Attention deficit hyperactivity disorder

Theory and practice examined through the lens of power

Dianne Rogers

Currently, discourses on Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) within Australia are in conflict. There are two dominant and conflicting knowledge bases: the biological and genetic approach, and the psychological approach, which includes behavioural and psychoanalytic theories on the cause of deviant or difficult behaviour. Other minor discourses also exist, including the diet perspective and an emerging strengths based discourse arising from support groups. The debate is not purely academic as theory, and the practice developed from that theory, have a huge impact on families. An overview of the competing discourses currently operating in Australia, particularly in Queensland, is presented. The author argues that the theories and the associated strategies recommended by professionals, result in varying outcomes for families and individuals affected by the disorder.

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The cause of ADD/ADHD is hotly debated with claims and counter claims as to the cause of the disorder and the best approach to take in dealing with families and children. Harborne, Wolpert and Clare (2004, p.336) have suggested that the experiences of families affected by ADD/ADHD are grounded in the debate 'about the causes and nature of ADHD'. The conflicting debate, therefore, has real implications for choice of treatment, and thus for families. While Harborne, Wolpert and Clare (2004, p.327) have noted that 'little is known about the individual experiences of those directly affected by the disorder and, in particular, how parents make sense of the variety of different aetiological models', the works of Malacrida (2003), Carpenter (1999), Mulsow, O'Neal and McBride Murry (2001), and Kendall and colleagues (Kendall, Leo, Perrin & Hatton 2005; Kendall & Shelton 2003) provide some insight into the effect of theory and practice on families.

It has been argued that 'theory and practice are inseparable' (McLaren 2002, p.48) and 'power and knowledge are joined together'(cited in McNay 1992, p.27).

McLaren (2002, p.41) outlines a simple, but useful, definition of the way in which power can be exercised: 'power over', 'power to', or 'power with'. Those who practise 'power over' seek to be dominant and to write the rules on what is normal and functional. The effect of 'power over' on the individual is frequently negative. Those who practise 'power to', as in change and transformation, and 'power with', which involves working alongside others and sharing power, are seen as empowering and positive forces. Thus, power can be seen to operate at a number of different levels.

In order to examine the impact of professional power on families, the theory base and the resultant practice will be examined using McLaren's (2002) definition of power and drawing on the limited overseas and Australian academic and lay literature. In the following section, a general overview of ADD/ADHD will be given before moving on to the two dominant knowledge bases – the genetic approach and the psychoanalytical/behaviourist approach. Two minor, but important, discourses – the diet perspective and a strengths based perspective arising from support groups will also be explored.

What is Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder without Hyperactivity (ADD)?

The National Health and Medical Research Council (NHMRC 1997) recommends that a diagnosis of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) be considered in accordance with the American Psychiatric Association's Diagnostic and Statistical Manual (DSM IV) and calls for a comprehensive assessment to be obtained from a variety of sources. The characteristics of ADD are: problems with paying attention, short-term memory, and difficulties with learning. Additional key features of ADHD are: hyperactivity, impulsivity and inflexibility (Serfontein 1990, p.19).

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Overview of diagnosis

The National Health and Medical Research Council's (NHMRC 1997, p.xi) report on Attention Deficit Hyperactivity Disorder stated that studies within this country have found the prevalence among children of ADHD/ADD to be between 2.3 and 6 per cent. Predominantly ADHD has been seen as a disorder affecting boys more than girls (NHMRC 1997, p.14). However, some research (Solden, 1995) suggests that females are not diagnosed as frequently as they tend to be less aggressive and not come to the attention of professionals. Girls, if diagnosed, usually present as having ADD, which is not as well researched as ADHD (NHRMC 1997, p.46). In examining adult ADD/ADHD, it is reported that women are presenting in the same numbers as men, thus suggesting that the disorder may not be gender specific (Hartmann 1999).

Legislation and government policy

ADD/ADHD is recognised under the Commonwealth Disabilities Discrimination Act (1992). Thus, families and individuals may be able to access some federally funded services, such as respite services or the Disability Officer at Universities. However, ADD/ADHD is not recognised as a disability under the Queensland Disability Services Act (1992) as, according to Disability Services Queensland, ADD/ADHD has not been shown to be of a permanent nature. Thus, in Queensland, as with most other states and territories, families are not entitled to access state based disability services. The exception is Western Australia, where the Disability Services Commission provides information, referral and advocacy (van Kraayenoord, Rice, Carroll, Fritz, Dillon & Hill 2001). In Queensland, ADD/ADHD is not covered under any legislation or policy, and therefore individuals and families are not entitled to any specialist services.

