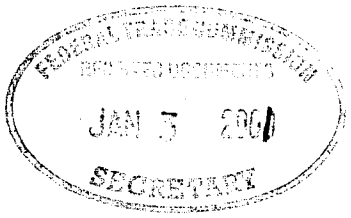
UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION



In the Matter of	)	
NATURAL ORGANICS, INC., a corporation, and	)	DOCKET NO. 9294
GERALD A. KESSLER, individually and as an officer of the corporation.	)	COMPLAINT COUNSEL'S MOTION FOR PARTIAL SUMMARY DECISION

TO: The Honorable James P. Timony
Chief Administrative Law Judge

Complaint counsel, pursuant to Section 3.24 of the Commission's Rules of Practice, move for partial summary decision against the respondents as to the following issues:

1. Respondent Gerald A. Kessler formulated, directed, or controlled the policies, acts, or practices of Natural Organics and, as a result, would be liable for deceptive representations contained in the company's advertisements (Complaint ¶ 2).

2. Respondents have represented that Pedi-Active A.D.D. will treat or mitigate ADHD or its symptoms (Complaint ¶ 7E).

3. Respondents have represented that Pedi-Active A.D.D. will improve the attention span of children who suffer from ADHD (Complaint ¶ 7C).

4. Respondents have represented that Pedi-Active A.D.D. will improve the scholastic performance of children who suffer from ADHD (Complaint ¶ 7D).

5. Respondents have represented that Pedi-Active A.D.D. will improve the attention span of children who have difficulty focusing on school work (Complaint ¶ 7A).

6. Respondents have represented that Pedi-Active A.D.D. will improve the scholastic performance of children who have difficulty focusing on school work (Complaint ¶ 7B).

In support of this motion, complaint counsel rely on the Respondents' Answer, the Respondents' Responses to Complaint Counsel's First Request for Admissions ("Respondents' Admissions"), and the attached exhibits.

I. The Applicable Standard for Summary Decision

Complaint counsel are entitled to partial summary decision "if the pleadings and any depositions, answers to interrogatories, admissions on file, and affidavits show that there is no genuine issue as to any material fact and that the moving party is entitled to such decision as a matter of law." Rules of Practice § 3.24(a)(2). Section 3.24 closely follows Rule 56 of the Federal Rules of Civil Procedure, and the Commission looks to decisions interpreting Rule 56 for guidance. See, e.g., The Hearst Corp., 80 F.T.C. 1011, 1014 (1972); Lehigh Portland Cement Co., 78 F.T.C. 1556, 1557 (1971). The moving party bears the burden of demonstrating that there are no genuine issues of material fact. C.f. Adickes v. S.H. Kress & Co., 398 U.S. 144, 157-59 (1970).

Once complaint counsel have established that no genuine issue exists, respondents "may not rest upon the mere allegations or denials of [their] pleading[s]; [their] response . . . must set forth specific facts showing that there is a genuine issue of fact for trial." Rules of Practice § 3.24(a)(3). C.f. First National Bank of Arizona v. Cities Serv. Co., 391 U.S. 253, 289 (1968); SEC v. Murphy, 626 F.2d 633, 640 (9th Cir. 1980) (the evidence offered in opposition must be "significantly probative" as to any fact claimed to be disputed). The evidence cited herein clearly demonstrates that no genuine issue of material fact exists about any of the issues on which

complaint counsel seek summary decision. Accordingly, complaint counsel are entitled to summary decision on these issues as a matter of law.

II. Respondent Gerald A. Kessler is liable for any deceptive representations contained in Natural Organics' advertisements

Respondent Gerald A. Kessler is liable for any deceptive representations contained in Natural Organics' advertisements because he "formulated, directed, or controlled the policies, acts, or practices of the corporation." Benrus Watch Co. v. Federal Trade Comm'n, 352 F.2d 313, 324-25 (8th Cir 1965), cert. denied, 384 U.S. 939 (1966); see also Federal Trade Comm'n v. Standard Educ. Soc'y, 302 U.S. 112 (1937), reh'g denied, 302 U.S. 779 (1937). The Commission and the courts examine, separately or in combination, a number of factors when determining individual liability. In National Housewares, 90 F.T.C. 512 (1977), the Commission explained that: "Both the courts and the Commission have looked at the unlawful practices involved, the respondent's involvement with the practices, the type of corporate entity, the respondent's ownership interest, the corporate office (if any) held, and the influence he exercised over corporate affairs." Id. at 598 (footnotes omitted). Under this standard, Mr. Kessler clearly is liable because he was actively involved in the advertising at issue and because of his position and role in the corporation.

Mr. Kessler admits that he participated directly in virtually all of the acts or practices at issue. Specifically, he admits that he participated in the development, preparation, or placement of Exhibits A, B, and D (Respondents' Admissions 54, 55 & 57). He also admits that he approved the content of those advertisements (Respondents' Admissions 58, 59 & 61) and controlled the activities of the employees of Natural Organics who participated in the

development, preparation, or placement of those advertisements (Respondents' Admissions 66, 67 & 69). In addition, Mr. Kessler's signature appears on Exhibit C.[1] The courts and the Commission have held that, when liability is based on personal participation in the unlawful acts, nothing more need be shown. See, e.g., Removatron Int'l Corp., 111 F.T.C. 206, 290 (1988), *aff'd*, 884 F.2d 1489 (1st Cir. 1989); Federal Trade Comm'n v. NCH, 1995-2 Trade Cas. (CCH) ¶ 71,114, at 75,351 (D. Nev. Sept. 6, 1995) Therefore, Mr. Kessler is liable for the claims contained in the challenged advertisements based upon his personal participation in their creation and dissemination.

Moreover, Mr. Kessler should be held individual liable for any deceptive claims that appear in any of Natural Organics advertisements because of the type of corporate entity Natural Organics is and because of Mr. Kessler's ownership interest in the company. Natural Organics is a closely-held corporation, and Mr. Kessler is its sole shareholder (Respondents' Admission 52). The courts and the Commission have held that it is appropriate to hold the owner of a closely-held corporation individually liable because his or her inclusion in the order would be necessary to make the order fully effective in preventing future violations of the law. See, e.g., Standard Educ. Soc'y, 302 U.S. at 120 (managers and sole stockholders held liable); Fred Meyer, Inc. v. FTC, 359 F.2d 351, 367-68 (9th Cir.), cert. denied, 308 U.S. 908 (1967) (individuals held liable

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[1] Curiously, while Mr. Kessler's signature appears on Exhibit C, respondents deny that he participated in the development, preparation, or placement of Exhibit C (Respondents' Admission 56); deny that he approved the content of Exhibit C (Respondents' Admission 60); and deny that he controls the activities of the employees of Natural Organics who participated in the development, preparation, or placement of Exhibit C (Respondents' Admission 68). They do admit, however, that employees of Natural Organics participated in the development, preparation, or placement of Exhibit C (Respondents' Admission 64), and that Gerald Kessler has veto power over Natural Organics' advertising (Respondents' Admission 53).

because the corporation was a "family corporation"). Because Natural Organics is the "alter ego" of Mr. Kessler, it is appropriate to hold him individually liable for the activities of the corporation.

Finally, Mr. Kessler should be held individually liable for any deceptive claims that appear in any of Natural Organics advertisements because of the role he plays in the corporation. Mr. Kessler, as Chief Executive Officer and sole shareholder, is not a mere figurehead in the corporation. He has active managerial and policy making responsibilities in the corporation. For example, he actively participates in the development, preparation, or placement of the company's advertisements (Respondents' Admissions 54, 55 & 57). In addition, he reviews the content of advertisements (Respondents' Admissions 58, 59 & 61) and has veto power over Natural Organic's advertising (Respondents' Admission 53). Given the corporate office that he holds and the influence he exercises over corporate affairs, Mr. Kessler certainly had the authority to control the activities of the employees who developed, prepared, or placed all of the advertisements at issue. See, e.g., Thiret v. FTC, 512 F.2d 176, 181-82 (10th Cir. 1975) (general manager held a "command position" over employees who committed illegal acts); Product Testing Co., 64 F.T.C. 857, 882 (1964), aff'd, 339 F.2d 602 (3d Cir. 1967) (president reviewed corporate advertising and possessed veto power over the advertising); Consumer Sales Corp. v. Federal Trade Comm'n, 198 F.2d 404, 406-408 (2d Cir. 1952), cert. denied, 344 U.S. 912 (1953) (officers of corporation directed and guided the corporation in matters of policy); see also Federal Trade Comm'n v. NCH, 1995-2 Trade Cas. (CCH) ¶ 71,114, at 75,351 (D. Nev. Sept. 6, 1995) ("authority to control the company can be evidenced by active involvement in business affairs and the making of corporate policy, including assuming the duties of corporate office").

