Difference between ADHD and ADD

**ADD** (Attention Deficit Disorder) is one of three types of **ADHD** (Attention-Deficit Hyperactivity Disorder), a neurobehavioral developmental disorder primarily characterized by “the co-existence of attentional problems and hyperactivity, with each behavior occurring infrequently alone” and symptoms starting before seven years of age.

While the term **ADD** is still used by laymen, it was formally changed to **ADHD predominantly inattentive** (ADHD-PI or ADHD-I) in 1994 with the publication of Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). The other two types of ADHD are **ADHD Predominantly hyperactive-impulsive** and **ADHD Combined hyperactive-impulsive and inattentive**.

**Comparison chart**

<table>
<thead>
<tr>
<th></th>
<th>ADD</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Classification</strong></td>
<td>Attention Deficit Hyperactive Disorder, Inattentive Type (ADHD-I)</td>
<td>ADHD is of 3 types, ADHD-I (erstwhile ADD); ADHD, Predominantly Hyperactive-Impulsive Type; and ADHD, Combined Type: Inattentive and hyperactive/impulsive</td>
</tr>
<tr>
<td><strong>Male to Female ratio</strong></td>
<td>2:1</td>
<td>4:1</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>Have trouble paying attention, finishing tasks, or following directions, are distracted; appear forgetful, careless and disorganized; and frequently lose things.</td>
<td>Might or might not display significant attention problems, appear restless, fidgety, overactive and impulsive. They “act before thinking” and often “speak before thinking” by blurting out and interrupting others.</td>
</tr>
<tr>
<td><strong>Behavior</strong></td>
<td>Sluggish and slow to respond and process information, have difficulty sifting through relevant and irrelevant information. Day dream and may be shy or withdrawn. This activity is consistent and not only in a certain setting.</td>
<td>People with these hyperactive/impulsive behaviors may play and interact loudly. They have difficulty staying in their seat, talk excessively, and have trouble waiting turns. They may seem to be perpetually “on the go.”</td>
</tr>
<tr>
<td><strong>Stands for</strong></td>
<td>Attention Deficit Disorder</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
</tbody>
</table>

**Symptoms and Diagnosis**

The American Medical Association concluded in 1998 that the diagnostic criteria for ADHD are based on extensive research and, if applied appropriately, lead to the diagnosis with high reliability.

**The DSM-IV criteria are listed below:**

**Inattention:**

Six or more of the following signs of inattention have been present for at least 6 months to a point that is disruptive and inappropriate for developmental level:

1. Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
2. Often has trouble keeping attention on tasks or play activities.
3. Often does not seem to listen when spoken to directly.
4. Often does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
5. Often has trouble organizing activities.
6. Often avoids, dislikes, or doesn’t want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework).
7. Often loses things needed for tasks and activities (such as toys, school assignments, pencils, books, or tools).
8. Is often easily distracted.
9. Often forgetful in daily activities.

**Hyperactivity:**
Six or more of the following signs of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for developmental level:
1. Often fidgets with hands or feet or squirms in seat.
2. Often gets up from seat when remaining in seat is expected.
3. Often runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless).
4. Often has trouble playing or enjoying leisure activities quietly.
5. Is often "on the go" or often acts as if "driven by a motor".
6. Often talks excessively.

**Impulsiveness:**
1. Often blurts out answers before questions have been finished.
2. Often has trouble waiting one’s turn.
3. Often interrupts or intrudes on others (example: butts into conversations or games).

II. Some signs that cause impairment were present before age 7 years.
III. Some impairment from the signs is present in two or more settings (such as at school/work and at home).
IV. There must be clear evidence of significant impairment in social, school, or work functioning.
V. The signs do not happen only during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. The signs are not due to some other another mental disorder (such as mood disorder, anxiety disorder, dissociative identity disorder, or a personality disorder).

**Prevalence**
ADHD is the most commonly studied and diagnosed psychiatric disorder in children, affecting about 3% to 5% of children globally and diagnosed in about 2% to 16% of school aged children. 5% of American adults are estimated to live with ADHD. ADHD inattentive type is subtle in nature, likely to manifest about at 8 to 9 years of age, while ADHD predominantly hyperactive, impulsive and combined type is usually obvious by 5 years of age and peaks in severity between 7 to 8 years of age.

**Medical prognosis**
Children diagnosed with ADHD have significant difficulties in adolescence. Those affected are likely to develop coping mechanisms as they mature. ADHD persists into adulthood in about 30-50% of cases.

ADHD inattentive type affects the cognitive development and remains throughout life. With maturation, these behaviors progressively decline and often have been "outgrown" by adolescence. However, impulse issues remain well into adulthood.