THEORY, PRACTICE FRAMEWORKS AND POWER

1. Heredity & Biology

Theory

ADD/ADHD is conceptualised as resulting 'from a subtle difference in the fine tuning of the brain' (Green & Chee 1994, p.19). Professionals whose practice is formed from a biological and genetic framework believe that seventy years of Freudian practices have blamed mothers for their children's behaviour (Barkley 2001b). Gordon Serfontein (1990) pioneered the acceptance in Australia that ADD/ADHD was a 'biological problem which was not caused by poor parenting' (Green & Chee 1984, p.87). Serfontein and others who held similar beliefs were accused of 'colluding' with parents but, 'in spite of immense opposition from many quarters' (Nash 1994, p.vii), set up a clinic in Sydney and later in Brisbane. Serfontein died prematurely in the early 1990s. However today there are a number of other advocates in Australia who view ADD/ADHD as primarily an inherited disorder (Green & Chee 1994; Levy & Hay 2001; Wallace 1996).

Practice framework

Diagnosis

Carpenter (1999, p.73) notes that 'there has been a silence in the literature about the positive effects of having a child diagnosed with ADHD'. A notable exception is Barkley (2001a), who states that 'the act of diagnosis is powerful', and that information regarding ADD/ADHD and the associated co-morbidities is crucial for parents (Barkley 1990; Harrison & Rees 1998; NHMRC 1997).

Interventions

One per cent of Australian school children are medicated to treat the disorder (Holowenko 1999; Thorp 1998). It has been suggested that this rate is much higher in some states (McHoul & Rapley 2005). Barkley (2001a) has stated that even though medication is seen as the most effective tool in managing ADD/ADHD, not all children diagnosed are medicated. Behaviour management is also recommended for children with ADD/ADHD. Barkley (1987; Barkley & Benton 1998) has written at least two parent training programs. However, Barkley (1987) has stated that his 'program is not effective with every parent or every child,

nor is it recommended for adolescents' (cited in Brochin & Horvath 1996, p.51).

Barkley (2001a), speaking in Sydney, claimed that behaviour management is more effective at the point of contact; for example, if the problem is in the school ground, the issues should be addressed in the school ground and not in the clinic. Recognition exists that many children with ADHD display oppositional behaviour and a significant number develop Conduct Disorder. Thus, strategies to address defiant behaviour take into consideration the characteristics of ADHD and explore different ways of handling day-to-day problems and defusing difficult situations (Barkley & Benton 1998; Wallace 1996). Some professionals also recommend speech and occupational therapy (NHMRC 1997).

Power – 'power over' or 'power to'?

Malacrida (2003, p.27), in her study of mothers of children with ADD/ADHD living in Canada and in the United Kingdom, reported that a medical label was often helpful to parents, as it assisted in removing stigma and blame, and parents were less likely to 'receive ... punishment' from professionals. In her Queensland study, Carpenter (1999, p.199) found that some of the women in her study who consulted medical doctors felt blamed for their children's 'condition'. Thus, Carpenter (1999, p.199) 'raises the question of whether doctors dispute the patholological origins of ADHD despite treating it medically'.

Medical doctors have been accused of abusing their power by pathologising children and prescribing drugs (Carpenter 1999; Jacobs 2002). Some authors have sought to show that the diagnosis of ADD/ADHD is 'routine and mundane' and that medication is prescribed 'merely on presentation for the possibility of the 'disorder'' (McHoul & Rapley 2005, p.419). It has been argued that this occurs despite the parents being 'manifestly sceptical about (even resistive to) the diagnosis and its methodological grounds' (McHoul & Rapley 2005), thus suggesting that medical professionals are operating from a 'power over' perspective in dealing with parents. In contrast, a number of authors (Glascoe, Altemeier & MacLean 1989; Glascoe & Dworkin 1995; Rodger & Mandich 2005) have stressed that parental concern is a major factor in diagnosing children with behavioural or developmental disorders, thereby implying that medical professionals are more inclined to operate from a 'power to' perspective in their practice. Clearly there are different views regarding the impact of the hereditary and biological approach on parents.

2. Psychoanalytic and Behaviourist Framework

Theory

Both psychoanalytic and behaviourist perspectives attribute ADD/ADHD to early childhood experiences within the family unit (Rafalovich 2001). The literature, including government publications, contains numerous articles and reports written within a psychoanalytic or behavioural framework, with references to attachment theories, dysfunctional families, single mothers, divorce and the decaying of family values as the cause of troubled children who have been given the diagnosis of ADD/ADHD (Chapman 1996; Mertin 1998; Osmond & Darlington 2001; Schmidt Neven, Anderson & Godber 2000).

