Hello, and welcome to Nimble Youth, the podcast designed to provide special expert insights and valuable resources for parents navigating the complexities of their child's mental health. I'm your host, Matt Butterman. And today, we begin a three part series on a topic that affects millions of families, attention deficit hyperactivity disorder or ADHD. And my guest today is doctor Gretchen Hoyle, a pediatrician based in Winston Salem, North Carolina. If you've ever wondered why your child struggles with focus, impulsivity, or boundless energy, or if you're navigating a recent diagnosis, you're not alone.

ADHD is one of the most common neurodevelopmental disorders impacting kids, teens, and even young adults in different ways. The prevalence of ADHD among children, adolescents, and young adults has shown a notable increase in recent years. According to the Centers for Disease Control and Prevention, the CDC, an estimated seven million US children, three to seventeen years, had ever been diagnosed with ADHD as of 2022, which represents an increase of one million diagnoses compared to 2016. And this upward trend is further supported by a study published in JAMA Network Open, which found that the prevalence of diagnosed ADHD among US children and adolescents rose from ten point two percent in 2017, '20 '18 to ten point four seven percent in 2021 to '22. Additionally, data from the National Health Interview Survey indicates that during 2020 to 2022, '11 point '3 percent of children and adolescents ages five to 17 had ever received an ADHD diagnosis with higher prevalence observed in non metropolitan areas, which is thirteen point nine percent compared to large central metropolitan areas, nine point four percent.

And these statistics further underscore the increasing recognition and diagnosis of ADHD across various demographics and regions. So in this episode, we'll break down what ADHD is, how it presents across different age groups, different forms of ADHD, and how clinicians make a diagnosis of ADHD. And joining me today is doctor Gretchen Hoyle, a pediatrician who has a special interest in pediatric and adolescent mental health. She has participated in supplemental training through the Reach Institute, organization dedicated to ensuring that the most effective scientifically proven mental health care reaches all children and families. Before we begin, however, we again remind you that the content of this podcast is intended for informational purposes only and should not be construed as medical advice.

While we aim to provide valuable insights on pediatric mental health, it's important to consult with a qualified health care professional for any concerns or questions regarding your child's mental well-being. Always seek the advice of your doctor or other qualified health provider with any medical concerns. So grab a cup of coffee, get comfortable, and let's talk about ADHD because understanding is the first step toward empowerment. Doctor Hoyle, welcome to Nimble Youth. Could you start by explaining what ADHD really is and how it affects a child's ability to function in daily life?

Sure. So ADHD is a neurodevelopmental disorder. And what that means, if you break down that word neurodevelopmental, so neuro, of course, meaning brain. Developmental is a word that we often assign to pediatric conditions because we expect that the function of any, you know, portion of the brain and the mind is going to change over the course of a child's, you know,

childhood, between infancy, childhood, adolescence, and even adulthood. And so ADHD has an impact on the development of the brain, and it does so in a way that we outwardly see three sort of categories of symptoms.

The first is inattention. And so kiddos who have ADHD have a lot of trouble, paying attention to things that are not inherently rewarding to them. So, and that inattention basket, you know, most of the time when we're thinking about that, we're thinking about, you know, what they need to be able to do in school. And so, you know, for most kids, at least some portion of the time, what the teacher is saying in the classroom setting, you know, may or may not be all that compelling to them at the moment as far as being able to hold their attention. But it is important that they are able to maintain their attention to what the teacher is saying.

And I'll often have parents ask, you know, saying, Oh, well, they can pay attention to, you know, a video game or a movie or some other media. And in reality, though, those types of interactions and experiences are inherently rewarding to them. And so, that because just because they can, they can, you know, play a video game for hours does not mean that they do not have ADHD because the video game is something that their brain finds rewarding, and they are able to attend to it. But, of course, most of life, especially in school, is someone else's agenda. Right?

