

## Tips for Coaching A Child With Attention Deficit/Hyperactivity Disorder

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Betsy, one of your 10 year old gymnasts, is very difficult for you to coach. She has difficulty following rules, has a short attention span, and while waiting in line to do a trick will frequently kick or push the child next to her. When the inevitable argument ensues, she always seems to need to get the last word in. Though physically talented, Betsy has difficulty spending the requisite time to perfect a trick - always looking to move on to something new. Sometimes you want to throw up your hands because, though Betsy doesn't pay attention, she requires three times the attention that your other gymnasts do. That's because Betsy has **ADHD. (Attention-Deficit / Hyperactivity Disorder)**

### What is ADHD?

To best manage Betsy and to draw out the best that's in her, it is essential that a coach first realize that ADHD behavior is **NOT** willful behavior. Rather, the behavior is a manifestation of a malfunction in Betsy's brain. ADHD children don't want to be inattentive, impulsive, aggressive or "wired" anymore than the asthmatic child wants to wheeze, or the child with migraines wants a headache. They just can't stop themselves.

Like asthma and migraines, ADHD's exact pathophysiology is unknown. However, we do know that the disorder has a strong genetic basis, is highly inheritable, and that the brains of ADHD children are structurally different from normal "controls." In fact, abnormalities have now been noted on the MRIs and Spect Scans of these children.

Such abnormalities dispel one popular misconception about ADHD - that it's a "fad" diagnosis, and doesn't really exist. To the contrary, ADHD is one of the best and longest researched (over 40 years) disorders in pediatric medicine, and its diagnosis is considered more valid than many other medical conditions. The latest thinking is that, along with the structural abnormalities, there are also deficiencies in the neurotransmitters norepinephrine and dopamine in certain areas of the lower brain. These crucial brain areas are responsible for 1) putting the "brakes" on motor activity, 2) filtering out unimportant stimuli so that the brain does not get cluttered, and 3) processing information, first through a "circuit board," so that the brain does not respond impulsively to it.

Given these neurotransmitter deficiencies, ADHD children usually present with some combination of: Hyperactivity (no brakes), Inattention and easy distractibility (no filter), and / or Impulsivity (no circuit board). If a child presents with enough specific symptoms in these three areas, the diagnosis is made.

ADHD prevalence rates in this country range from 5% to 30%, with boys three times more likely to have it than girls. Some wonder whether ADHD children can succeed at gymnastics, given their difficulties with braking, distractibility and impulsivity. After all, gymnastics is a sport that requires intense focus. Fortunately, from preschool through 10 years of age, most gymnasts at the "recreational" level are not trying tricks that are very risky, and close attention by coaches can prevent most mishaps. As they advance in skill

level, however, special care must be taken in supervising and spotting, as children with ADHD may minimize danger, and can be excessive, impulsive risk-takers.

If a coach understands the disorder, gymnastics can be a wonderful activity for a child with ADHD. The sport teaches impulse control, enhances a participant's self-discipline, adds to a child's sense of physical well-being, and, perhaps most importantly, can boost a child's self-esteem as they acquire skills that their peers may not have ("Hey, look, I can do the splits!"). If the ADHD is under good control, interaction with teammates in a gymnastics setting helps promote socialization and cooperation skills, all within an environment where rules can be learned and successfully followed.

Because of the attentional demands that gymnastics places upon its participants, it is the author's experience that an ADHD child will most likely succeed in the sport if he or she is placed on a medication that will raise neurotransmitter levels to normal. This situation is no different than prescribing insulin for a Diabetic. With insulin, which the Diabetic is lacking, the Diabetic can live a normal life. Without insulin, the diabetes wreaks havoc. Ritalin, Dexedrine, Cylert and Adderal are the most widely prescribed medications to correct the neurochemical deficit in the brains of ADHD children.

These drugs are classified medically as stimulants, and some parents and coaches wonder why a stimulant would be prescribed to a child who is already "climbing the walls." The answer is that, in ADHD children, these drugs don't work as stimulants at all. Instead they act "paradoxically" (in an opposite way than expected), helping areas of the lower brain exert their braking and filtering functions, thus "normalizing" behavior. Anti-depressants such as Norpramin, which raises norepinephrine levels, or Wellbutrin, which raises dopamine, are also sometimes prescribed for ADHD. To correct another popular misconception, children prescribed these medications are not being "drugged," "sedated," or "tranquilized." As with the Diabetic taking Insulin, they are merely being helped to be normal.

Yet, another misconception about ADHD is that these medications are over-prescribed. However, a recent (July 1999) study in the Journal of the American Academy of Child and Adolescent Psychiatry showed just the opposite: that many children with ADHD were not getting any treatment at all-prescription or otherwise - and that many of the children who were receiving medication were being prescribed less than effective doses.

When these findings are combined with the results of another recent NIMH study which found that, predominantly, it is the medication that makes the difference in successful ADHD treatment outcome, it becomes imperative that physicians, educators, and, yes, coaches ask the parent of a child who had been diagnosed with ADHD whether that child has been given an adequate trial of medication. Often parents will resist placing their child on medication for ADHD, hoping that the child will "outgrow it." Unfortunately, 50% of children with ADHD continue to have this disorder into adolescence (only about half appear to improve with the brain maturational spurt at puberty). And it is estimated that between 30-70% of adolescents with ADHD, will continue to have the disorder as an adult.

Of course, medication is not the only answer to managing the ADHD child. As mentioned above, many ADHD children may be receiving no medication, be under-medicated, or like the rest of us, just have a "bad day" now and then. To be successful with the ADHD child, coaches must be familiar with Behavior Modification Principles, as these will greatly improve the chances that the ADHD gymnast (and the rest of the gym) will function

normally.