Given these undisputed facts, it is clear that respondent Gerald A. Kessler formulated, directed, or controlled the policies, acts, or practices of Natural Organics and, as a result, would be liable for representations contained in the company's advertisements. For the reasons stated above, complaint counsel are entitled to summary decision on the issue of Mr. Kessler's liability because no genuine issue of material fact exists.

III. The Advertisements attached to the Complaint Convey the Challenged Representations

Respondents have disseminated advertisements that contain the representations alleged in the Complaint. The Commission will conclude that an advertisement conveys a claim "if consumers, acting reasonably under the circumstances, would interpret the advertisement to contain that message." Kraft, Inc., 114 F.T.C. 40, 120 (1991), aff'd 970 F.2d 311 (7th Cir. 1992), cert. denied 507 U.S. 909 (1993); Thompson Medical, 104 F.T.C. 648, 788 (1984), aff'd, 791 F.2d 189 (D.C. Cir. 1986), cert. denied, 479 U.S. 1086 (1987). The representations alleged in the complaint do not have to be the only reasonable interpretations of the challenged advertising; "[a]n advertisement that reasonably can be interpreted in a misleading way is deceptive, even though other, non-misleading interpretations may be equally possible." Kraft, 114 F.T.C. at 120 n.8; Thompson Medical, 104 F.T.C. at 789 n.7, 818; Bristol-Myers Co., 102 F.T.C. 21, 320 (1983), aff'd, 738 F.2d 554 (2d Cir. 1984), cert. denied, 469 U.S. 1189 (1985). In addition, "[a]n interpretation may be reasonable even though it is not shared by a majority of consumers in the relevant class, or by particularly sophisticated consumers." Kraft, 114 F.T.C. at 122; Federal Trade Commission Policy Statement on Deception, appended to Cliffdale Assocs., Inc., 103 F.T.C. 177, n.20 (1984) [hereinafter "Deception Statement"]. Therefore, as a matter of law, complaint counsel's burden is to show that each alleged claim is one reasonable interpretation of

respondents' advertisements.

In this matter, respondents admit that they disseminated the advertisements attached to the complaint (Respondents' Admissions 1, 12, 23, 34). These advertisements contain language that is expressly made or clear enough on its face to demonstrate that respondents made the alleged claims. The Commission "may rely on its own reasoned analysis to determine what claims, including implied ones, are conveyed in a challenged advertisement, so long as those claims are reasonably clear from the face of the advertisement." Kraft, Inc. v. F.T.C., 970 F.2d 311, 319 (7th Cir. 1992); Thompson Medical, 104 F.T.C. at 789, 793, 799, 810-11; Deception Statement, 103 F.T.C. at 176. Extrinsic evidence is not necessary when the Commission is "confronted with claims that are implied, yet conspicuous ... because common sense and administrative experience provide the Commission with adequate tools to make its findings." Kraft, Inc., 970 F.2d at 320. Therefore, the Commission may determine that respondents made the alleged claims after considering only the advertisements themselves because the claims are clear from the face of the advertisements.

A. Respondents have represented that (1) Pedi-Active A.D.D. will treat or mitigate attention deficit/hyperactivity disorder ("ADHD") or its symptoms; (2) Pedi-Active A.D.D. will improve the attention span of children who suffer from ADHD; and (3) Pedi-Active A.D.D. will improve the scholastic performance of children who suffer from ADHD.

There is no genuine issue of material fact that respondents' advertisements have represented that Pedi-Active A.D.D. will treat or mitigate ADHD or its symptoms (Complaint ¶ 7E); that Pedi-Active A.D.D. will improve the attention span of children who suffer from ADHD (Complaint ¶ 7C); and that Pedi-Active A.D.D. will improve the scholastic performance of children who suffer from ADHD. (Complaint ¶ 7D).

1. The Product's Name

The product's very name, Pedi-Active A.D.D., conveys a claim that this product is effective for children with ADHD. All of the Exhibits to the Complaint repeatedly refer to the product as "Pedi-Active A.D.D.," often in boldface. "A.D.D" is an acronym for "attention deficit disorder," which was a prior name for this disorder. See, e.g., American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (3d ed. 1980) ("DSM-III") (Exhibit E). The official name of the disorder did not change to attention deficit/hyperactivity disorder until 1987, with the printing of the revised third edition of the DSM. See American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (3d ed. - revised 1987) ("DSM-IIIR") (Exhibit F). For this reason, the terms ADHD and ADD are often used interchangeably. See, e.g., Exhibits attached to Declaration of Craig Kauffman ("Kauffman Declaration") (Exhibit H).[2] Respondents, themselves, have referred to the disorder as "attention deficit disorder" in a letter they sent to consumers who inquired about Pedi-Active A.D.D. in 1997. See Complaint, Exhibit C; Respondents' Admission 23. In addition, the "Pedi-Active" part of the product's name clearly is a play on the word "hyperactive," which describes one class of symptoms associated with ADHD. See American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, (4th ed. 1994) ("DSM-IV") (Exhibit G). For all of these reasons, one reasonable interpretation of respondents' advertisements is that the product will treat

[2] Organizations that provide resources and support to individuals with this disorder and their parents refer to this disorder as ADD and/or ADHD. See, e.g., Kauffman Declaration, Exs. 2 & 7 (Exhibit H). The press and Internet search engines refer to this disorder as ADD or use the terms ADHD and ADD interchangeably. See, e.g., Kauffman Declaration, Exs. 2, 3, 4, 5, 6, & 9 (Exhibit H). Even products and services marketed to these consumers have used both terms or used the term ADD alone. See, e.g., Kauffman Declaration, Exhibits 10 & 11 (Exhibit H).

or mitigate ADHD or its symptoms.

2. References to the Symptoms of ADHD

In addition to repeatedly stating the product's name, the advertisements attached to the complaint make numerous references to the symptoms that are associated with ADHD. For example, respondents ask parents in their advertisements whether "yelling, begging and pleading doesn't get you child to do their homework," if their child is having "difficulty paying attention," "[d]oes not follow instructions," and "do[es] not perform as well in school" because of "the child's inability to remain focused." Complaint, Exhibits A and B. Similarly, some of respondents' advertisements characterize the children who would benefit from the use of Pedi-Active A.D.D. as being "hyperactive," or as the "active child." Complaint, Exhibits C and D.

These are all symptoms of ADHD that are listed in the fourth edition of the DSM. See DSM-IV (Exhibit G). They include: (1) "often fails to give close attention to details ... in schoolwork;" (2) "often has difficulty sustaining attention in tasks;" (3) "Often does not follow through on instructions and fails to finish schoolwork." Id. In addition to these symptoms of inattention, DSM-IV includes symptoms of hyperactivity-impulsivity. that can result in an ADHD diagnosis. Id. Therefore, because these advertisements refer to the symptoms of ADHD and because respondents offer Pedi-Active A.D.D. as a product that will treat these symptoms, one reasonable interpretation of these advertisements is that the product will treat or mitigate ADHD or its symptoms.

3. Exhibits A and B

Exhibits A and B also claim that the product will improve specific symptoms of ADHD. Specifically, these advertisements represent that the product will improve the attention span and

improve the scholastic performance of children with ADHD. Exhibit A is a print advertisement that respondents have disseminated throughout the United States since 1997 (Respondents' Admission 1). In Exhibit A, respondents state:

> **If yelling, begging and pleading doesn't get your child to do their homework, maybe this will.**
>
> ***REPORT CARD.*** *Not working up to capabilities. Has difficulty paying attention. Does not follow instructions. Does not work well with others.*
>
> In many cases children will score very high on I.Q. tests. Still, they do not perform as well in school as their parents and teachers know they can. The problem is often not their intelligence, but the child's inability to remain focused. A skill which is essential for success in the classroom and beyond.
>
> Nature's Plus has approached the problems of the active child from a nutritional perspective. Pedi-Active A.D.D.$_{TM}$, a formula which combines phosphatidylserine, DMAE and activated soy phosphatides in a state-of-the-art nutritional supplement. Each incredibly delicious, mixed berry flavor, chewable tablet supplies a complete profile of the most advanced neuronutrients available.
>
> Isn't your child worth the best nutritional support science has to offer?

Exhibit A. This advertisement also depicts a child who is holding a pen and apparently focusing on his school work. This depiction is shown next to a bottle of Pedi-Active A.D.D. Id.

Exhibit B is a brochure that respondents have disseminated to customers throughout the United States since 1997 (Respondents' Admission 12). The first page of the brochure contains a depiction of a very young child holding a teddy bear on the front cover. On the second page, the brochure depicts a report card showing poor to satisfactory performance. The brochure then states:

> **Not working up to capabilities.**
>
> **Has difficulty paying attention.**

Does not follow instructions.