So, the teacher has a curriculum that they need to cover and the child needs to be able to engage in that curriculum and pay attention at whatever developmental level is appropriate. And so kiddos who have ADHD have a lot of trouble doing that. The second big basket of, like, ADHD symptoms is difficulty controlling impulses. And so, you know, impulsivity is, is a real challenge for these kids, and I think that kind of the way to think about that is that, you know, we all kind of go through life, especially childhood, where, you know, we something catches our eye that's of interest or looks like it would be fun to do, but most of those impulses that come to our brains, we pretty much need to suppress. Right?

So, because if everything that caught your interest you went and engaged in, then you would look very much like a really young child. That's what toddlers and young children do is that they're kind of into everything everywhere all the time because it looks interesting to them and they don't maintain attention on any one thing. But, of course, as we get older, the expectation is that you're gonna be able to, you know, constant to to pay attention to what you need to and also control the impulses that would pull you off task and also control impulses that might be really, like, if you're looking at, especially with young children, the difference between good and bad choices. So a lot of times the impulse is to, you know, make a quote unquote bad choice, and we need to, you know, recognize for kids with ADHD that they have a really hard time controlling those impulses a lot of the time. Right.

So, it's often been mentioned that ADHD could better be described as a disorder of executive function and self regulation. Right. Could you expand a little bit on that and explain why the term might offer a clearer understanding of the condition? Sure. Sure.

And just to, like, you know, clarify too, there's the hyperactivity component that is, you know, is also that increased motor activity, which kind of goes along with the inattention and the impulsivity, but those are all kind of in that diagnosis. And so that's how we have sort of constructed it in modern Western medicine, but there is a psychologist, whose name is Russell Barkley, who has written many books and has a pretty significant presence on social media, and I highly recommend his books and information. I think we can link those, I guess. We'll link those in our website for sure. And so he has suggested that perhaps a better name for ADHD is disorder of executive function and self regulation.

And I think that that really, like, sort of encapsulates what's happening with these kiddos. They have a lot of trouble with what we call executive function, which is the idea that, you know, in the very, very front part of your brain, we have a center that is that develops as we get older that allows us to plan and see consequences and attend to things that may not be inherently rewarding to us, sequence events, those kinds of things. And that is the prefrontal cortex? Correct. That's correct.

Yeah. Part of the way to sort of think about this, I'll talk with parents about it, is that, you know, the brain is in many levels. And so sort of the lower part of the brain that's closest to the spinal cord is responsible for doing things that we don't even think about, that are, you know, involuntary, that, like, keeps our heart beating and our breathing in and out and all of our functions moving along. And then as you come up further towards the forehead, sort of at the top of the skull, there's our motor and sensory cortex, and these are functions that our brain has, you know, from the beginning. So, you know, young children can do those functions, and lower species can do those functions and those are Sort of baked in abilities.

Correct. Exactly. Yeah. But those are voluntary. So we are aware of them and we make choices to do them or not as far as, like, you know, moving our arms or legs or running or whatever.

And then as you get further closer the brain is, is less developed, of course, in younger children, and it gets, you know, it continues to develop as we get older. But that is our really highest functioning area. So the things that really make us separate us as humans from lower species, but then also tend to, you know, help with our maturity as individuals, that's happening in the prefrontal cortex. And so the executive functioning that happens there is our ability to, you know, control our impulses, see what the consequences of our actions are gonna be. The things that parents worry about that kids are not, you know, if their child is struggling with that, those are often the signs and symptoms that folks think of as that are related to ADHD.

So, ADHD is not just a a school problem. Right? That's It's Mhmm. It's something that can affect a child's life in a very broad sense. Is that right?