**Adult ADHD**
A good 4% - 5% of adults in the United States (i.e. 8 million adults) are said to have ADHD. Adult ADHD can be the continuation of childhood ADHD. Even though ADHD affects boys at higher rate than it does girls in childhood, this ratio seems to even out by adulthood.

Adults with ADHD may have difficulty concentrating, staying organized, following directions, remembering information, or completing work within time limits. If these difficulties are not managed appropriately, they can cause associated behavioral, emotional, social and professional problems.

Adults with ADHD are more likely to perform poorly and change employers frequently, have less job satisfaction and fewer occupational achievements.

**Treatments**
ADHD cannot be completely cured, but many of the symptoms that interfere with functioning and cause distress can be controlled with a combination of medication (Concerta, Ritalin, Aderall, among others) and psycho-social therapy. Organization aids like calendars, planners, task managers and timers are other ways to help people with ADHD function better.

*Psycho-Social Therapy - This therapy is designed to help a client adjust to and develop the social skills necessary to interact constructively with others. These are the skills that allow a person to interact and to act appropriately in given social contexts. The skills include assertiveness, coping, communication and friendship making skills.*
Autism vs. Asperger Syndrome

Autism is a spectrum of disorders that are diagnosed on the basis of an individual's behavior in two realms — social communication and social interaction, and repetitive or restricted patterns of behavior. While autistic people may share some characteristics, there is a huge variation in how the disorder manifests itself. Hence the use of the word "spectrum" in describing the condition. In fact, there is so much variation in autism symptoms that it is commonly said: "If you've met one autistic person, you've met one autistic person."

Asperger's syndrome was considered a subtype of "high-functioning" autism, characterized by the absence of a key symptom of classic autism — developmental delay in speech and language acquisition. However, DSM-5 eliminated this classification of Asperger's and autism is now categorized differently.

The prevalence of autism in the United States has increased dramatically in the past two decades, the most recent available estimate being 1 in 68 children. The disorder is 5 times more common in boys (1 in 42) than among girls (1 in 189).

Defining Autism

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the official diagnostic and classification tool for the American Psychiatric Association. In 2013, the fifth edition of this manual (DSM-5) was released and a big change was made to the classification of autism spectrum disorders.

The only clinical difference between Asperger syndrome (often just called Asperger's) and classic autism was that language acquisition was not delayed in Asperger's and there was no significant delay in cognitive development. Individuals with Asperger's — often called Aspies — often have difficulty in social settings, which ranges from awkwardness to anxiety, lack of empathy to preoccupation with a narrow subject, and one-sided verbosity. However, as kids grow up, they are able to better cope in a neurotypical world because their cognitive abilities are intact (and, some may argue, often superior).

DSM 5 Diagnostic Criteria

A good guide to the (relatively new) DSM-5 diagnostic criteria for autism can be found here. A summary of the criteria is as follows:

1. Social Communication: Persistent deficits in social communication and social interaction across contexts, not accounted for by general developmental delays, and manifest by all 3 of the following: Deficits in social-emotional reciprocity; ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interaction.

2. Deficits in nonverbal communicative behaviors used for social interaction; ranging from poorly integrated verbal and nonverbal communication, through abnormalities in eye contact and body language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures.

3. Deficits in developing and maintaining relationships, appropriate to developmental level (beyond those with caregivers); ranging from difficulties adjusting behavior to suit different social contexts through difficulties in sharing imaginative play and in making friends to an apparent absence of interest in people.

4. Repetitive Behaviors or Restricted Interests: Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least 2 of the following 4 symptoms: Stereotyped or repetitive speech, motor movements, or use of objects; (such as simple motor stereotypies, echolalia, repetitive use of objects, or idiosyncratic phrases).

5. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change; (such as motoric ritual, insistence on same route or food, repetitive questioning or extreme distress at small changes).

6. Highly restricted, fixated interests that are abnormal in intensity or focus; (such as strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests)

7. Hyper or hypo reactivity to sensory input or unusual interest in sensory aspects of environment; (such as apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects)

With the new criteria defined in DSM-5, Asperger syndrome is no longer a separate diagnosis. The severity of autism is determined based on the severity of the symptoms outlined in the two broad areas.
Treatment

Early intervention is important in autism treatment. Autism treatment options for children usually include:

- **ABA therapy**: ABA or Applied Behavioral Analysis is used to teach children and young adults a variety of adaptive skills. For non-verbal children, the focus of ABA is often teaching communication. Other kids learn academic skills, social skills or even physical motor planning through ABA techniques. There are many flavors of ABA, like PRT (Pivotal Response Training), ESDM (Early Start Denver Model) and VB (Verbal Behavior). These flavors have considerable overlap in their techniques, the biggest being the use of reinforcements to create incentives for the behaviors you want the child to engage in. Some autistic adults oppose ABA, especially therapy where children are not allowed to stim. (Stimming is a soothing behavior that autistics use when overwhelmed by something in their environment.)