Does not work well with others.

In many cases children will score very high on I.Q. tests. Still, they do not perform as well in school as their parents and teachers know they can. The problem is often not their intelligence, but the child's inability to remain focused. A skill which is essential for success in the classroom and beyond.

Nature's Plus has approached the problems of the active child from a nutritional perspective. Introducing **Pedi-Active A.D.D.,** a precisely calibrated formula designed for the active child. Each incredibly delicious, chewable tablet supplies a complete profile of the most advanced neuronutrients available, including a diversified combination of phosphatidylserine, DMAE and activated soy phosphatides, such as phosphatidylcholine. **Pedi-Active A.D.D.** is a state-of-the-art nutritional supplement that naturally complements an active child's delicate system.

Isn't your child worth the best nutritional support science has to offer?

Complaint, Exhibit B. The brochure also depicts a bottle of Pedi-Active A.D.D.

These words and depiction in Exhibits A and B, on their face, mean that Pedi-Active A.D.D. will improve the attention span and the scholastic performance of children who suffer from ADHD. These advertisements strongly imply that, if these children take Pedi-Active A.D.D., they will "do their homework," and will not have "difficulty paying attention," will "follow instructions," and will "work well with others" in school. These children will "remain focused," a "skill which is essential for success in the classroom." Therefore, one reasonable interpretation of these advertisements is that Pedi-Active A.D.D. is effective in treating or mitigating ADHD or its symptoms in general, and that Pedi-Active A.D.D. will improve the attention span and the scholastic performance of children who suffer from ADHD.

4. Exhibit C

Respondents also expressly state or strongly imply in Exhibit C that Pedi-Active is

effective for children with ADHD. Exhibit C is a letter that Natural Organics sent to consumers who inquired about Pedi-Active A.D.D. in 1997. Respondents' Admission 23. It contains the following language:

> Thank you for your interest in Pedi-Active A.D.D. from Nature's Plus. We know that sometimes yelling, pleading and begging your child to [sic] their homework just isn't enough. Research has shown that many of the problems [sic] **a child who is hyperactive or suffering from Attention Deficit Disorder** can be related to improper nutrition. What your child needs is a nutritional supplement that supplies a complete profile of the most advanced neuronutrients available to help your child live up to their full potential. Each delicious mixed berry flavored chewable tablet combines phosphatidylserine, DMAE and activated soy phosphatides to provide the nutritional support your active child needs.

Complaint, Exhibit C (emphasis added). In that letter, the respondents expressly refer to the disorder "Attention Deficit Disorder" and state that research has shown that improper nutrition may be the cause of many of these children's "problems," one of which is failing to complete their homework. Respondents then claim that Pedi-Active A.D.D. will provide these children with the "nutritional support" they need, which will allow them to "live up to their full potential." Because the advertisement expressly refers to the disorder and states that the product will provide the solution to the problems these children experience, one reasonable interpretation of this advertisement is that the product will treat or mitigate ADHD or its symptoms. Furthermore, because the advertisement strongly implies that, if these children take Pedi-Active A.D.D., they will be more successful in completing their homework, another reasonable interpretation of Exhibit C is that Pedi-Active A.D.D will improve the scholastic performance of children who suffer from ADHD.

Accordingly, because there is no genuine issue of material fact that respondents made these claims in Exhibits A, B, C, and D, complaint counsel are entitled to summary decision on

these issues.

5. Respondents' Assertions are Without Merit

Respondents assert in their Answer that the "A.D.D" in Pedi-Active A.D.D. refers to "Advanced Dietary Delivery System." See Answer ¶ 3. This assertion is disingenuous, at best. In any event, as described above, regardless of what respondents intended, consumers clearly will interpret the letters "ADD" in the name of the product as being the acronym for attention deficit disorder.

In addition, the words "Advanced Dietary Delivery System" do not correct the ADHD efficacy representations that these advertisements convey. The advertisements do not indicate in any way that "A.D.D." is an acronym for "Advanced Dietary Delivery System." The words "Advanced Dietary Delivery System" simply appear above the product's name on the label. The remainder of the advertising copy, which repeatedly mentions "Pedi-Active A.D.D.," makes no reference to "Advanced Dietary Delivery System" or any other supposed acronym. For example, in Exhibits A, C, and D, these words appear only in smaller lettering on the bottle of Pedi-Active A.D.D. which is depicted in these advertisements. The words do not appear anywhere in the text of these advertisements. In Exhibit B, the words also appear in the text of the advertisement, but only on the front page of a multi-page brochure. Many of the statements that convey the alleged claims in Exhibit B are contained on the inside of the brochure. Therefore, the words "Advanced Dietary Delivery System" do not adequately qualify the ADHD representations because of their content and placement in the advertisements.

Respondents' assertion might have a modicum of credibility if the product's name was "Pedi-Active A.D.D.S." Instead, respondents used the acronym "A.D.D." and the remainder of

the advertising for Pedi-Active A.D.D. clearly attempts to appeal to parents of children with ADHD.

Exhibit D also contains a disclaimer that dietary supplement manufacturers are required to make under certain circumstances under Section 343 of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 343 (1999). Under this law, dietary supplement manufacturers may describe on the label the supplement's effects on the "structure or function" of the body or the "well-being" achieved by consuming the dietary ingredient if they have substantiation that the statements are truthful and not misleading, and as long as the product label bears the statement:

> This statement has not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure, or prevent any disease.

Id. at § 343(r)(5)(D)(6).

This disclaimer, however, is insufficient to correct the representation that respondents make in Exhibit D that this product is effective for children with ADHD. First, this disclaimer appears on all products that Natural Organics sells on its Web site and does not specifically refer to ADHD. The Commission has stated that "pro forma statements or disclaimers may not cure otherwise deceptive messages or practices." Federal Trade Commission Policy Statement on Deception, appended to Cliffdale Assocs., Inc., 103 F.T.C. 174, 180 (1984) [hereinafter "Deception Statement"] (citing Warner Lambert, 86 F.T.C. 1398, 1414 (1975), aff'd, 562 F.2d 749 (D.C. Cir. 1977), cert. denied, 435 U.S. 950 (1978)). This disclaimer is a pro forma statement that the FDA has not evaluated the product and, as a result, the product is not intended to diagnose, treat, cure, or prevent any disease. The message that comes across to consumers is that, while this product and dietary supplements in general do not have FDA approval to make

disease claims, Pedi-Active A.D.D. is effective for children with ADHD.

In addition, Exhibit D conveys the representation primarily through the headline and text of the advertisement. The headline of the advertisement identifies the product as "Pedi-Active A.D.D. Chewables." The text of the advertisement states that this product is a "precisely calibrated formula designed for the active child." The Commission has held that fine print disclosures may not remedy a false headline because reasonable consumers may glance only at the headline. See Litton Indus., 97 F.T.C. 1, 71 n.6 (1981), aff'd as modified, 676 F.2d 364 (9th Cir. 1982) (fine print disclosures that the surveys included only "Litton authorized" agencies were inadequate to remedy the deceptive characterization of the survey population in the headline). For the above reasons, this disclaimer in Exhibit D is inadequate because of its content and placement in the advertisement.

The words and depiction in these advertisements, on their face, mean that Pedi-Active A.D.D. will treat or mitigate ADHD or its symptoms and will improve the attention span and the scholastic performance of children who suffer from ADHD. In addition, the words "Advanced Dietary Delivery System" do not adequately qualify these claims because of their content and placement in the advertisements. Moreover, the FDA disclaimer in Exhibit D does not adequately qualify the claim that the product will treat or mitigate ADHD also because of its content and placement in the advertisement. Therefore, one reasonable interpretation of these advertisements is that Pedi-Active A.D.D. will treat or mitigate ADHD or its symptoms. Another reasonable interpretation of Exhibits A and B is that Pedi-Active A.D.D. will improve the attention span of children who suffer from ADHD. Finally, another reasonable interpretation of Exhibits A, B, and C is that Pedi-Active A.D.D. will improve the scholastic performance of

children who suffer from ADHD. Accordingly, because there is no genuine issue of material fact that these claims were made, complaint counsel are entitled to summary decision on these issues.

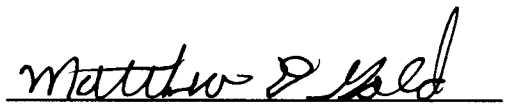
B. Respondents have represented that (1) Pedi-Active A.D.D. will improve the attention span of children who have difficulty focusing on school work and (2) Pedi-Active A.D.D. will improve the scholastic performance of children who have difficulty focusing on school work.