Very much so. You know, if you think about making good choices and bad choices, there was a a study at one point that actually looked at the prefrontal cortex on imaging studies. And that's not to say that, like, you should go to your doctor and say, you know, I want an imaging study or MRI with my child to look at their ADHD because that's not we don't really use it in a clinical

sense like that. But we do there are studies where they have looked at kids and done imaging where they can see that the part of the prefrontal cortex that is sort of the busy part, cortical thickness in that area is gets thicker as you get older and such that for kiddos who have ADHD, they often have a prefrontal cortical thickness. So that busy part of that part of the brain is actually thinner, and it's more like this the thickness of a child who is a year to a year and a half younger.

Right? So let's say you have a five year old, but they have the executive functioning of a child who's three and a half. That is going to, like, cause challenges in the kindergarten classroom. Right? So, those kids are gonna have three and a half year old levels of being able to sit in a circle and walk in a line and keep your hands off your neighbor and try to do the things that you need to be able to do to be sort of successful in a kindergarten setting.

Right. And, and so that is certainly a school problem, but it is also, you know, a a social challenge too. So if you're a five year old, the size of a five year old, and you're, you know, your executive functioning is at the level of three and a half year old, then, you know, you can do some pretty significant damage to yourself and potentially to other people. And so if you're having impulses that particularly, you know, are either annoying to other children where you just constantly interrupt and can't, you know, hold a conversation, they don't have the back and forth with other kids that you would. Or if you're doing things where, you know, if somebody comes up, you know, and sort of teases you, calls you a name, and then you punch them in the face, you know, that's a problem.

Right? So, like, because that is that difficulty controlling that impulse. And so that kind of also goes along with the self regulation part. And so if you think about, like, our executive functioning, that helps us sort of cognitively make decisions, but part of those decisions are also being influenced by what our emotional state is at the time that we're trying to make those decisions. And so we talk a lot nowadays about dysregulation, and so when people get upset or angry or panicked or, you know, scared or sad or any of the sort of, challenging emotions, then, you know, you really are for self regulation.

If you're able to self regulate, then you're gonna be able to get your brain involved with making it so that you're able to control your behaviors even in the face of feeling uncomfortable. Right? Right. So if you're angry, if you yourself if you're able to self regulate, then you are able to control that impulse to do something aggressive or lash out against another kid or do something, you know, else. And so, it's super important in social settings to be able to do that effectively and kids with ADHD have a lot of trouble with that.

I mean, young children in general have trouble with that. So, that's a life skill to learn and it is something that we all have to work on all of the time, like how do we help regulate our internal emotional experience so that it matches the behavior that we want to display to the world. But for kids who struggle with ADHD, you know, you can imagine where that would cause, you know, some social challenges. So they may be the kind of kiddo who, you know, may not get invited to play dates and get the opportunity to, you know, socialize as much with other kids.

And as we, like, learned from the pandemic, for sure, those interactions that we used to not maybe think about so much, but now we really realize how super important those are.

And so if a kid for sure. Yeah. So if it is so because we had a whole generation of kids or not a whole generation, but like a whole group of kids who, you know, kind of missed different, you know, developmental stages. Yeah. Yeah.

Because they were in isolation and, you know, if you have a kid who's kind of we're recognizing how important those are. And so if there's a kid who has behavioral challenges, that makes it difficult for them to be able to access those kinds of social interactions. So it's not just a school thing. It's also how they get along with their peers. It's how they get along with their family members, siblings.

A lot of it is, you know, being able to regulate within their own household so that things run smoothly. And that is it's just a real challenge for families where there are kiddos who struggle with this, and that is this is kind of how I explain it to parents when I see them in clinic that, you know, these are challenges that are, for the most part, you know, for the kid, it's not something that they want to have. It's not something that they are choosing to do. They are just having a lot of trouble being able to access their executive functioning, and to maintain a self regulated state because of their ADHD. Right.

So that brings up another, another issue. So how ADHD manifests in one child will not be the same for another. Right? Very true. So let's talk a little bit about the different types of ADHD.

Three sorts of categories. One would be inattentive. Mhmm. Another would be hyperactive or impulsive. And then the third would be combined.