## **Principles of Coaching the ADHD Gymnast**

Many parents are reluctant to share their child's ADHD condition with the coach. It's a sensitive subject to discuss and they do not want their child "labeled" difficult by teachers and coaches. To help parents "open up" and to better assess the needs of each child, the author suggests that a general questionnaire be given (preseason) to each parent in the gym. In the questionnaire, the coach might state that he or she cares about the "total child," and would like to know about any special areas of parental concern. Does the child have any special conditions that the coach should be aware of, and is the child taking medication? The ADHD medications mentioned above have few side-effects, but possible ones are insomnia, loss of appetite (and weight loss), and increased heart rate.

Having determined that a gymnast has been diagnosed with ADHD, if there are related behavioral and attentional problems, a period of observation should take place during the gymnast's first week or two in the gym. During this time, problematic ("target") behaviors would be observed and recorded. A collaborative effort would begin involving the coach, the parents, and sometimes the child's treating physician or therapist. Such an effort places extra demands on a coach's already limited time and energy, and some ADHD children require what amounts to great sacrifice, but commitment to a Behavior Modification regime will ultimately ensure the best outcome.

Once target behaviors are observed and recorded, a search for conditions in the gym which precede them is undertaken. For example, Betsy would physically and verbally bother other girls while waiting in line for an apparatus. Eventually, her impatience and impulsivity would cause her to jump the line. This would invoke the resentment and jealousy of her peers, leading to a verbal exchange that would escalate to uncomfortable levels. Betsy's coach looked at what she could change about the scenario immediately preceding this behavior, and decided that lines could be made shorter when Betsy was in attendance. The coach also made sure to put Sue, the girl least annoyed by Betsy, immediately in front of her in line. She then put Kristen, the girl most annoyed by Betsy, in a completely separate line. As Betsy's behavior began to improve, she was continuously praised by the coaching staff for refraining from target behaviors, and for staying "on task."

This underscores the important principle that working on antecedents to target behavior is only half the equation in Behavior Management. One must also be lavish and immediate with praise when the gymnast is able to control the target behavior, and quick and consistent with consequences when she is not.

Many clinicians and educators have found that a point system works well in this regard. The child brings a card to practice and a point is given by the coach each time a child successfully controls a target behavior (stays in line without pushing). Remember, points and praise are given for when a behavior does not appear. Each point is entered immediately on the card and can be redeemed for a reward at the end of practice (extra time spent on the trampoline), or toward a reward to be given by the parent at home (being able to stay up 30 minutes later).

## **Undesirable behaviors result in the following consequences:**

1. **No point is awarded.**
2. **A time-out is given. Here, the child may be asked to sit off to the side of the gym for between 5 to 30 minutes, depending on the age of the child. For very unacceptable behavior, the child may be asked to leave practice. (For very unacceptable behavior at home, the child may be forbidden from attending practice at all that day).**

Setting up a firm "game plan" with the parents and child, and adhering to it consistently, are key. When coaches understand ADHD, and when all members of the athletic triad-coach, parent and athlete - are working together, the ADHD child can not only enjoy gymnastics and receive its many benefits, but can succeed at a very high level as well.

## 10 Tips For Coaching The ADHD Child

1. **Short time periods for short attention spans.** Some ADHD gymnasts, rather than working out for three hours a day for two days a week, would do better with a schedule of one hour a day, five days a week. Make sure a clock is visible. ADHD children can often control their behavior for a set amount of time if they know what that time is, and the time is clearly visible to them.
2. **Communicate and coordinate efforts closely with parents.** Somedays parents forget to give medication, or may give it to the gymnast so late that good ADHD control is not achieved until the final ten minutes of practice.
3. **Look for antecedent activities outside the gym** that may be followed by an increase in target behavior during practice. For example, contrary to popular belief, physical activity does not decrease ADHD behavior. In general, therefore, a parent should not bring an ADHD child to practice directly from a softball game, after which they will likely be stimulated, or directly from swimming practice, after which they are likely to be fatigued. Fatigue makes ADHD worse. In addition, parents should try not to get into power struggles or arguments with the gymnast on the way to practice, as this will predispose the child to argumentativeness and oppositionalism in the gym.
4. **Be prepared to handle other parents' resentment.** It is important to be able to explain to the parents of other children that an ADHD gymnast has a medical condition that needs to be accomodated in a special way, and that you would do the same for any other child with any other condition.
5. **Small classes and close adult supervision are optimal.** At times, it is best for an ADHD child to come to those practices that are sparsely attended so that the coach/gymnast ratio is favorable. Parents may need to adjust their schedule so that the gymnast can be brought to these optimal practices.
6. **Try to showcase the gymnast.** One ADHD gymnast glittered at promotional shows because he was able to do a flip that others could not. The audience "oohed and aahed," which greatly enhanced the gymnast's self-esteem.
7. **Provide structure.** ADHD children respond best to routine, and the best coach for an ADHD gymnast is one who is very organized and structured, and whose workouts go as planned. In addition, the coach should review with the gymnast what is expected of

them each time they line up for each apparatus.

8. **"Be a slot machine for praise."** ADHD children are in constant need of reward and praise. When a child follows the rules, heap on the praise.
9. **Act, don't yack.** Avoid "stepping into the arena" and engaging in debate with an ADHD child. You'll never "win." Either praise, withhold a point, or give a time-out.
10. **Look for welcome behaviors and count on unwelcome behaviors.** ADHD children have bad days and good days, just like the rest of us.

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**NOTE: An article on Alternative Medical Approaches for Attention-Deficit / Hyperactivity Disorder will follow in the January 2000 issue of *Techniquemagazine*.**