There is no genuine issue of material fact that respondents' advertisements have represented that Pedi-Active A.D.D. will improve the attention span and scholastic performance of children who have difficulty focusing on school work (Complaint ¶ 7A and B). In particular, respondents make these representations in Exhibits A and B of the Complaint, which we described above. These words and depictions in these advertisements, on their face, claim that the product will improve the attention span and scholastic performance not only of children who suffer from ADHD, but also of children who have difficulty focusing on school work. In particular, the advertisements describe children who are "not working up to capabilities" because they are having "difficulty paying attention" or because of their "inability to remain focused." These advertisements then strongly imply that, if these children take Pedi-Active A.D.D., they will "do their homework," and will not have "difficulty paying attention," will "follow instructions," and will "work well with others" in school. These children will "remain focused," a "skill which is essential for success in the classroom." Therefore, one reasonable interpretation of these advertisements is that Pedi-Active A.D.D. will improve the attention span and the scholastic performance of children who have difficulty focusing on school work. Accordingly, because there is no genuine issue of material fact that these claims were made, complaint counsel are entitled to summary decision on these issues.

IV. Conclusion

For the reasons stated above, complaint counsel respectfully request that this motion for partial summary decision be granted as to each of the issues described herein.

Respectfully submitted,



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Dated: January 2, 2001

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

In the Matter of	)	
NATURAL ORGANICS, INC., a corporation, and	)	DOCKET NO. 9294
GERALD A. KESSLER, individually and as an officer of the corporation.	)	

TO: The Honorable James P. Timony
Chief Administrative Law Judge

STATEMENT OF THE MATERIAL FACTS AS TO WHICH COMPLAINT COUNSEL CONTENDS THERE IS NOT GENUINE ISSUE

1. Gerald Kessler is Chief Executive Officer of Natural Organics (Answer ¶ 2).

2. Gerald Kessler is the sole shareholder of Natural Organics (Respondents' Admission 52).

3. Gerald Kessler has veto power over Natural Organics' advertising (Respondents' Admission 53).

4. Gerald Kessler participated in the development, preparation, or placement of Exhibits A, B, and D of the Complaint (Respondents' Admissions 54, 55, & 57).

5. Gerald Kessler approved the content of Exhibits A, B, and D of the Complaint (Respondents' Admissions 58, 59, & 61).

6. Employees of Natural Organics participated in the development, preparation, or placements of Exhibits A, B, C and D of the Complaint (Respondents' Admissions 62, 63, 64 & 65).

7. Gerald Kessler controls the activities of the employees of Natural Organics who participated in the development, preparation, or placements of Exhibits A, B, and D of the Complaint (Respondents' Admissions 66, 67, & 69).

8. Exhibit A to the Complaint is a true and correct copy of an advertisement prepared by Natural Organics and disseminated from time to time in various magazines throughout the United States since 1997 (Respondents' Admission 1).

9. Exhibit B to the Complaint is a true and correct copy of an advertisement prepared by Natural Organics and disseminated to customers throughout the United States since 1997 (Respondents' Admission 12).

10. Exhibit C to the Complaint is a true and correct copy of a letter Natural Organics sent to some consumers who inquired about Pedi-Active A.D.D. in 1997 (Respondents' Admission 23).

11. Exhibit D to the Complaint is a true and correct copy of a page on Natural Organics' Web site that was disseminated in 2000 (Respondents' Admission 34).

12. Attention deficit/hyperactivity disorder is a mental disorder that is recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, (4th ed. 1994) ("DSM-IV") (Exhibit G).

13. Attention deficit/hyperactivity disorder was called "attention deficit disorder" in a prior edition of the Diagnostic and Statistical Manual of Mental Disorders. (Exhibit E).

14. The abbreviation or term "A.D.D." is commonly used by the public to refer to ADHD (Exhibit H).

15. DSM-IV lists the following as symptoms of ADHD:

Symptoms of Inattention

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities

(b) often has difficulty sustaining attention in tasks or play activities

(c) often does not seem to listen when spoken to directly

(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (no if oppositional behavior or doesn't understand instructions)

(e) often has difficulty organizing tasks and activities

(f) often avoids, dislikes, or is reluctant to engage in tasks or activities that require sustained mental effort (such as schoolwork or homework)

(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)

(h) often easily distracted by extraneous stimuli

(i) often forgetful in daily activities

Symptoms of Hyperactivity

(j) often fidgets with hands or feet or squirms in seat

(k) often leaves seat in classroom or in other situations in which remaining seated is expected

(l) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

(m) often has difficulty playing or engaging in leisure activities quietly

(n) is often "on the go" or often acts as if "driven by a motor"

(o) often talks excessively

Symptoms of Impulsivity

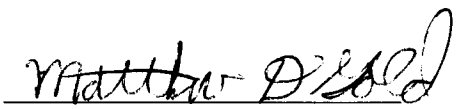
(p) often blurts out answers before questions have been completed

(q) often has difficulty awaiting turn

(r) often interrupts or intrudes on others (e.g., butts into conversations or games)

(Exhibit G)

Respectfully submitted,



Matthew D. Gold
Kerry O'Brien
Linda K. Badger

Complaint Counsel
Western Region
Federal Trade Commission
901 Market Street, Suite 570
San Francisco, CA 94103
(415) 356-5266

Dated: January 2, 2001

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

In the Matter of	)	
NATURAL ORGANICS, INC., a corporation, and	)	DOCKET NO. 9294
GERALD A. KESSLER, individually and as an officer of the corporation.	)	

TO: The Honorable James P. Timony
Chief Administrative Law Judge

EXHIBITS IN SUPPORT OF COMPLAINT
COUNSEL'S MOTION FOR PARTIAL SUMMARY DECISION

Attached hereto as Exhibits A through H are true and correct copies of documents produced by the parties as described below.

1. Exhibit A is identical in all respects to Exhibit A attached to the complaint.

2. Exhibit B is identical in all respects to Exhibit B attached to the complaint.

3. Exhibit C is identical in all respects to Exhibit C attached to the complaint.

4. Exhibit D is identical in all respects to Exhibit D attached to the complaint.

5. Exhibit E is a true and correct copy of American Psychiatric Association, "Attention Deficit Disorder," Diagnostic and Statistical Manual of Mental Disorders (3d ed. 1980) ("DSM-III).

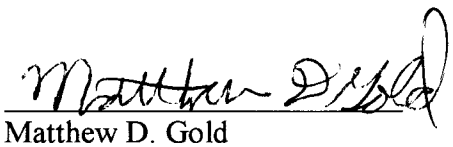
6. Exhibit F is a true and correct copy of American Psychiatric Association, "Attention-deficit Hyperactivity Disorder (ADHD)," Diagnostic and Statistical Manual of Mental

Disorders (3d ed. - revised 1987) ("DSM-IIIR").

7. Exhibit G is a true and correct copy of American Psychiatric Association, "Attention-Deficit/Hyperactivity Disorder," Diagnostic and Statistical Manual of Mental Disorders, (4th ed. 1994) ("DSM-IV").

8. Exhibit H is a Declaration of Craig Kauffman, dated December 29, 2000.

Respectfully submitted,



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In the Matter of	)	
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GERALD A. KESSLER, individually and as an officer of the corporation.	)	

ORDER GRANTING COMPLAINT COUNSEL'S
MOTION FOR PARTIAL SUMMARY DECISION

Complaint counsel seek an order granting partial summary decision as to the following six issues:

1. Respondent Gerald A. Kessler formulated, directed, or controlled the policies, acts, or practices of Natural Organics and, as a result, would be liable for deceptive representations contained in the company's advertisements (Complaint ¶ 2).

2. Respondents have represented that Pedi-Active A.D.D. will treat or mitigate ADHD or its symptoms (Complaint ¶ 7E).

3. Respondents have represented that Pedi-Active A.D.D. will improve the attention span of children who suffer from ADHD (Complaint ¶ 7C).

4. Respondents have represented that Pedi-Active A.D.D. will improve the scholastic performance of children who suffer from ADHD (Complaint ¶ 7D).

5. Respondents have represented that Pedi-Active A.D.D. will improve the attention span of children who have difficulty focusing on school work (Complaint ¶ 7A).

6. Respondents have represented that Pedi-Active A.D.D. will improve the scholastic performance of children who have difficulty focusing on school work (Complaint ¶ 7B).