Correct. All those things combined. And so how do the symptoms compare or differ across each type of ADHD? Yeah. That's a great question.

So they are different from each other. And then I would also say that sometimes depending on the age of the child, their own ADHD can change over time. So, like, the classic, I think, patient with ADHD that I think a lot of us think about are young children, maybe kindergarten, early elementary age, and the primary problem that folks are recognizing is the hyperactivity slash impulsivity. Right? So they are doing things particularly in a classroom setting or even, you know, prior to that, even before they're in school, where, you know, their ability to make good choices is just not on level with their peers.

Right. Okay. And sometimes that can be really, like, dangerous stuff. So there have been occasionally, like, you know, usually for most of my kids the diagnosis, you know, if they're gonna get a diagnosis in elementary age, it's gonna be, you know, once they're in school, but occasionally I will see kids who are a little younger than that, so four year olds who are in preschool, but the issue for them is that they are engaging in sort of that hyperactive impulsive behavior that is so problematic Right. That I'm worried that they are going to get really hurt.

And, of course, kids get hurt all the time, and I'm completely fine with that. I mean, you know, we're gonna have the normal bumps and bruises of childhood. I'm in no way saying that, you know, that I'm trying to keep people from ever, you know, having any of that happen. You can't live in a bubble. No.

Absolutely not. But I would say, like, if you are four and you're, your primary care giver when your parents are at work is your grandmother and you keep running out in the street Yeah. Then you can't do that. Right? Yeah, exactly.

And so and so we have to sort of consider the context entirely and make it so that, you know, we are able to mitigate the risk of a kid who is, you know, having significant executive functioning, what that means to that kid in their lives. Right? Right. And so, but for the for typical, we're looking at elementary aged kids and, and and the first thing that people start to notice especially like in a, you know, kindergarten, first grade classroom is just the constant mobility. So hyperactivity, you know, a lot of times people will consider this like the question here I think that gets to it the most is like does it feel like your child is driven by a motor?

Right. Like they just sort of turn on and then they are in motion until something or someone really, you know, kind of puts a stop to that. Like, so they are constantly moving and, and that, you know, does, you know, young children, of course, are busy and moving around a lot and that is developmentally appropriate, but you there are kiddos. I think we can all think about, you know, being in elementary school, if you can remember that back that far, but there always are kids where that, that problem is it's just they're standouts. Right?

They have more trouble with that. Yeah. And they are doing things like, you know, jumping up on the furniture and jumping off of the furniture and getting hurt and kind of emotionally accidentally, you know, involving other kids and, and just unable to sort of control their impulses, especially in a setting, like in a classroom setting where there are lots of fun, potentially fun things to do, but you have to be willing to do them based on what the teacher's agenda is. Right? Right.

Right. So and so these are the kids who really have a hard time, you know, being able to sort of settle down and like come to the carpet, sit on the carpet, and let's do, you know, the alphabet or whatever. And they just are still in motion. And that's that's our sort of most common, like, initial diagnosis story Right. For young kids.

Right. Okay. And I I I think it's important to point out that ADHD, while it's characterized by these behavioral problems Mhmm. The inability to regulate behavior has nothing to do with intelligence or creativity because, in fact, sometimes, kids with ADHD have very high intelligence and, you know, creativity as well. Yeah.

Those are two different things. Yeah. For sure. And in fact, like, you know, some of the kids who are, you know, the like and and so as far as, like, the inattentive type, you know, a lot of times

sometimes kids who have initially hyperactive behavior and that's how they get their initial diagnosis, as they get older, they just look more inattentive. They just have a harder time sort of staying on task, and so we're still sort of managing that, for them. So I will tell parents a lot of the time, a lot of the time, my kiddos with ADHD have the ability information.

And so they're very right. They've got a lot of, a lot of information going on in their head. And sometimes the more information you have, the more trouble you have focusing on what the agenda is. Right? And so I will liken it to, like, the idea, like, if your child's brain is like an office and they've got just tons of of information, you know, swirling around in there, like, they've got tons of like, let's say each piece of paper is is new information to them.