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Some writers, in seeking to counter the genetic basis of ADD/ADHD, claim that they 'place[s] the child at the centre' of their inquiry, as opposed to 'the needs of the parent' (Schmidt Neven et al. 2000, pp.5-6). Furthermore, some have embarked on a crusade to protect 'the physical health and emotional well-being' of children from the use of medication (Jacobs 2002, p.72). Both psychoanalysts and behaviourists clearly see themselves aligned with the child, a protector of children, especially boys. They warn professionals 'not to collude with parents in blaming the child for having the problem' as they believe that parents scapegoat the child and, in doing so, 'deny the complexities of the difficulties they face as a family' (Schmidt Neven et al. 2000, p.58). Professionals with this perspective believe that they have the knowledge to assess the 'context of the problematic attentional and self regulatory deficits' (Schmidt Neven et al. 2000, p.51). Accordingly, the ADD/ADHD label and medication are said to act as screens which mask family problems and dysfunction (Clark 1996; Jacobs 2002).

Although professionals operating from a psychoanalytic or behaviourist framework espouse forming partnerships with parents, they see their role as assisting parents to understand 'how the problem originates in the first place' and to 'tolerate uncertainty and to contain anxiety' (Schmidt Neven et al. 2000, p.60 & 59). Parents, especially mothers, are viewed as needing education to understand their children and are spoken of as being 'emotionally inaccessible' (Clark 1996, p.109). The absence of fathers is discussed and seen as contributing to the problem (Biddulph 1997).

Practice framework

Family therapy is viewed as a tool for families to come to grips with their issues (Clark 1996). The Positive Parenting

Program (Triple P), supported and run by the Queensland Government, is also seen as a strategy for difficult children or struggling parents. Triple P 'draws on social learning, cognitive behavioural and developmental theory' (Triple P 2004, p.1) and was developed on the understanding that 'poor parenting, family conflict and non supportive environments may increase the susceptibility of young people to major behavioural and emotional problems' (Australian Institute of Criminology 2003, p.32). Behaviour management programs like Triple P see positive parent child interactions as crucial to the development of normal behaviour in children and the elimination of pathology (Bor, Sanders & Markie-Dadds 2002). Thus, Triple P instructs parents and through that instruction seeks to change children's behaviour (McTaggart 2002; Triple P 2004). Family therapy and Triple P are widely used in Queensland.

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The use of medication to treat children with behavioural problems has been a subject of concern and has been reported in the media (Bagnall 2000; Cauchi 2002; Jaksa 1999; Lawrence 1998; Tanner 2000). Echoing this concern, the peak youth agency, the Youth Affairs Network of Queensland (YANQ), commissioned Dr Robert Jacobs to write the report, *Queensland children at risk: The overdiagnosis of 'ADHD' and the overuse of stimulant medication* (Jacobs 2002). Jacobs (2002, 2004), from the United States, is particularly alarmed at the widespread use of medication which he believes turns children into 'zombies' (2004) and calls for a ban on medication until the cause of ADD/ADHD can be identified.

Interventions

Malacrida (2003) found that practitioners who saw the child's problem stemming from the mother or the family of origin, implemented family therapy and/or counselling sessions. The sessions were described by some mothers as 'invasive, unpleasant and 'useless'' (Malacrida 2003, p.132). Malacrida (2003, p.132) reported that mothers often engaged in these sessions, even though they were very unhappy about the therapy, explaining 'Well, what else could I do?' She gives one example of an English mother's experience of family therapy. The mother reported that the professional insisted on seeing the whole family together, even though she was concerned about 'speaking negatively' about her child and the impact that it would have on him (Malacrida 2003, p.230). Eventually, the mother gave in to the insistence of the professional to have her son present, saying 'we did so unhappily' (Malacrida 2003, p.230).

Malacrida (2003, p.172) found that in the United Kingdom mothers encounter almost universal 'mother blame' for their child's difficulties. Furthermore, mothers went along with professionals' insistence of therapies, because to refuse may ...

> ... produce negative fallout for their children in the form of reduced services, refusals to refer children to other professionals, or negative reports being passed on to other professionals (Malacrida 2003, p.230).

Carpenter (1999, p.200) gives an example from an Australian context, reporting that many of the mothers who consulted one particular government agency psychologist 'felt that he had emotionally abused them'.

Triple P

There is little in the academic literature critical of the use of current parenting programs, in particular the use of Triple P, as an intervention strategy for the parents of children with ADD/ADHD. However, in Queensland, Harrison and Rees (1998, p.vi), in referring to programs offered to the parents of children with ADD/ADHD, state that programs which focus heavily on 'child management strategies' have been found wanting by parents. Criticism of Triple P, and behaviour management programs in general, by parents and some community services has been expressed in the Townsville media (Elms 2002; Harris 2002). Accordingly, it is useful to examine the broader literature to explore the efficacy of behaviour management programs, particularly Triple P, for families affected by ADD/ADHD.