As to the first issue, the Commission has repeatedly held that an officer of a corporation

may be subject to a Section 5 cease and desist order if the corporation violates Section 5 and the officer "formulated, directed, or controlled the policies, acts, or practices of the corporation." Benrus Watch Co. v. Federal Trade Comm'n, 352 F.2d 313, 324-25 (8th Cir 1965), cert. denied, 384 U.S. 939 (1966); see also Federal Trade Comm'n v. Standard Educ. Soc'y, 302 U.S. 112 (1937), reh'g denied, 302 U.S. 779 (1937). If complaint counsel proves that Natural Organics violated Section 5, Mr. Kessler clearly is individually liable because he participated directly in the acts or practices at issue, because he is the sole shareholder of Natural Organics, a closely-held corporation, and because Mr. Kessler held active managerial and policy making responsibilities relating to the corporation's advertising during the period of time in question.

As to the last five issues, complaint counsel submit numerous advertisements and exhibits. These materials amply establish, on their face, that respondents have made the alleged claims.

Complaint counsel have established that there is no genuine issue of material fact as to the allegations contained in Paragraphs 2 and 7 of the complaint. IT IS ORDERED that complaint counsel's motion for partial summary decision be, and it hereby is, granted.

James P. Timony
Administrative Law Judge

Dated:

If yelling, begging and pleading doesn't get your child to do their homework,

maybe this will.

REPORT CARD: Not working up to capabilities. Has difficulty paying attention. Does not follow instructions. Does not work well with others.

In many cases children will score very high on I.Q. tests. Still, they do not perform as well in school as their parents and teachers know they can. The problem is often not their intelligence, but the child's inability to remain focused. A skill which is essential for success in the classroom and beyond.

Nature's Plus has approached the problems of the active child from a nutritional perspective. Pedi-Active A.D.D.™, a formula which combines phosphatidylserine, DMAE and activated soy phosphatides in a state-of-the-art nutritional supplement. Each incredibly delicious, mixed berry flavor, chewable tablet supplies a complete profile of the most advanced neuronutrients available.

Isn't your child worth the best nutritional support science has to offer? Help your child live up to their full potential with Nature's Plus Pedi-Active A.D.D., available at your local health food store. Fill out the coupon below for discount offers toward your first purchase. Or call:

1-800-937-0500, ext. 4710

Yes, send me discount coupons toward my child's nutritional well-being and my first purchase of Pedi-Active A.D.D. Please mail to: Nature's Plus, P.O. Box 91719, Long Beach, CA 90809-1719

Name _____

Address _____

City _____ State _____ Zip _____

Signature _____ Date _____

Offer expires 8/31/97 4710

Nature's Plus®
The Energy Supplements®
http://www.natplus.com

Exhibit A

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NaturalO

Nature's Plus®
The Energy Supplements®

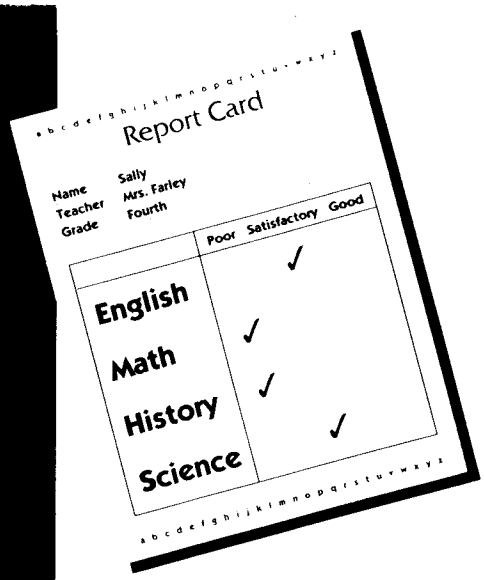
NUTRITIONAL SUPPORT FOR THE ACTIVE CHILD

ADVANCED DIETARY DELIVERY SYSTEM

PEDI-ACTIVE A.D.D.™

Chewable Phosphatidylserine DMAE Complex

Exhibit B-1



Not working up to capabilities.

Has difficulty paying attention.

Does not follow instructions.

Does not work well with others.

In many cases children will score very high on I.Q. tests. Still, they do not perform as well in school as their parents and teachers know they can. The problem is often not their intelligence, but the child's inability to remain focused. A skill which is essential for success in the classroom and beyond.

Nature's Plus has approached the problems of the active child from a nutritional perspective. Introducing **Pedi-Active A.D.D.,** a precisely calibrated formula designed for the active child. Each incredibly delicious, chewable tablet supplies a complete profile of the most advanced neuronutrients available, including a diversified combination of phosphatidylserine, DMAE and activated soy phosphatides, such as phosphatidylcholine. **Pedi-Active A.D.D.** is a state-of-the-art nutritional supplement that naturally complements an active child's delicate system.

Isn't your child worth the best nutritional support science has to offer?

Bottles of 60
Product #3000

Each Chewable Tablet Contains:

LECI-PS® * (phosphatidylserine-rich purified lecithin concentrate)	50 mg.
Supplying Activated Phosphatides:	
Phosphatidylserine (PS)	10 mg.
Phosphatidylcholine (PC)	10 mg.
Cephalin (phosphatidylethanolamine)	6 mg.
Phosphoinositides	3 mg.
DMAE (2-dimethylaminoethanol bitartrate)	50 mg.

* LECI-PS® is a registered trademark of Lucas Meyer Inc.

References

Gianotti C; Porta A; De Graan PN; Oestreicher AB; Nunzi MG, B-50/GAP 43 Phosphorylation in Hippocampal Slices From Aged Rats: Effects of Phosphatidylserine Administration. Neurobiol Aging (United States). Sep-Oct 1993, 14(5) p401-6.

Osvaldo RÉ, 2-Dimethylaminoethanol (Deanol): A Brief Review of its Clinical Efficacy and Postulated Mechanism of Action. Current Therapeutic Research, Vol. 16, No. 11, 1974.

Heiss WD; Kessler J; Slansky I; Mielke R; Szelies B; Herholz K, Activation PET as an Instrument to Determine Therapeutic Efficacy in Alzheimer's Disease. Ann NY Acad Sci (United States). Sep 24 1993, 695 p327-31.

THE NATURE'S PLUS COMMITMENT

Nature's Plus is committed to supplying the highest quality supplements that meet or exceed industry standards for potency, purity and disintegration. Look for Nature's Plus The Energy Supplements logo as your guarantee of quality.

Nature's Plus®
The Energy Supplements™
548 Broadhollow Rd., Melville, NY 11747-3708 **(516) 293-0030**
2500 Grand Ave., Long Beach, CA 90815-1764 **(562) 494-2500**
http://www.natplus.com
Div. of Natural Organics, Inc.

9024/6362

Nature's Plus®
The Energy Supplements®

MARKETING SERVICES • 2500 Grand Avenue • Long Beach, CA 90815-1764 • 1-800-937-0500
http://www.natplus.com

2 2 MAA

June 1997

Dear

Thank you for your interest in **Pedi-Active A.D.D.** from Nature's Plus. We know that sometimes yelling, pleading and begging your child to their homework just isn't enough. Research has shown that many of the problems a child who is hyperactive or suffering from Attention Deficit Disorder can be related to improper nutrition. What your child needs is a nutritional supplement that supplies a complete profile of the most advanced neuronutrients available to help your child live up to their full potential. Each delicious mixed berry flavored chewable tablet combines phosphatidylserine, DMAE and activated soy phosphatides to provide the nutritional support your active child needs.

And, if you're looking for a delicious multivitamin you child will eat up, try **Source of Life Animal Parade.** Each cherry and new orange flavored chewable animal supplies 16 vitamins and 8 minerals in a whole food base of fruit, vegetables and spirulina.

To introduce you to these two formulas, clip the coupons below and redeem them at your local health food store or any of the following.

SOUTH END NATURALS
517 COLUMBUS AVE
BOSTON, MA 02118
(617) 536-2119

BREAD & CIRCUS
15 WESTLAND AVENUE
BOSTON, MA 02115
(617) 375-1010

BREAD & CIRCUS
115 PROSPECT STREET
CAMBRIDGE, MA 02139
(617) 492-0071

Experience for yourself why Nature's Plus is known as ***The Energy Supplements.***

Sincerely,

Gerald Kessler

Founder, Nature's Plus

27251331

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NaturalO

1972-1997 A Celebration Of Quality 25

Expires on: 10/04/97 287044448

$1.00 OFF 60 Tablets

Nature's Plus®

PEDI-ACTIVE A.D.D.™

Chewable Phosphatidylserine
DMAE Complex.
NUTRITIONAL SUPPORT FOR THE ACTIVE CHILD.

Available Only at Your Local Health Food Store.
Manufacturer's Coupon

Expires on: 10/04/97 287044448

Exhibit C

$1.00 OFF 90 Tablets

Nature's Plus®

Source of Life

ANIMAL PARADE®

Children's Chewable Multi-Vitamin & Mineral Formula
with Very Cherry and Burst of Orange Natural Flavors.