And it's like they're, you know, that office is full of papers that are swirling around and to manage their ADHD, we need to get them a file cabinet, right, so that they can then organize all that information. And the brighter that you are, a lot of times, you know, the more that's going on in that office and it's harder to get everything together and organize it because you just have, you know, more information to organize them. Right. Sometimes other kids your age and so a lot of my ADHD kiddos or just, you know, generally the idea of kids, you know, we're starting to use other terms that, that kind of encapsulate of different conditions, but, you know, neurodiversity versus neurotypical, and a lot of kids who are neurodiverse or have, you know, different strengths, are super intelligent and it just makes it a little harder for them to be able to, you know, organize the high amount of information that they have going on in their head. Right.

Right? And so ADHD can look, you know, very challenging for them. Right. Yeah. So, I think you've touched on this a bit, but as a clinician Mhmm.

When a parent brings a child into your office and, there's no, you know, there's no blood test for ADHD Correct. Yeah. No no chemical result that will make the diagnosis. So how do you make that diagnosis? What do you look for?

Yeah. That's a great question. Yeah. I'm kind of happy there's no blood test for that because that's never fun. No.

But, but yeah. So ADHD is a clinical diagnosis, and we do it based on, especially in the early ages of something called behavioral rating scales. And the most common one that we use is one called the Vanderbilt, scales or Vanderbilt forms. And the way that these are set up, you know, all of these mental health conditions, whether it's ADHD or anxiety or depression or autism, all of them are described in the DSM manuals. Right?

And so they all have, like, a list of potential symptoms. And so, really, what happens with the potential symptoms. And so really what happens with the Vanderbilt forms is that it asks the parent and the teacher or sometimes with other people will I get I'll be like, can I get a Vanderbilt from your child's tutor or their Sunday school teacher or their coach? I mean, different folks. You need at least, you know, you need a parent plus at least one other person because part of meeting the diagnostic criteria is that you're having trouble in more than one environment.

It's not just at home. It's also at school or in some other social setting. Right. Okay. So assuming that you've got both of those, then the first, like, questions on the Vanderbilt, are about inattention.

Yeah. So the first nine questions are basically like, does your child have difficulty keeping their attention to what they're supposed to be doing? And you can say never, occasionally, often, very often. Okay? And so the idea here being and most teachers are trained on this is that, you know, you do have to like, the good the thing for teachers is that they're looking at a bunch of kids who are in the same age group so they can tell whether or not a child is sort of a standout on that.

Because you would never, I mean, you know, if you compare a five year old with an eight year old as to how often they're able to stay on task, that wouldn't be fair. Right? But if you're comparing an eight year old to other eight year olds, then that's you know, if you're and you're feeling like that that child either often or very often has trouble staying on task, then, trouble staying on task, then, you know, that's helpful for us Sure. Diagnostically. Right?

Yeah. So the first nine questions are about the sort of inattention, symptoms. And the second nine are about impulsivity and hyperactivity. So it asked, does it feel like your child is driven by a motor? And that's sort of our best sort of way to get to hyperactivity.

And then, you know, just other impulsive questions like, you know, are they having trouble different with controlling impulses is basically what we're asking. And it's on a scale of never, occasionally, often, very often. Gotcha. And that scale then converts to a zero to three. That was my next question.

Actually. Is there a numerical score? Correct. There's a numerical score for that. And so, the initial Vanderbilt, both for the parent and the teacher, has additional screenings for other conditions.

So it does. The first nine questions are inattention. The next questions are hyperactivity and impulsivity. The next set of questions are screening for what we call comorbidities, so other conditions that go along with ADHD. Mhmm. The most prominent of those is a sort of oppositional defiant disorder.