Behaviour management programs, including Triple P, do not take into consideration difference or possible biological basis of behaviour (Attention Deficit/Hyperactivity Disorder, psychosocial treatments, behaviour management 2004). Mulsow, O'Neil and McBride Murry (2001, p.40) point out that interventions which are used with 'nonimpaired children may not work with ADHD children'. Another aspect which may diminish the effectiveness of programs such as Triple P is the families' inability to implement the strategies suggested. Brochin and Horvath (1996) have noted that the parents of children with ADD/ADHD may be unable to implement behaviour management strategies due to their own ADD/ADHD. Furthermore, Brochin and Horvath (1996) acknowledge that, even when programs are specifically tailored for the parents

of children with ADD/ADHD, the program's efficacy is limited in some cases.

There are other factors which may impact on a parent's ability to implement strategies. It is reported that mothers experience a great deal of stress trying to cope with their children's ADD/ADHD, sometimes their partner's ADD/ADHD (Smith 1998) and sometimes also their own ADD/ADHD (Daly & Fritsch 1995; Eugene 1996; Messy purse girls 2004). Marriage break up (Green & Chee 1994; Serfontein 1990; van Kraayenoord et al. 2001) and depression (Carpenter 1999; Harrison & Rees 1998; Kendall & Shelton 2003; van Kraayenoord et al. 2001; Wallace 1996) are often the result of this stress. Under these circumstances, common interventions, such as parenting programs, may be difficult for parents, particularly mothers, and in some circumstances may be inappropriate (Kendall & Shelton 2003; Mulsow et al. 2001).

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Power - 'power over'?

In viewing the research that has been conducted to date, it could be argued that a psychoanalytic or behaviourist approach operates from a deficit base and is experienced by many, in particular mothers, as blame ridden. Some professionals operating from this perspective claim that they are protecting children. While they may believe that they are acting in the best interest of the child, a conflict situation between the needs of the parent and the professional's assessment of the child's needs may develop. Thus, professionals who operate from this approach run the risk of being criticised for placing their knowledge above the knowledge of parents. While behavioural interventions and family therapy may be of assistance to some families, by viewing the limited literature it can be seen that both psychoanalytical and behaviourist approaches may operate from a 'power over' position in dealing with stressed families.

3. SUPPORT GROUPS AND THE STRENGTHS PERSPECTIVE

Theory

Charles Rapp (1998) defines the strengths model as: valuing and building on existing skills; exploring the environment to locate resources; acknowledging that families often know what they need to assist them; valuing respectful relationships; and being proactive. In a similar fashion, Elliot, Mulroney and O'Neil (2000, p.xvi) urge family workers to adopt an 'optimistic stance' which builds on 'the strengths and capacities of family members'. The 'optimistic stance' involves some key factors: listening and hearing the families' views; respectful relationships; goal setting; practical assistance; developing networks; and utilising the strengths and skills that exist within the family.

Practice framework

A number of support groups have formed in Queensland to offer practical support and information to parents and individuals affected by ADD/ADHD and associated co-morbidities. Various authors attest to the importance of support groups (Barber 1991; Butler & Wintram 1991; Reiger 1995). The value of ADD/ADHD support groups – in providing information on ADD/ADHD through to guidance on which professionals to consult, and in giving a 'voice' to isolated groups – is noted in the existing literature (Brochin & Horvath 1996; Carpenter 1999; Malacrida 2003; van Kraayenoord et al. 2001).

The ADD Association Queensland (ADDAQ), formerly known as Attention Deficit Disorder Information Support Services Inc (ADDIS) (2003), which operates in the south east corner of the state, describes itself as 'a committed group of parents, educators, health professionals and interested individuals, whose common aim is to address the needs of ADD and ADHD sufferers and their families'. The group states that it 'was born out of the frustrations of others' and that 'it will survive because of yours' (ADDIS 2003). Accordingly, the organisation supplies information to individuals and regularly organises workshops and seminars to promote awareness and to advocate for families.

ADDAQ and the North Queensland Attention Deficit Disorder Support Group (NADDS) promote ADD/ADHD as a biological disorder, with a strong hereditary component. They offer information in relation to medication and diet. In general, they do not endorse psychoanalytical or behaviourist approaches as to the cause or treatment of ADD/ADHD. Furthermore, both groups have advocated for the recognition of ADD/ADHD as a disability (NADDS promotional flyer, ADDIS information sheets).

Power - 'power with'?

The NADDS' (2003) mission statement clearly outlines the purpose and aim of the group:

- awareness and recognition
- providing information and resources
- the provision of a safe environment for the discussion of issues

- working alongside professionals and the community to assist those affected by ADD/ADHD.