Available Only at Your Local Health Food Store.
Manufacturer's Coupon

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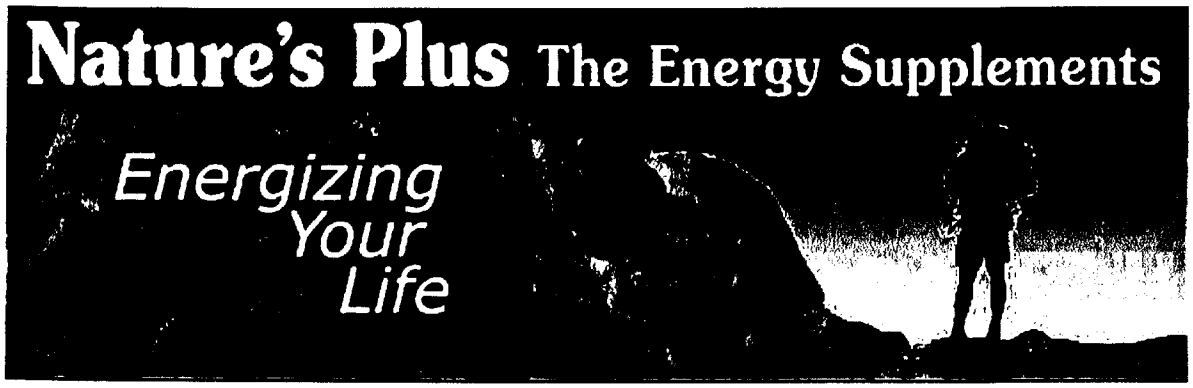

Supplements
Healthy Brain Function

Pedi-Active A.D.D. Chewables ▼ Go there!

Pedi-Active A.D.D. Chewables
Product No. 3000

Pedi-Active A.D.D. is a precisely calibrated formula designed for the active child. Each naturally sweetened, delicious chewable tablet supplies a complete profile of the most advanced neuronutrients available, including a diversified combination of phosphatidylserine, DMAE and activated soy phosphatides. Pedi-Active A.D.D. is a state-of-the art nutritional supplement that naturally complements an active child's delicate system. Choose the Pedi-Active A.D.D. tablets or the convenient Pedi-Active Liposomal Spray, and supplement either with the naturally delicious Pedi-Active Bar.

These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure, or prevent any disease.

Sizes Available:
Bottles of 60 #3000 - 120 #3001

Two chewable tablets contain	
LECI-PS (phosphatidylserine-rich purified lecithin concentrate) (supplying activated phosphatides: phosphatidylserine [PS] [20 mg], phosphatidylcholine [PC] [20 mg], cephalin [phosphatidylethanolamine] [12 mg] and phosphoinositides [6 mg])	100 mg

Find Supplement by Keyword
Enter your search keyword(s) separated by commas, then click *Search*.

Search

Exhibit D-1

001896
NaturalO

■ Product Information	☐ Your Health Library	☐ Where To Buy
☐ Work With Us	☐ More Info	☐ Return To Home
☐ What's New	☐ Unwavering Commitment	☐ Contact Us

Exhibit D-2

001897
NaturalO

Diagnostic and Statistical Manual of Mental Disorders

(Third Edition)

Exhibit E-1

C. Onset before the age of 18.

(If there are behavioral symptoms requiring attention or treatment [e.g., aggressive behavior, self-mutilation, anxiety symptoms] that are not part of another disorder, the non-ICD-9-CM code "1" may be recorded in the fifth digit. Otherwise, code "0".)

ATTENTION DEFICIT DISORDER

The essential features are signs of developmentally inappropriate inattention and impulsivity. In the past a variety of names have been attached to this disorder, including: Hyperkinetic Reaction of Childhood, Hyperkinetic Syndrome, Hyperactive Child Syndrome, Minimal Brain Damage, Minimal Brain Dysfunction, Minimal Cerebral Dysfunction, and Minor Cerebral Dysfunction. In this manual Attention Deficit is the name given to this disorder, since attentional difficulties are prominent and virtually always present among children with these diagnoses. In addition, though excess motor activity frequently diminishes in adolescence, in children who have the disorder, difficulties in attention often persist.

There are two subtypes of the active disorder, Attention Deficit Disorder with Hyperactivity, and Attention Deficit Disorder without Hyperactivity, although it is not known whether they are two forms of a single disorder or represent two distinct disorders. Finally, there is a residual subtype for individuals once diagnosed as having Attention Deficit Disorder with Hyperactivity in which hyperactivity is no longer present, but other signs of the disorder persist.

314.01 Attention Deficit Disorder with Hyperactivity

The essential features are signs of developmentally inappropriate inattention, impulsivity, and hyperactivity. In the classroom, attentional difficulties and impulsivity are evidenced by the child's not staying with tasks and having difficulty organizing and completing work. The children often give the impression that they are not listening or that they have not heard what they have been told. Their work is sloppy and is performed in an impulsive fashion. On individually administered tests, careless, impulsive errors are often present. Performance may be characterized by oversights, such as omissions or insertions, or misinterpretations of easy items even when the child is well motivated, not just in situations that hold little intrinsic interest. Group situations are particularly difficult for the child, and attentional difficulties are exaggerated when the child is in the classroom, where sustained attention is expected.

At home, attentional problems are shown by a failure to follow through on parental requests and instructions and by the inability to stick to activities, including play, for periods of time appropriate for the child's age.

Hyperactivity in young children is manifested by gross motor activity, such as excessive running or climbing. The child is often described as being on the go, "running like a motor," and having difficulty sitting still. Older children and adolescents may be extremely restless and fidgety. Often it is the quality of the motor behavior that distinguishes this disorder from ordinary overactivity in that hyperactivity tends to be haphazard, poorly organized, and not goal-directed.

In situations in which high levels of motor activity are expected and appro-

priate, such as on the playground, the hyperactivity seen in children with this disorder may not be obvious.

Typically, the symptoms of this disorder in any given child vary with situation and time. A child's behavior may be well-organized and appropriate on a one-to-one basis but become dysregulated in a group situation or in the classroom; or home adjustment may be satisfactory and difficulties may emerge only in school. It is the rare child who displays signs of the disorder in all settings or even in the same setting at all times.

Associated features. Associated features vary as a function of age and include obstinacy, stubbornness, negativism, bossiness, bullying, increased mood lability, low frustration tolerance, temper outbursts, low self-esteem, and lack of response to discipline.

Specific Developmental Disorders are common, and should be noted on Axis II.

Nonlocalized "soft" neurological signs, motor-perceptual dysfunctions (e.g., poor eye-hand coordination), and EEG abnormalities may be present. However, in only about 5% of the cases is Attention Deficit Disorder associated with a diagnosable neurological disorder, which should be coded on Axis III.

Age at onset. Onset is typically by the age of three, although frequently the disorder does not come to professional attention until the child enters school.

Course. There are three characteristic courses. In the first, all of the symptoms persist into adolescence or adult life. In the second, the disorder is self-limited and all of the symptoms disappear completely at puberty. In the third, the hyperactivity disappears, but the attentional difficulties and impulsivity persist into adolescence or adult life (Residual Type). The relative frequency of these courses is unknown.

Impairment. Academic difficulties are common; and although impairment may be limited to academic functioning, social functioning may be impaired as well. Infrequently children with this disorder require residential treatment.

Complications. School failure, Conduct Disorder, and Antisocial Personality Disorder are the major complications.

Predisposing factors. Mild or Moderate Mental Retardation, epilepsy, some forms of cerebral palsy, and other neurological disorders may be predisposing factors.

Prevalence. The disorder is common. In the United States, it may occur in as many as 3% of prepubertal children.

Sex ratio. The disorder is ten times more common in boys than in girls.

Familial pattern. The disorder is apparently more common in family members than in the general population.

Differential diagnosis. Age-appropriate overactivity, as is seen in some particularly active children, does not have the haphazard and poorly organized quality characteristic of the behavior of children with Attention Deficit Disorder. Children in **inadequate, disorganized,** or **chaotic environments** may appear to have difficulty in sustaining attention and in goal-directed behavior. In such cases it may be impossible to determine whether the disorganized behavior is simply a function of the chaotic environment or whether it is due to the child's psychopathology (in which case the diagnosis of Attention Deficit Disorder may be warranted).

In **Severe** and **Profound Mental Retardation** there may be clinical features that are characteristic of Attention Deficit Disorder. However, the additional diagnosis of Attention Deficit Disorder would make clinical sense only if the Mental Retardation were Mild or Moderate in severity.

Many cases of **Conduct Disorder** have signs of impulsivity, inattention, and hyperactivity. The additional diagnosis of Attention Deficit Disorder is frequently warranted.

In **Schizophrenia** and **Affective Disorders with manic features** there may be clinical features that are characteristic of Attention Deficit Disorder. However, these diagnoses preempt the diagnosis of Attention Deficit Disorder.

