential to putting his behaviors in context.

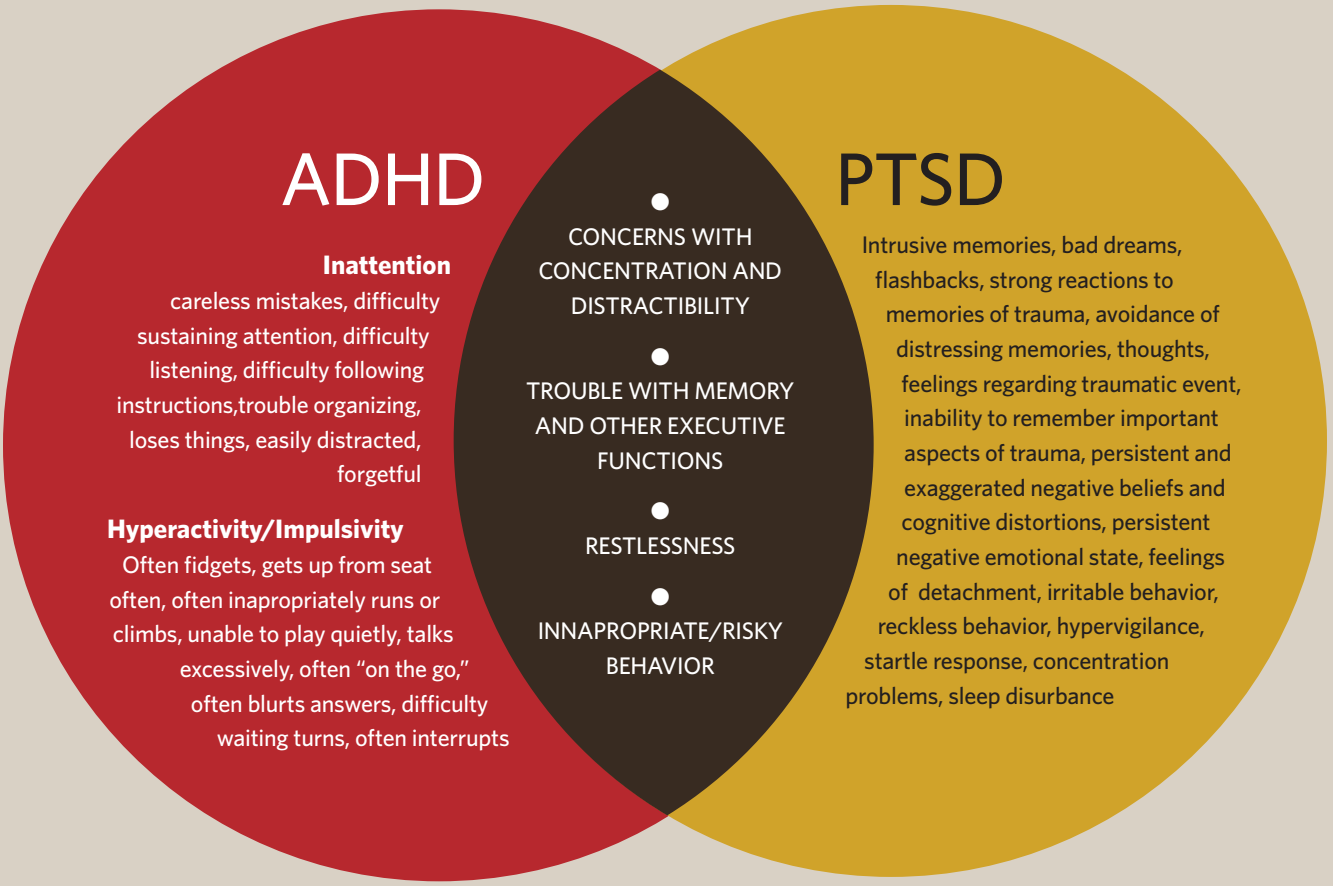
Consider a timeline

When considering behavior and internal thoughts and feelings, it is important for a provider to consider the child's history and timeline of challenges. Getting a history of the child's behavior from a caregiver can shed light on when the behaviors were first noticed. Talking to teachers and examining report cards also can be helpful. For example, you may want to consider if the child always has been struggling with these behaviors, or if they started a few months after a scary event, which may be more indicative of a trauma response.

After a thorough review, it appears that in Sebastian's case, he has been exposed to community violence and domestic arguments at a young age, thus it is difficult to assess his particular timeline. This is the case with many children presenting with comorbid symptoms of PTSD and ADHD, and unfortunately this presents as a difficult assessment when teasing apart each diagnosis.

Consulting with a professional

If you think a child is struggling with ADHD and/or PTSD related symptoms, the next step would be collaborating with a



mental health provider. When consulting with a provider, it is helpful to objectively and descriptively voice your concerns. For example, it is more helpful to describe that "This child has difficulty staying in his seat and gets up from his chair roughly four to five times a day," rather than labeling the child as "unruly or lazy." Another nice example would be, "This child has trouble sleeping and wakes up three to four nights a week from nightmares." Importantly, comprehensive mental health referrals can lead to appropriate evaluations and services. One of the hallmark ways to see if a child is truly experiencing PTSD or ADHD is for providers to assess the child after engaging in some part of treatment tailored to their perceived needs.

Teasing apart ADHD and PTSD symptoms takes time, consultation with professionals, and collaborative problem solving. The guidelines discussed here shed light on how this process can occur and information that may be helpful for providers. Every child deserves the opportunity to be understood, and efforts in uncovering patterns in their behaviors, thoughts, and feelings can help children succeed in the face of adversity.

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