- **Speech and language therapy (SLT)**: It might seem that Aspies (or, more formally, individuals diagnosed with Aspergers) do not need speech therapy. This is often but not always the case. Speech and language therapy includes nonverbal means of communication such as gestures, body language and eye contact. It also includes pragmatic language, which involves the use of language in social situations, listening as part of communication, and socially appropriate exchanges. For example, not interrupting other people when they are talking, recognizing when the other person is interested in the topic of conversation, and reading body language. Sometimes these skills are taught by Speech and Language Pathologists, either in a one-on-one setting or in a social skills group.

- **Social skills groups**: Many autistic children have challenges with social interaction because they may not know how to interact with peers. Some are genuinely asocial in that they are not interested in other people. But more often they are simply unsure what to say, how to approach their peers and engage in a social exchange. They could even be afraid of what they assume the peer will say to them. Social skills groups are a great resource in such situations. Many such groups work by teaching kids "social scripts" — canned scripts to facilitate short social interactions, with the aim of equipping children enough to make them comfortable trying social interactions. With practice, this gets easier and they are able to generalize these skills to other situations outside the social skills group.

- **Occupational therapy**: Other disorders like dyspraxia and hypotonia occur more commonly in autistic children than neurotypical children, so occupational therapy is often required to improve fine motor skills and adaptive skills such as writing by hand, tying shoe laces, or toileting.

- **Physical therapy**: Delayed development of gross motor skills is often observed in autistic children. Some may have trouble with motor planning or other disorders like hypotonia. Physical therapy helps in these cases. Another advantage of physical therapy is that improved hand-eye coordination improves playground skills, which is a great help in socializing with peers.

- **Dietary interventions**: Children with autism spectrum disorder face a higher than average risk for experiencing gastrointestinal problems. So dietary interventions help children who may have GI issues. The most common dietary interventions include a gluten-free diet, a dairy-free diet, eliminating food coloring, eliminating MSG, and eating organic food exclusively. A restricted elimination diet (RED) has also been found to be useful for treating ADHD in some children, which is often a comorbid condition for people on the autism spectrum.[4][5]

- **Medication**: There is no medication for autism but several disorders like ADHD, gastrointestinal disorders and epileptic seizures are comorbid with the autism spectrum. A study published in the journal Pediatrics concluded that psychotropic medication is commonly prescribed to individuals on the autism spectrum, despite limited evidence of their effectiveness.

Other systems that often help autistic individuals are:

- **Routine**: Knowing what to expect and minimizing surprises can help prevent meltdowns. Making a schedule in advance helps people on the spectrum plan and function better.

- **Warning**: Sometimes autistic children have a hard time with transitions, especially from preferred to non-preferred activities. It helps to give sufficient warning, e.g. "In 2 minutes it will be time to stop playing and get dressed." Sometimes multiple warnings may be required e.g. at five-, two- and one-minute marks before the transition.

- **Visual aids**: Some people can consume, interpret and remember information much better if presented in a visual format rather than verbal instructions. For
common tasks like using the bathroom or getting dressed, visual aids can sometimes be very effective.

- **Social stories**: Social stories describe a situation, skill, or concept in terms of relevant social cues, perspectives, and common responses in a specifically defined style and format. More information on social stories is available here.

- **Video modeling**: Video modeling is a mode of teaching that uses video recording and display equipment to provide a visual model of the targeted behavior or skill. It is similar to social stories but suits some kids better because they may learn better with video. More information on video modeling is available here.

- **Sleep aids**: Sleep is vital for the development of the brain and for the body to rejuvenate. Many children on the autistic spectrum have trouble either falling asleep or staying asleep through the night. Sleep aids like weighted blankets, or medication like melatonin, can help some kids.

**Treatments outside of the mainstream**

There isn’t a definite known cause of autism, nor is there a "cure". This has led many parents to resort to unconventional methods ranging from benign probiotics to potentially harmful chelation, hyperbaric chambers or methyl-B12 shots and pills. None of these have been scientifically validated, nor are they recommended by the American Academy of Pediatrics. Always consult your pediatrician before administering any medication or procedure to your child.

**Autistic Person or Person with Autism?**

There are two schools of thought on whether it's better to use "person-first" language, such as "child with autism" or "person with autism". Proponents of person-first language believe that autism does not define the individual, and that respect for the individual is enhanced by use of language that puts the person first.

