



**NEW OAKLAND
CHILD-ADOLESCENT
AND FAMILY CENTER**

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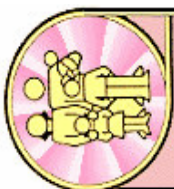
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**NEW OAKLAND CHILD-ADOLESCENT
AND FAMILY CENTER**
12850 Fountain Sq., Ste. 106, Davisburg, MI 48350



New Oakland
Child-Adolescent and Family Center is
also accredited for Crisis Intervention
by the Commission on Accreditation
of Rehabilitation Facilities
(CARF).

**NEW OAKLAND CHILD-ADOLESCENT
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**THE THREE FACES
OF
A.D.H.D.**

- **Cognitive/Perceptual/Sensory
Motor Deficit (C.P.S.M.)**
- **Learning Disability (L.D.)**
&
- **Emotionally Based Reaction**
as
**Developmental-Educational
Sustained Stress Disorder
(D.E.S.S.D.)**

**A COMPREHENSIVE REVIEW-
ASSESSMENT OF THE TRUE
PICTURE OF A.D.H.D.**

**FACE to FACE System Approaches and
Recommended Revision-Elimination
of the
Diagnosis of A.D.H.D./A.D.D.**

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INTRODUCTION

The **THREE FACES of ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)** as a study is introduced as a new concept that moves away from the simplistic symptom based diagnosis of ADHD/ADD and moves toward a more sophisticated and developmental approach to diagnosing a child's ambiguous complex condition.

CLINICAL STUDY AND HISTORICAL REVIEW

For the past 50-60 years, there has been no significant growth or research in the understanding or etiological and dynamic aspects of ADHD. Since the early introduction of Strauss Syndrome, the scientific community has only moved toward name/title changes of this syndrome; namely, Hyperkinetic Disorder, Minimal Brain Dysfunction, and now Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder.

Historically, we have remained concerned about the simplicity of this diagnosis as it often takes place by inference. In the meantime, our children have gone through educational, social, interfamily, and more significantly, developmental-educational alienation stressors in their lives, growing old with vague generalized symptom based inferences of ADHD along with the negative labeling that ensues.

CLINICAL STUDY

Studying nearly 1300 youngsters for the past 10 to 12 years, referred for re-evaluation of poor response or non-response to present treatment methods, we at New Oakland Child-Adolescent and Family Center uncovered the following through our research:

- ◆ 72% of the youngsters simultaneously suffer from Cognitive/Perceptual/Sensory Motor delay/dysfunction (**C.P.S.M.**), more significant among preadolescents and girls;
- ◆ 68% of the youngsters also suffer from a more advanced form of Learning Disability (**LD**), more significantly among adolescents and boys;
- ◆ 78% of the population suffer from continuous emotional difficulty in the form of Depression, Anxiety, Impaired Self-Esteem, and eventually, poor motivation and rage reaction;
- ◆ Impairment of parenting attitudes and approaches with paradoxical parenting 72% of the time: pro-active mothering and reactive fathering; and
- ◆ Six major developmental-educational, in-family, social-peer, culture based, emotional and inner growth with eventual vulnerability-submissive and exhaustive based stressors affecting 63-65% of the youngsters.

Along with these discoveries, there has also been a significant link between inferential ADHD and child-adolescent problems/occurrences of anger, anger control, anger management, and difficulties with rage reaction toward violent adjustments

THE THREE FACES OF ATTENTION DEFICIT HYPERACTIVITY DISORDER as Developmental-Educational Sustained Stress Disorder (D.E.S.S.D.)

In our study, we introduced Cognitive/Perceptual/Sensory Motor (**C.P.S.M.**) vulnerability, Learning Disability (**LD**), and Emotional Impairment (**EI**) and reaction with anger, rage, and violence as the main factors for the youngsters' difficulty or impairment. The simplistic, non-contributory symptoms of **inattentiveness, hyperactivity and impulsivity** not only camouflage the etiological aspect of the child's difficulty, but also seriously camouflage and simplify the need for an appropriate intervention, such as educational, emotional, and family based intervention and alleviation of various sustained stressors.

RECOMMENDED DIAGNOSTIC APPROACHES

The outcome data from our study recommends that the focus of the diagnostic approach should include heavy emphasis on:

- 1) Visual/Perceptual impact assessment (reading, spelling, etc.);
- 2) Auditory/Perceptual assessment (receptive and expressive language);
- 3) Sensory Motor assessment (handwriting, coordinated activity);
- 4) Cognitive function (comprehension, memory, recall, and focused learning) assessment;
- 5) Study of all functioning as part of **C.P.S.M.** deficit and in the advanced form of learning disability (**LD**) within the provision of appropriate services;
- 6) Study of various emotional, developmental, anxiety-depression and anger-rage reaction; and
- 7) Review and study of the various aspects of stressors identified earlier in child's educational, cultural, developmental, family, and social life.

We must simultaneously avoid the following:

- a. **False** reference and reliance on the discrepancy differential of the #21 that exists between Verbal IQ and Performance IQ. We believe any discrepancy between the #5-20 is important and needs to be addressed also;
- b. **Medicalizing** the diagnosis of youngsters as ADHD by inferences and quick use of medication; and

- c. **Camouflaging** the knowledge about Cognitive/Perceptual/Sensory Motor delay and Learning Disability in children.

TREATMENT PLANNING

We recommend a comprehensive, interdisciplinary approach and study to this condition providing the following:

- Educational assessment and planning;
- Developmental assessment and planning;
- Medical and mental health assessment and planning;
- Family based assessment and planning identifying paradoxical parenting;
- Assessment of various stressors in the life of the child-adolescent;
- Adjunctive prescriptive assessment and planning;
- Advocacy based interdisciplinary assessment and planning for all children and adolescents;
- Use of medications (i.e. stimulants) for cognitive/perceptual/sensory motor impairment and learning disability and emotional reaction must be titrated as it relates to each condition;
- Eliminate the three symptom based references of **inattentiveness, impulsivity, and hyperactivity** as recommended by the DSM-IV and the Connor Questionnaires as primary diagnostic factors of ADHD. These symptoms are present in fourteen (14) other psychiatric conditions;
- Revise, change, and/or eliminate the diagnosis and terminology of ADHD/ADD;
- Embrace the foundation of **C.H.A.P.P.C.S. (CHildren-Adolescents with Primary Perceptual-Cognitive and Sensory motor impairment)** an Advocacy Group established in each school district to support and reinforce pro-active appropriate assessment and planning;
- Avoid **Medicalization** of the condition and forego rapid application of medication without comprehensive assessment;
- Cognitive/Perceptual/Sensory Motor based coordinated remediation, tutorials and educational services in basic reading, reading comprehension, handwriting, mathematics and other cognitive functions are essential; and
- Support family based educational services and parenting to replace the demeaning approaches that compromise the integrity of the child.

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Research-study reference on the **Three Faces of Attention Deficit Hyperactivity Disorder** is available by request from New Oakland Child-Adolescent and Family Center.