Right. And I really loathe to make that diagnosis even if the even if it's positive just because it it's a diagnosis that, you know, I just I want a shorter treat their ADHD and see if we can get those other oppositional things better because I I wanna be careful about labeling kids as people who are argumentative or aggressive or any of that. Because in reality, I think most of it, especially for young kids, is that they're just their impulse control. Right. And so I don't, you know, I don't wanna stick a label on there that was like, he's oppositional.

And that and, and so it helps me, like, get a numeric score on those, but I don't typically take that information and then make a diagnosis based on that. But it helps me follow it. The next set of questions are about something called conduct disorder, which is really more pertinent to older kids and it's often about sort of getting into trouble and legal things and, you know, and so most of the time for our young kids, those are all nos, zeros. They never do that and that's good. Good.

And then it also screens a little bit for anxiety and depression, which is super helpful. Mhmm. A lot of kiddos, and we'll talk about that at a later time. But Right. But a lot of kids who have a lot of anxiety, can have very similar symptoms to ADHD because they're so worried that they can't pay attention and because they're, you know, thinking about something that they're, you know, scared of.

And so, and so those there's a lot of overlap there, but it also helps me sort of determine whether that's part of the picture for them. And so we get all of those questions and we get them from both the parent and at least one other person, but the more the merrier. The more information I can get, the better I feel about, making that diagnosis of ADHD and, and the more that, you know, I the more similar the scores are, then also the more confidence I have that, you know, we're in the right ballpark. But, basically, the idea here is that the first eighteen questions are the core questions for ADHD. And so since they're scored, like, zero to three, then the maximum you could get is a 54 if you were threes on everything.

And so what I tell folks is that I rarely see kids who you know, that's their score. A lot of times, you know, on the initial evaluation, they're in the thirties or forties. Yeah. The goal of what we would consider to be therapeutic treatment for ADHD would be to get the score to about eighteen, and eighteen would mean that they're getting a score of occasionally on each of the questions. My goal is definitely not to get it to zero.

Right? So I'm not trying to make it so that they never have trouble paying attention or they never, you know, engage in, you know, mischief or whatever. I am not it's not my goal at all. Right. Because that's part of being a child.

Correct. Exactly. And so I think that a lot of times when folks are worried about getting a label for their child as having ADHD or treating their child with medicine that they're worried about flattening out their personality Mhmm. I definitely worry about that as well. I don't sure.

And the word that people often use is, you know, I don't want my child to be a zombie and that is an appropriate way to describe it, honestly. If your child is really flattened out and they are kind of feeling, like, kind of robotic and they're only doing what the teacher says and they're not engaging with their friends, they have zero interest in any kind of like social risk taking behavior, nothing, then that would be that is not where I'm trying to Right. Get to. Right. So it's trying to figure out how to thread that needle to get them functional in the classroom, but still maintain their essence and their personality.

And so, and so at some point when we talk about medicines, we'll talk about how to potentially do that. But that will help us sort of determine whether the child sort of meets the criteria for a diagnosis of ADHD over there's Vanderbilt questionnaires. And, of course, you know, we also do, you know, we do a full history of developmental Family history. Yeah. Yeah.

History and all that stuff. Yeah. Absolutely. And all that stuff is, you know, super important because, you know, it it you wanna make sure that you're not looking at something else. Sure.

But, you know, generally speaking, you know, the Vanderbilt is kind of our, kind of go to tool, to make the diagnosis. And so when folks, like, come to see me in in the office, and if there's if if it's the kind of thing where we're there for a checkup and they happen to bring it up or if they're coming for some other reason and they have to bring it up and I and I don't know about it at all in advance, then usually I will do the Vanderbilt form with the parent there and then I will hand them forms to get to the teacher. Right. Or I'll have someone arrange for us to get forms for the teacher. So if I don't have both, if I don't have a a form from a second person, I can't make the diagnosis on that first day.