The other camp, which notably includes many autistic people themselves, believes that autism is a part of their personality. They prefer the use of autistic as a descriptor — "autistic people" is like saying "left-handed people." They feel that "person with autism" is somewhat like "person with diabetes", which makes autism seem like a disease. For them, autism is not a disease but simply a different neurology, one that makes them who they are. This point of view is somewhat analogous to homosexuality. Decades ago, before 1970, it was believed that homosexuality is a mental disorder and the DSM classified it as such. However, it is no longer considered a disorder and gay and lesbian individuals have wide acceptance in society today. In a way, the struggle is similar for autistic individuals to be accepted for who they are instead of society trying to "cure" them. Stimming, being non-verbal, or not making eye contact are some characteristics that make it hard to be accepted in the neuro-typical world. Many autism advocates hope to change that by making society more tolerant and appreciative of neurological differences.

**Low-functioning vs High-functioning**

Another pair of labels often used is "high-functioning" and "low-functioning" autism, or "severe" and "mild" autism. However, advocates for autistic people feel that such labels should not be used. The "high-functioning" label makes light of the challenges and struggles faced by some autistics, who may appear neuro-typical but often have to exert themselves really hard and deal with severe anxiety in order to behave in a way that is not natural to them. For example, suppressing their urge to stim. Conversely, the "low-functioning" label — often used for autistics who are non-speaking — automatically overlooks their strengths and abilities, disrespects them and makes their opinions less likely to be heard. What is wrong with Functioning Labels? Summarizes this point of view, with quotes and links to several blog posts — here, here, and here — explaining why it is wrong to use functioning labels.

**ADHD Scouts Have Great Attributes Too!**

If your Scout has ADHD, let your Scout leader know. Tell him what works well AND what does not help. If your Scout takes medication to help him focus at school, it may help him focus better during Scout activities as well. You may want to discuss this issue with your Scout’s physician.

Prescription medication is the responsibility of the Scout taking the medication and/or his parent or guardian. A Scout leader, after obtaining all necessary information, can agree to accept the responsibility of making sure a Scout takes the necessary medication at the appropriate time, but BSA policy does not mandate nor necessarily encourage the Scout leader to do so. Also, if state laws are more limiting, they must be followed.

- Make sure your Scout knows that his medication is meant to help him focus, not to make him behave or "be good."
• Be sure to tell the Scout leader what your son’s needs are if he is going on a day trip a weekend camping trip, or a week at summer camp.
• There are many things the leader can do to help your Scout be successful and have fun— if he is informed.
• Consider getting trained to be a Scout leader yourself.
• Try to let the ADHD Scout know ahead of time what is expected.
• When activities are long or complicated, it may help to write down a list of smaller steps.
• Repeat directions one-on-one when necessary, or assign a more mature buddy to help him get organized.
• Compliment the Scout whenever you find a genuine opportunity.
• Ignore minor inappropriate behavior if it is not dangerous or disruptive.
• Provide frequent breaks and opportunities for Scouts to move around actively but purposefully.
• It is NOT helpful to keep ADHD Scouts so active that they are exhausted, however.
• When you must redirect a Scout, do so in private, in a calm voice, unless safety is at risk.
• Avoid yelling.
• Never publicly humiliate a Scout.
• Whenever possible, “sandwich” correction between two positive comments.

Be aware of early warning signs, such as fidgety behavior, that may indicate the Scout is losing impulse control. When this happens, try a Private, nonverbal signal or Proximity control (move close to the Scout) to alert him that he needs to focus.

• During active games and transition times, be aware when a Scout is starting to become more impulsive or aggressive.
• Expect the ADHD Scout to follow the same rules as other Scouts.
• ADHD is NOT an excuse for uncontrolled behavior.
• If it has not been possible to intervene proactively and you must impose consequences for out-of-control behavior, use time-out or “cooling off.”
• Offer feedback and redirection in a way that is respectful and that allows the Scout to save face.
• When Scouts are treated with respect, they are more likely to respect the authority of the Scout leader.
• Keep cool! Don’t take challenges personally.
• ADHD Scouts want to be successful, but they need support, positive feedback, and clear limits.

• Find out about medical needs.
• Make sure you have what your council requires to ensure the Scout’s medical needs can be met, or have the parent come along.
• If you must administer medication, don’t tell the Scout that it is a “smart pill,” or that it will make him “behave.”

Offer opportunities for purposeful movement, such as:
• Leading cheers
• Performing in skits
• Assisting with demonstrations
• Teaching outdoor skills to younger Scouts

This may improve focus, increase self-confidence, and benefit the troop as a whole.

ADHD Scouts are generally energetic, enthusiastic, and bright. Many have unique talents as well. Help them use their strengths to become leaders in your troop.

Why Scouting Is a Great Program for Youth with ADHD
• Scouting is a well-thought-out, highly structured program that provides a step-by-step sequence of skills for Scouts to master.
• Scouting promises fun, friendship, and adventure.
• Scouting offers frequent positive recognition.
• Scouting develops social skills and leadership skills.

Through systematic Explanation, interactive Demonstration, and Guided practice, Scouting Enables ADHD Scouts to discover and develop their unique strengths and interests.

Small acts can have great consequences.