In a similar fashion, the information service ADDAQ states that it is committed to providing information, advocacy and promoting awareness. Thus, it can be argued that the 'optimistic stance' (Elliot, Mulroney & O'Neil 2000) and a strengths based approach are reflected in the mission statements of NADDS and the aims of ADDAQ. Therefore, some grass roots support groups and information services have the potential to operate from a 'power with' approach.

4. DIET PERSPECTIVE

Theory

The diet perspective is centred on the original works of Feingold (1975), who hypothesised that certain foods and preservatives caused behavioural and learning problems. Accordingly, Dengate was particularly interested in investigating a link between the preservative 282 (Calcium Propionate), a mould inhibitor, and children's behaviour and learning. Subsequent research undertaken in Darwin revealed that preservative 282, commonly found in bread, adversely affected children's sleep, their ability to concentrate and their behaviour (Dengate & Ruben 2002). Dengate's work caught the attention of an Australian bread shop chain. As that company's bread is free from preservatives, they cited Dengate's research in their promotional material (Brumby's 2002).

Practice framework

Dengate (1994) has written and lectured on diet in relation to behaviour and learning problems common to people affected by ADD/ADHD. Dengate (1994, p.196) recommends the elimination of 'artificial colours, flavours, preservatives, salicylates, amines and MSG' from the diet to assist with learning and behaviour. Accordingly, foods containing artificial preservatives such as soft drink, bread and fast foods and some natural foods, such as oranges, grapes and broccoli, need to be excluded from the diet (ADDIS 2002). Dengate (2005a) urges parents and professionals to modify a child's diet 'as a first means of treatment' before any other interventions, such as medication or behaviour management, are utilised to assist with learning or behaviour.

Breakey (1999), a Queensland dietitian, is another well-known advocate of the role of diet in treating ADD/ADHD. She states that, like other treatments, following or changing a diet is not always easy, as all treatments require a commitment (Breakey 1999). Breakey is convinced that changing or modifying diet can assist many people with ADD/ADHD (1999). Both Breakey and Dengate aim to assist individuals and families who appear to be food intolerant. However, it should be noted that much of the changing and monitoring of diet falls to the mother.

Power – 'power to'?

The benefits of diet to individuals and families affected by ADD/ADHD are primarily found in the websites of organisations or individuals who support modified diets in the treatment of ADD/ADHD (Dengate 2005b; HACSG 2005). Parents report that a modified diet has assisted their children and their family (Dengate 2005b; HACSG 2005). The diet perspective offers alternatives to the other options currently available. If diet is a factor in learning or behaviour problems, modifying the diet is empowering to both the individual and the family. Practitioners espousing diet modification do not necessarily claim that all children with the diagnosis of ADD/ADHD have sensitivity to food. Thus, as long as parents, usually mothers, are not pressured into using diet modification, the diet framework operates from a 'power to' framework.

> *There needs to be recognition that knowledge does not reside solely with professionals and that a great deal can be learnt from listening to families. Positive gains are to be made from working alongside families, valuing their experiences and respecting their expertise.*

DOGMA OR EMPOWERMENT

The different theoretical models, subsequent practices and the effects of power produce varied results for families, a summary of which is provided in Table 1.

In examining the different theoretical models which can be used to assist clients, Saleebey (1992, p.5) states that:

> the obsession with problems, pathologies, and defects, while productive of an impressive lode of technical and theoretical writing, may be less productive when it comes to actually helping clients.

Saleebey (1992, p.7) goes on to say that:

> you can build little of lasting value on pathology and problems, but you may build an enduring edifice out of strength and possibility inherent in each individual.