But for parents who call in and they're talking to our scheduling folks and our nurses, and our nurses are really good triage wise at trying to figure out, you know, whether that's a concern, then a lot of times we can get the forms to them beforehand, and then when we get together, we've got the information that we need. Right. So is there a particular age, like, grade level or age where you see, the diagnosis of ADHD, made most commonly? Right. So so, usually, I mean, kindergarten, like, especially if kiddos have not had a lot of preschool experience.

Right. Sometimes, you know, most of the time in preschool, you know, they're just being like, oh, he's really lively, and that's great. I mean, you know, but most of the time, they're not gonna be like, oh, you know, something is you know? It's not dysfunctional necessarily. Correct.

Right. Because you're not really expecting them to do, like, complex academic tasks. And you're not really, I guess, expecting that too much in kindergarten. Although, I will say kindergarten is like the new first grade. The goal, I think, is for a lot of these kids is to be reading at some level by the time they're, you know, finishing up.

I mean, there's a lot for them to cover in kindergarten, and so when kids are really struggling with that, you know, that often comes to us. The bigger thing in kindergarten, though, is more the hyperactive impulsive behavior that causes them to seek our attention because it's disrupting the class and that, you know, there are limits to what the schools can manage in a classroom setting. And so there will be some threshold at which the teacher will reach out to the parent and say, hey, we need some help with this. Right. And that's coming from me.

My mom taught, you know, thirty years of kindergarten. Yeah. And so, like, you know, it's so interesting to, like, you know, pick her brain. She's been retired for a while but, like, you know, there are a lot of things that, especially in that entry year, that have to kind of get accomplished for kids and that's academically and behaviorally and socially and all the things that, you know,

now that they're coming into the school system, we need to be able to sort of sort some things out. So that is typically the most common age.

I will have kiddos who will, you know, kind of there will be some information about it during those kindergarten, first, and second grade. Sometimes parents are resistant and we just sort of watch it for a little bit and we're like, okay. We're gonna see what happens. And then the next time is like third grade, because of the EOGs. Yeah.

Okay. So and this is again, like, this is just my this is just my observations. So I'm not trying to say that, you know, that, like, schools are needing you to pass EOGs, but it is a metric. Right? And so and so for kids that pay that teachers can see in third grade where you're like, this kid is super bright and they just cannot perform on this test.

Like, this is a big red flag. That's a red flag. It's and it's a trip, it's trouble, it's problematic for the school, and I get that. Like, the EOGs are a measurement of, you know, how things are going in the classroom setting, but it does impact that child. Like like, it is going to be, like, it is going to continue to come up for them usually.

And then and then if you have a really bright child who then gets, you know, tracked into classes where they're not, you know, getting as high level of information as they can handle because they're disorganized, then, you know, that it's just not a good match. Right? So then they're more bored, but they can't, you know, produce the work. You have to you there are just agendas that as a kid in school that you have to be able to do in order to, to progress in a way that's gonna be for your own best outcome. Sure.

Sure. And so third grade's a really common time. I mean, this time of the year, honestly, like, I think a lot teachers, third grade teachers and I haven't had anybody actually you know, I haven't picked anybody's brain on this specifically, but I I can imagine that if you're if you're a teacher where you're like, this kid can should totally be able to do fine on these tests, they're super bright, their vocabulary is great. They can do math problems in their head, but they cannot sit still to do Right. You know, worth a lick.

And so that is a rational time that people start, you know, presenting to the clinic and have us have a conversation about it. Gotcha. Gotcha. Next time, we're gonna talk a little bit more about ADHD throughout the youth life cycle and continuing care for it. Is, the key to better outcomes with ADHD, diagnosing it early?

Correct. Yep. Yeah. So there's really good evidence that shows that if you get a diagnosis, like age nine or earlier and you treat it, you know, effectively for, like, a five year period, this is how this is how the study was set up. Right?