Diagnostic criteria for Attention Deficit Disorder with Hyperactivity

The child displays, for his or her mental and chronological age, signs of developmentally inappropriate inattention, impulsivity, and hyperactivity. The signs must be reported by adults in the child's environment, such as parents and teachers. Because the symptoms are typically variable, they may not be observed directly by the clinician. When the reports of teachers and parents conflict, primary consideration should be given to the teacher reports because of greater familiarity with age-appropriate norms. Symptoms typically worsen in situations that require self-application, as in the classroom. Signs of the disorder may be absent when the child is in a new or a one-to-one situation.

The number of symptoms specified is for children between the ages of eight and ten, the peak age range for referral. In younger children, more severe forms of the symptoms and a greater number of symptoms are usually present. The opposite is true of older children.

A. **Inattention.** At least three of the following:
   (1) often fails to finish things he or she starts
   (2) often doesn't seem to listen
   (3) easily distracted
   (4) has difficulty concentrating on schoolwork or other tasks requiring sustained attention

(5) has difficulty sticking to a play activity

B. **Impulsivity.** At least three of the following:

(1) often acts before thinking
(2) shifts excessively from one activity to another
(3) has difficulty organizing work (this not being due to cognitive impairment)
(4) needs a lot of supervision
(5) frequently calls out in class
(6) has difficulty awaiting turn in games or group situations

C. **Hyperactivity.** At least two of the following:

(1) runs about or climbs on things excessively
(2) has difficulty sitting still or fidgets excessively
(3) has difficulty staying seated
(4) moves about excessively during sleep
(5) is always "on the go" or acts as if "driven by a motor"

D. Onset before the age of seven.

E. Duration of at least six months.

F. Not due to Schizophrenia, Affective Disorder, or Severe or Profound Mental Retardation.

314.00 Attention Deficit Disorder without Hyperactivity

All of the features are the same as those of Attention Deficit Disorder with Hyperactivity except for the absence of hyperactivity; the associated features and impairment are generally milder. Prevalence and familial pattern are unknown.

Diagnostic criteria for Attention Deficit Disorder without Hyperactivity

The criteria for this disorder are the same as those for Attention Deficit Disorder with Hyperactivity except that the individual never had signs of hyperactivity (criterion C).

314.80 Attention Deficit Disorder, Residual Type

Diagnostic criteria for Attention Deficit Disorder, Residual Type

A. The individual once met the criteria for Attention Deficit Disorder with Hyperactivity. This information may come from the individual or from others, such as family members.

B. Signs of hyperactivity are no longer present, but other signs of the illness have persisted to the present without periods of remission, as evidenced by signs of both attentional deficits and impulsivity (e.g., difficulty organizing work and completing tasks, difficulty concentrating, being easily distracted, making sudden decisions without thought of the consequences).

C. The symptoms of inattention and impulsivity result in some impairment in social or occupational functioning.

D. Not due to Schizophrenia, Affective Disorder, Severe or Profound Mental Retardation, or Schizotypal or Borderline Personality Disorders.

CONDUCT DISORDER

The essential feature is a repetitive and persistent pattern of conduct in which either the basic rights of others or major age-appropriate societal norms or rules are violated. The conduct is more serious than the ordinary mischief and pranks of children and adolescents.

Four specific subtypes are included: Undersocialized, Aggressive; Undersocialized, Nonaggressive; Socialized, Aggressive; and Socialized, Nonaggressive. These subtypes are based on the presence or absence of adequate social bonds and the presence or absence of a pattern of aggressive antisocial behavior. The validity of these diagnostic subtypes within the category of Conduct Disorder is controversial. Some investigators believe that a more useful distinction would be on the basis of the variety, frequency, and seriousness of the antisocial behavior rather than the type of disturbance, whereas others believe that the Undersocialized and Socialized types represent distinct disorders.

The *Undersocialized* types are characterized by a failure to establish a normal degree of affection, empathy, or bond with others. Peer relationships are generally lacking, although the youngster may have superficial relationships with other youngsters. Characteristically the child does not extend himself or herself for others unless there is an obvious immediate advantage. Egocentrism is shown by readiness to manipulate others for favors without any effort to reciprocate. There is generally a lack of concern for the feelings, wishes, and well-being of others, as shown by callous behavior. Appropriate feelings of guilt or remorse are generally absent. Such a child may readily inform on his or her companions and try to place blame on them.

The *Socialized* types show evidence of social attachment to others, but may be similarly callous or manipulative toward persons to whom they are not attached and lack guilt when these "outsiders" are made to suffer.

The *Aggressive* types are characterized by a repetitive and persistent pattern of aggressive conduct in which the rights of others are violated, by either physical violence against persons, or thefts outside the home involving confrontation with a victim. The physical violence may take the form of rape, mugging, assault, or, in rare cases, homicide. In some cases, the physical violence may be

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

(THIRD EDITION - REVISED)

DSM-III-R

Published by the
American Psychiatric Association
Washington, DC
1987

the symptoms of these disorders covary to a high degree. In the literature the behaviors that these disorders encompass have been referred to as "externalizing" symptoms.

314.01 Attention-deficit Hyperactivity Disorder (ADHD)

The essential features of this disorder are developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity. People with the disorder generally display some disturbance in each of these areas, but to varying degrees.

Manifestations of the disorder usually appear in most situations, including at home, in school, at work, and in social situations, but to varying degrees. Some people, however, show signs of the disorder in only one setting, such as at home or at school. Symptoms typically worsen in situations requiring sustained attention, such as listening to a teacher in a classroom, attending meetings, or doing class assignments or chores at home. Signs of the disorder may be minimal or absent when the person is receiving frequent reinforcement or very strict control, or is in a novel setting or a one-to-one situation (e.g., being examined in the clinician's office, or interacting with a videogame).

In the *classroom or workplace*, inattention and impulsiveness are evidenced by not sticking with tasks sufficiently to finish them and by having difficulty organizing and completing work correctly. The person often gives the impression that he or she is not listening or has not heard what has been said. Work is often messy, and performed carelessly and impulsively.

Impulsiveness is often demonstrated by blurting out answers to questions before they are completed, making comments out of turn, failing to await one's turn in group tasks, failing to heed directions fully before beginning to respond to assignments, interrupting the teacher during a lesson, and interrupting or talking to other children during quiet work periods.

Hyperactivity may be evidenced by difficulty remaining seated, excessive jumping about, running in classroom, fidgeting, manipulating objects, and twisting and wiggling in one's seat.

At *home*, inattention may be displayed in failure to follow through on others' requests and instructions and in frequent shifts from one uncompleted activity to another. Problems with impulsiveness are often expressed by interrupting or intruding on other family members and by accident-prone behavior, such as grabbing a hot pan from the stove or carelessly knocking over a pitcher. Hyperactivity may be evidenced by an inability to remain seated when expected to do so (situations in which this is the case vary greatly from home to home) and by excessively noisy activities.

With *peers*, inattention is evident in failure to follow the rules of structured games or to listen to other children. Impulsiveness is frequently demonstrated by failing to await one's turn in games, interrupting, grabbing objects (not with malevolent intent), and engaging in potentially dangerous activities without considering the possible consequences, e.g., riding a skateboard over extremely rough terrain. Hyperactivity may be shown by excessive talking and by an inability to play quietly and to regulate one's activity to conform to the demands of the game (e.g., in playing "Simon Says," the child keeps moving about and talking to peers when he or she is expected to be quiet).

Age-specific features. In preschool children, the most prominent features are generally signs of gross motor overactivity, such as excessive running or climbing. The child is often described as being on the go and "always having his motor running." Inattention and impulsiveness are likely to be shown by frequent shifting from one activity to another. In older children and adolescents, the most prominent features tend to be excessive fidgeting and restlessness rather than gross motor overactivity. Inatten-

tion and impulsiveness
tions, or careless perfo
displayed in social act
moment instead of at
doing homework).

Associated feature
self-esteem, mood labi
underachievement is c
In clinic samples,
Conduct Disorder, and
Encopresis and Functio
is relatively rare in child
Disorder are found to h
Nonlocalized, "so
poor eye-hand coordin

Age at onset. In ap
four. Frequently the dis

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tion and impulsiveness may contribute to failure to complete assigned tasks or instructions, or careless performance of assigned work. In adolescents, impulsiveness is often displayed in social activities, such as initiating a diverting activity on the spur of the moment instead of attending to a previous commitment (e.g., joy riding instead of doing homework).

Associated features. Associated features vary as a function of age, and include low self-esteem, mood lability, low frustration tolerance, and temper outbursts. Academic underachievement is characteristic of most children with this disorder.