Table 1: Theory and practice examined through the lens of power

	Psychological Framework	Biological Framework	Diet Perspective	Strengths Perspective
Position on ADD	Difficult or deviant behaviour is caused by early childhood trauma or poor parenting.	Biological condition and strong heritability.	Contributes to ADD – behaviour and learning problems.	Primarily biological & heredity focus but acknowledges that diet and trauma may contribute.
Child	Central to their concern & treatment.	Acknowledge the difficulty of rasing the child.	Food intolerant.	Combination of – concern & hope. Often receives the most attention & time within the family.
Siblings	At risk.	May have ADD or another disorder, need support e.g. respite, camps.	May benefit from modified diet.	May have ADD or another disorder Non ADD siblings need support as they are often left out.
Mother	Needs to be educated and accept responsibility.	Needs information on ADD. Needs to provide structure, undertake parent training, supervise & implement therapy.	Implement & monitor diet. Needs to observe & note behaviour changes.	Often doing it alone, needs validation & support. Often feels blamed & under a lot of stress. May also have ADD.
Father	Needs to play a more active role but not seen as central to the problem.	Acknowledges that he may be absent or have ADD.	Could also benefit from the diet.	Absent physically or practically. May have ADD & contributes to stress in the family. Looks for ways to involve father in a positive way.
Intervention	Family therapy, Triple P, education on child development.	Multimodal: Medication Parent training Behaviour management at the point of contact Other therapies e.g. remedial, speech.	Elimination diet and adherence to diet. Other therapies as recommended by treating doctor.	Multimodal: Medication Parent Support programs Diet if applicable Programs to assist children with their difficulties Other therapies, eg, remedial & speech.
Policy Direction	Strengthen the family.	Provision of intervention strategies in Education & Disability sectors.	More recognition of sensitivity to food.	ADD recognised as a disability & services provided. Recognition that people with ADD are different and have different requirements.
What they want	A society which is more child centred.	Research to assist understanding.	Up to date research.	Strengths based intervention not blame or marginalisation.
Reality for family	Mother blamed. Intervention is often of little value to the family.	Relief they are not to blame. Multi Model treatments are not always available. Few services to assist.	May assist. Responsibility for diet usually falls to the mother.	Offers hope & provides information. Recognises that it is a tough road with little support from the government or community in general.

It can be argued that the strengths based approach is particularly useful in dealing with families affected by ADD/ADHD (Elliot et al. 2000). While they acknowledge that professionals can use a number of approaches or theories in dealing with families, Elliot et al. (2000) believe that all practices need to adopt an 'optimistic stance' which centres on the belief that strength and change is located within the family. They encourage practitioners to reject dogma and …

> … to look beyond their beliefs about what the family needs and focus on the world from the family's point of view (Elliot et al. 2000, p.143).

CONCLUSION

In Australia, discourses on ADD/ADHD are in conflict, with two competing theories, genetics and the psychoanalytic and behaviourist approach, seeking to dominate. However, two minor but important knowledge bases seek to influence the discourse – the diet perspective and the self help/support group approach which has adopted a strengths based perspective. The theory base of each camp in turn shapes the practice framework and outcome for families. The outcome for each family depends on the way in which power is used: to dominate, to assist with change, or to empower. In dealing with families affected by ADD/ADHD, professionals need to ask, are we working alongside families ('power with'), or do we employ a 'power over' approach where we, the

experts, instruct and dictate? There needs to be recognition that knowledge does not reside solely with professionals and that a great deal can be learnt from listening to families. Positive gains are to be made from working alongside families, valuing their experiences and respecting their expertise. ❖

REFERENCES

ADDIS (2002) *Food Allergies, ADDIS Information Sheet*, Milton, Brisbane: Attention Deficit Disorder Information & Support Services.

ADDIS (2003) *Food Allergies, ADDIS Information Sheet*, Milton, Brisbane: Attention Deficit Disorder Information & Support Services.

Attention Deficit / Hyperactivity Disorder, psychosocial treatments, behaviour management (2004) Retrieved 7th January, 2004, from www.mentalhealth.org.nz/con...play.asp?contentID=104&condition=4

Australian Institue of Criminology (2003) *Triple P: Positive Parenting Program*, retrieved 9th September, 2003, from www.aic.gov.au/publications/rpp/31/rpp31-16.html

Bagnall, D. (2000) 'Mother's little helper', *The Bulletin*, 24 October, pp. 42-43.

Barber, J.G. (1991) 'Beyond Casework', in *Beyond casework: Practical social work*, J. Campling (ed.), London: Macmillan Education Ltd.

Barkley, R. (1987) *Defiant children*, New York: Guilford.

Barkley, R. (1990) *Attention Deficit Hyperactivity Disorder: A handbook for diagnosis and treatment*, New York: The Guilford Press.

Barkley, R. (2001a) *Modern management of ADHD*, paper presented at the ADHD in the third millennium: Perspectives for Australia, Westmead Hospital, Sydney.

Barkley, R. (2001b) *The neurobiology of ADHD and its implications for diagnosis and management*, paper presented at the ADHD in the third millennium: Perspectives for Australia, Westmead Hospital, Sydney.

Barkley, R. & Benton, C.M. (1998) *Your defiant child: 8 steps to better behavior*, New York, London: The Guilford Press.

Biddulph, S. (1997) *Raising boys: Why boys are different - and how to help them become happy and well-balanced men*, Australia: Finch Publishing.

Bor, W., Sanders, M.R. & Markie-Dadds, C. (2002) *The effects of the Triple P-Positive Parenting Program on preschool children with co-occurring disruptive behavior and attentional/hyperactive difficulties*, retrieved 7th January, 2004, from http://www.findarticles.com/cf_dls/m0902/6_30/95790470/print.jhtml

Breakey, J. (1999) *The role of diet*, paper presented at the Positive Approaches to ADD, ADDIS Seminar, March1999, Brisbane.