So, if you do that, then the outcomes are much better than if you take a child who does meet criteria but does not get treatment. And so a lot of times when parents are, like, concerned about, you know, getting that diagnosis and considering medication and and I tell people, you

know, if I could wake up in a world where no one needed medicine, I would love that. Sure. But, you know, we just don't really live in that world and I would say that a lot of things that parents worry about managing a child's ADHD is one of the most important things that we can do to reduce the likelihood of the kind of outcomes that we're scared of. So, you know, people who have untreated ADHD as they get into adolescence will often take the opportunity to self medicate Right.

Which can lead them to substance use, which is a huge, like, problem, of course. Sure. That's a big fear for parents and rightfully so. I mean, statistically, that's a it's a big deal. Yeah.

And so, you know, we want to mitigate that risk, for kids who have ADHD if they are if, you know, a lot of times what I will see is that if they have had struggles in the classroom and were not and that's not getting better and they're kind of constantly getting called down and, you know, they're hearing their name in a sort of a negative tone from the teachers and the adults around them, then as they get a little bit older, they will start to internalize that and their own sort of self esteem starts to suffer because they feel like they are not as good as their peers even if they are smarter or more capable. I mean, they have a lot of great qualities, but if they are the biggest thing that we ask kids to do is to be able to hang in the classroom and do what yeah. And that's what they are, they spend more hours trying to do that than anything else. So if it's not going well It's often difficult for a young person with ADHD to sort of jump through the hoops. Right?

Correct. Yeah. Exactly. Yeah. And yeah.

And so I think that it is reasonable for us to argue as to whether or not all the hoops and all of the grades are developmentally appropriate. I completely understand that argument that maybe some of this stuff is a little beyond what we can rightfully expect folks to do, but I can't change any of that. Right? And so my goal is to try to give that child the best possible outcome based on the evidence that we have. And so I know that, you know, managing their ADHD early and effectively reduces the likelihood of, you know, substance use in the future.

It reduces the likelihood of what we call comorbidities, which is like anxiety and depression because they're not being successful in school, which is the most prominent thing in their lives, really. So even if your kid, you know, does sports or does other activities, all of that is awesome, but they're not gonna spend as many hours doing that as they're gonna do if they're in, like, traditional in person school. Mhmm. And so we for them being successful in the classroom I think is important for you to be able to, you know, grow up with a good self esteem. Right.

And then also like managing their ADHD, you know, if we look at things that, you know, cause morbidity and mortality in young adult young adults and adolescents, it's almost, you know, entirely behavioral or a good portion of it is behavioral and so it's things like accidents and a lot of times that is, you know, sort of connected to risk taking behavior and so kids as they get older and if they're still having a lot of trouble with impulsivity, then that can, you know, lead to impulsive behavior that's actually, you know, pretty dangerous. So when it comes to driving or

any things that you need for them to make good choices with is important. And then, you know, also, you know, that ability to feel like they are being successful and that they're and they can project themselves into the future and recognize that they, you know, have sort of the world as their options as opposed to feeling like those options are narrowing because, you know, school's not going well. So ADHD is a a huge topic. That's why, we're devoting three episodes to it.

We could probably dedicate more episodes. I'm sure we will revisit the topic again. But next time, we're gonna talk a little bit more about the treatments for ADHD. Mhmm. And, you will again be joining us.

Thank you, doctor Hoyle, for today's insight. We talked a little bit about what ADHD is, and the various types of ADHD, and then, how you make a diagnosis as a clinician. And, so we'll explore the topic a little further next time about how you treat it. So thank you, Doctor. Hoyle, and thank you, listeners, for joining us today.

We're excited to have you along on this journey, as we explore the complexities of parenting in the modern world. Again, be sure to subscribe at our website, www.nimbleyouthpodcast.com. That way you don't miss an episode, and, we're also gonna be posting links there to some of the research studies and the books we mentioned. So in the next episode, we'll just continue our discussion with doctor Hoyle. And, until next time, take care, care and remember having a mentally nimble child isn't just about preparing them for the world, it's about helping them thrive in it.