Brochin, A.H. & Horvath, J.A. (1996) 'Attention-Deficit/Hyperactivity Disorder', in *Adolescent dysfunctional behavior: Causes, interventions, and prevention*,G.M. Blau & T.P. Gullotta (eds.), Thousand Oaks: Sage Publications.

Brumby's. (2002) *Why Brumby's breads have no preservatives*, Thuringowa: Brumby's The World's Best Bread.

Butler, S. & Wintram, C. (1991) *Feminist Groupwork*, London: Sage.

Carpenter, L.R. (1999) *The effect of a child's Attention Deficit Hyperactivity Disorder on a mother: The hidden disability of motherhood*, unpublished Doctoral Thesis, Griffith, Brisbane.

Cauchi, S. (2002) 'Doctors' ADHD concern', *The Age*, 19 November.

Chapman, J. (1996) 'Introduction: Attention Deficit Disorder', *A.N.Z.J. Fam. Ther.*, 17(2), 105-111.

Clark, R. (1996) 'Victoria, symptom or cause? Working with families with ADD, Attention Deficit Disorder', *A.N.Z.J. Fam. Ther.*, 17(2), 105-111.

Daly, J.A. & Fritsch, S.L. (1995) 'Case study: Maternal residual attention deficit disorder associated with failure to thrive in a two-month-infant, *Journal of American Academy of Child and Adolescent Psychiatry*, 34(1), 55(53).

Dengate, S. (1994) *Different kids: Growing up with Attention Deficit Disorder*, Sydney: Random House.

Dengate, S. (2005a) *Fed up with children's behaviour*, paper presented at the Playgroup Queensland, Townsville, 8 June.

Dengate, S. (2005b). *Food Intolerance Network*, retrieved 11th January 2005, from www.fedupwithfoodadditives.info

Dengate, S. & Ruben, A. (2002) 'Controlled trial of cumulative behavioural effects of a common bread preservative', *Journal of Paediatrics and Child Health*, 38(4), 373.

Elliot, B., Mulroney, L. & O'Neil, D. (2000) *Promoting family change: The optimism factor*, Australia: Allen & Unwin.

Elms, S. (2002, Monday, July 15). 'Mothers blamed', Letters to the Editor, *Townsville Bulletin*, 15 July, p. 8.

Eugene, A.L. (1996) 'Sex differences in ADHD: Conference summary', *Journal of Abnormal Child Psychology*, 24(5), 555-569.

Feingold, B. (1975) *Why your child is hyperactive*, New York: Random House.

Glascoe, F.P., Altemeier, W.A. & MacLean, W.E. (1989) 'The importance of parents' concerns about their child's development', *American Journal of Disabilities in Children*, 143, 955-958.

Glascoe, F.P. & Dworkin, P.H. (1995) 'The role of parents in the detection of developmental and behavioural problems', *Pediatrics*, 95, 829-836.

Green, C. & Chee, K. (1994) *Understanding ADD: Attention Deficit Disorder*, Sydney: Doubleday.

HACSG (2005) *Better children*, retrieved 11th January, 2005, from www.hacsg.org.uk/Better%20Children%20v2.htm

Harborne, A., Wolpert, M. & Clare, L. (2004) 'Making sense of ADHD: A battle for understanding? Parents' views of their children being diagnosed with ADHD', *Clinical Child Psychology and Psychiatry*, 9(3), 327-339.

Harris, P. (2002) 'Bit of cop-out', Letters to the Editor, *Townsville Bulletin*, 20 July, p.8.

Harrison, C.A. & Rees, B. (1998) *Psychoeducation & support program for parents of ADHD children*, Brisbane: The University of Queensland, Psychology Clinic (BRTC - St Lucia).

Hartmann, T. (1999) *Attention Deficit Disorder: A different perception*, Dublin: Newleaf.

Holowenko, H. (1999) *Attention Deficit/Hyperactivity Disorder: A multidisciplinary approach*, London and Philadelphia: Jessica Kingsley Publishers.

Jacobs, B. (2002) *Queensland children at risk: The overdiagnosis of 'ADHD' and the overuse of stimulant medication*, Youth Affairs Network of Queensland.

Jacobs, B. (2004) *ADHD: An alternative perspective*, paper presented at the presentation sponsored by the Youth Affairs Network of Queensland, LifeLine Community Care North Queensland, 8 June.

Jaksa, P. (1999) *ADHD myths, Ritalin fears and media responsibility*, retrieved 12/23/99 from www.add.org/content/research/editorial.htm

Kendall, J., Leo, M.C., Perrin, N. & Hatton, D. (2005) 'Modeling ADHD child and family relationships', *Western Journal of Nursing Research*, 27(4), 500-518.

Kendall, J. & Shelton, K. (2003) 'A typology of management styles in families with children with ADHD', *Journal of Family Nursing*, 9(3), 257-280.

Lawrence, K. (1998) 'Row over virus of the '90s: Drug shame - the 'naughty' schoolkids who queue for medication', *The Sunday Mail*, 22 February, p.4.

Levy, F. & Hay, D. (2001) 'Attention Genes and ADHD', in F. Levy & D. Hay (eds.), East Sussex: Brunner-Routledge.

Malacrida, C. (2003) *Cold comfort: Mothers, professionals, and Attention Deficit Disorder*, Toronto: University of Toronto Press.

McHoul, A. & Rapley, M. (2005) 'A case of attention-deficit/hyperactivity disorder diagnosis: Sir Karl and Francis B. slug it out on the consulting room floor', *Discourse & Society*, 16(3), 419-449.

McLaren, M.A. (2002) *Feminism, Foucault and embodied subjectivity*, USA: State University of New York Press.

McNay, L. (1992) *Foucault and feminism: Power, gender and the self*, Cambridge: Polity Press.

McTaggart, P. (2002) Every Family Project. *Frame of Mind: Mental Health in General Practice, Queensland Divisions of General Practice, 10*, 1.

Mertin, P. (1998) 'Attention-Deficit Hyperactivity Disorder among children in respite care: Room for doubt', *Children Australia*, 23(1), 29-32.

Messy purse girls (2004) 'Messy purse girls - living with ADHD', *North Queensland Combined Women's Services Inc. Newsletter* (July/August).

Mulsow, M.H., O'Neal, K.K. & McBride Murry, V. (2001) 'Adult Attention Deficit Hyperactivity Disorder, the family, and child maltreatment', *Trauma, Violence & Abuse*, 2(1), 36-50.

NADDS (2003) *Mission Statement*, Townsville: North Queensland Attention Deficit Disorder Support Group.

Nash, H. (1994) *Kids, families and chaos: Living with Attention Deficit Disorder*, Australia: Ed.Med Publishers.

NHMRC (1997) *Attention Deficit Hyperactivity Disorder (ADHD). December 1996.* Commonwealth Department of Health and Family Services: National Health and Medical Research Council.

Osmond, J. & Darlington, Y. (2001).*Attachment theory and child protection practice*, Information Sheet 2: UKIP, University of Queensland.

Rafalovich, A. (2001) 'Psychodynamic and neurological perspectives on ADHD: Exploring strategies for defining a phenomenon', *Journal for the Theory of Social Behaviour*, 31(4), 397-418.

Rapp, C.A. (1998) *The strengths model: Case management with people suffering from severe and persistent mental illness*, New York: Oxford University Press.

Reiger, K. (1995) *Motherhood ideology*, (2nd edition), Melbourne: Longman Australia.

Rodger, S. & Mandich, A. (2005) 'Getting the run around: Accessing services for children with developmental co-ordination disorder', *Child: Care, Health & Development*, 31(4), 449-457.

Saleebey, D. (1992) 'Introduction: Power in People', in *The Strengths Perspective in Social Work Practice*, D. Saleebey (ed.), New York: Longman.

Schmidt Neven, R., Anderson, V. & Godber, T. (2000) *Attention Deficit Disorder: An illness for our time: New perspectives in integrating psychodynamic, neuropsychological and public health approaches*, Victoria: Centre for Child and Family Development.

Serfontein, G. (1990) *The hidden handicap: How to help children who suffer from dyslexia, hyperactivity and learning difficulties*, Australia: Simon Schuster.

Smith, W. (1998) 'Under control', *Courier Mail*, 28 February, p.23.

Solden, S. (1995) *Women with Attention Deficit Disorder: Embracing disorganization at home and in the workplace*, Grass Valley, California: Underwood Books.

Thorp, D. (1998) 'Come in spinner', *Australian*, p.11.

Tanner, L. (2000) 'It's mind blowing', *Townsville Bulletin*, 26 February, p.47.

Townsville District CYMHS (1999) *A.D.D. Info Pack*, Townsville District Child & Youth Mental Health Services.

Triple P (2004) *The Triple P Model of Parenting and Family Support*, retrieved 7th January from www.triplep.net/02_model1/model.htm

van Kraayenoord, C.E., Rice, D., Carroll, A., Fritz, E., Dillon, L. & Hill, A. (2001) *Attention Deficit Hyperactivity Disorder: Impact and implications for Queensland*, Disability Services Queensland.

Wallace, I. (1996) *You & your ADD child: Practical strategies for coping with everyday problems*, Australia: Harper Collins.

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