In clinic samples, some or all of the symptoms of Oppositional Defiant Disorder, Conduct Disorder, and Specific Developmental Disorders are often present. Functional Encopresis and Functional Enuresis are sometimes seen. Although Tourette's Disorder is relatively rare in children with ADHD, in clinic samples many children with Tourette's Disorder are found to have ADHD as well.

Nonlocalized, "soft," neurologic signs and motor-perceptual dysfunctions (e.g., poor eye-hand coordination) may be present.

Age at onset. In approximately half of the cases, onset of the disorder is before age four. Frequently the disorder is not recognized until the child enters school.

Course. In the majority of cases manifestations of the disorder persist throughout childhood. Oppositional Defiant Disorder or Conduct Disorder often develops later in childhood in those with ADHD. Among those who develop Conduct Disorder, a significant number are found to have Antisocial Personality Disorder in adulthood. Follow-up studies of clinic samples indicate that approximately one-third of children with ADHD continue to show some signs of the disorder in adulthood. Studies have indicated that the following features predict a poor course: coexisting Conduct Disorder, low IQ, and severe mental disorder in the parents.

Impairment. Some impairment in social and school functioning is common.

Complications. School failure is the major complication.

Predisposing factors. Central nervous system abnormalities, such as the presence of neurotoxins, cerebral palsy, epilepsy, and other neurologic disorders, are thought to be predisposing factors. Disorganized or chaotic environments and child abuse or neglect may be predisposing factors in some cases.

Prevalence. The disorder is common; it may occur in as many as 3% of children.

Sex ratio. In clinic samples, the disorder is from six to nine times more common in males than in females. In community samples, multiple signs of the disorder occur only three times more often in males than in females.

Familial pattern. The disorder is believed to be more common in first-degree biologic relatives of people with the disorder than in the general population. Among family members, the following disorders are thought to be overrepresented: Specific Developmental Disorders, Alcohol Dependence or Abuse, Conduct Disorder, and Antisocial Personality Disorder.

Differential diagnosis. Age-appropriate overactivity, as is seen in some particularly active children, does not have the haphazard and poorly organized quality characteristic of the behavior of children with Attention-deficit Hyperactivity Disorder. Children in **inadequate, disorganized,** or **chaotic environments** may appear to have difficulty in sustaining attention and in goal-directed behavior. In such cases it may be impossible to determine whether the disorganized behavior is primarily a function of the chaotic environment or whether it is due largely to the child's psychopathology (in which case the diagnosis of Attention-deficit Hyperactivity Disorder may be warranted).

In **Mental Retardation** there may be many of the features of ADHD because of the generalized delay in intellectual development. The additional diagnosis of ADHD is made only if the relevant symptoms are excessive for the child's mental age.

Symptoms characteristic of ADHD are often observed in **Pervasive Developmental Disorders;** in these cases a diagnosis of ADHD is preempted.

In **Mood Disorders** there may be psychomotor agitation and difficulty in concentration that are difficult to distinguish from the hyperactivity and attentional difficulties seen in Attention-deficit Hyperactivity Disorder. Therefore, it is important to consider the diagnosis of a Mood Disorder before making the diagnosis of Attention-deficit Hyperactivity Disorder.

Signs of impulsiveness and hyperactivity are not present in **Undifferentiated Attention-deficit Disorder.**

Diagnostic criteria for 314.01 Attention-deficit Hyperactivity Disorder

Note: Consider a criterion met only if the behavior is considerably more frequent than that of most people of the same mental age.

A. A disturbance of at least six months during which at least eight of the following are present:

(1) often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)
(2) has difficulty remaining seated when required to do so
(3) is easily distracted by extraneous stimuli
(4) has difficulty awaiting turn in games or group situations
(5) often blurts out answers to questions before they have been completed
(6) has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension), e.g., fails to finish chores
(7) has difficulty sustaining attention in tasks or play activities
(8) often shifts from one uncompleted activity to another
(9) has difficulty playing quietly
(10) often talks excessively
(11) often interrupts or intrudes on others, e.g., butts into other children's games
(12) often does not seem to listen to what is being said to him or her
(13) often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)

Diagnostic criteri continued

(14) often e possible into stre

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Criteria for seve

Mild: Few, if any, only minimal or

Moderate: Sympt "severe."

Severe: Many sy significant and pe peers.

Conduct Disorder

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Diagnostic criteria for 314.01 Attention-deficit Hyperactivity Disorder continued

(14) often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking

Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the DSM-III-R criteria for Disruptive Behavior Disorders.

B. Onset before the age of seven.

C. Does not meet the criteria for a Pervasive Developmental Disorder.

Criteria for severity of Attention-deficit Hyperactivity Disorder:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis **and** only minimal or no impairment in school and social functioning.

Moderate: Symptoms or functional impairment intermediate between "mild" and "severe."

Severe: Many symptoms in excess of those required to make the diagnosis **and** significant and pervasive impairment in functioning at home and school and with peers.

Conduct Disorder

312.20 group type
312.00 solitary aggressive type
312.90 undifferentiated type

The essential feature of this disorder is a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated. The behavior pattern typically is present in the home, at school, with peers, and in the community. The conduct problems are more serious than those seen in Oppositional Defiant Disorder.

Physical aggression is common. Children or adolescents with this disorder usually initiate aggression, may be physically cruel to other people or to animals, and frequently deliberately destroy other people's property (this may include fire-setting). They may engage in stealing with confrontation of the victim, as in mugging, purse-snatching, extortion, or armed robbery. At later ages, the physical violence may take the form of rape, assault, or, in rare cases, homicide.

Covert stealing is common. This may range from "borrowing" others' possessions to shoplifting, forgery, and breaking into someone else's house, building, or car. Lying and cheating in games or in schoolwork are common. Often a youngster with this disorder is truant from school, and may run away from home.

Associated features. Regular use of tobacco, liquor, or nonprescribed drugs and sexual behavior that begins unusually early for the child's peer group in his or her milieu are common. The child may have no concern for the feelings, wishes, and well-being of others, as shown by callous behavior, and may lack appropriate feelings of guilt or remorse. Such a child may readily inform on his or her companions and try to place blame for misdeeds on them.

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Fourth Edition

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are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder. For example, this category includes "atypical autism"—presentations that do not meet the criteria for Autistic Disorder because of late age at onset, atypical symptomatology, or subthreshold symptomatology, or all of these.

Attention-Deficit and Disruptive Behavior Disorders

Attention-Deficit/Hyperactivity Disorder

Diagnostic Features

The essential feature of Attention-Deficit/Hyperactivity Disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development (Criterion A). Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years (Criterion B). Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and is not better accounted for by another mental disorder (e.g., a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder) (Criterion E).

Inattention may be manifest in academic, occupational, or social situations. Individuals with this disorder may fail to give close attention to details or may make careless mistakes in schoolwork or other tasks (Criterion A1a). Work is often messy and performed carelessly and without considered thought. Individuals often have difficulty sustaining attention in tasks or play activities and find it hard to persist with tasks until completion (Criterion A1b). They often appear as if their mind is elsewhere or as if they are not listening or did not hear what has just been said (Criterion A1c). There may be frequent shifts from one uncompleted activity to another. Individuals diagnosed with this disorder may begin a task, move on to another, then turn to yet something else, prior to completing any one task. They often do not follow through on requests or instructions and fail to complete schoolwork, chores, or other duties (Criterion A1d). Failure to complete tasks should be considered in making this diagnosis only if it is due to inattention as opposed to other possible reasons (e.g., a failure to understand instructions). These individuals often have difficulties organizing tasks and activities (Criterion A1e). Tasks that require sustained mental effort are experienced as unpleasant and markedly aversive. As a result, these individuals typically avoid or have a strong dislike for activities that demand sustained self-application and mental effort or that require organizational demands or close concentration (e.g., homework or paperwork) (Criterion A1f). This avoidance must be due to the person's difficulties with attention and not due to a primary oppositional attitude, although secondary oppositionalism may also occur. Work habits are often disorganized and the materials necessary for doing

the task are often scattered, Individuals with this disorde interrupt ongoing tasks to at ignored by others (e.g., a car are often forgetful in daily lunch) (Criterion A1i). In sc shifts in conversation, not list and not following details or

Hyperactivity may be ma A2a), by not remaining seat running or climbing in situa difficulty playing or engagin to be often "on the go" or excessively (Criterion A2f). developmental level, and th Toddlers and preschoolers w by being constantly on the g the door before their coat is and have difficulty participat listening to a story). School- frequency or intensity than seated, get up frequently, a fidget with objects, tap their get up from the table during r they talk excessively; and adolescents and adults, sym ness and difficulty engaging

Impulsivity manifests its out answers before question one's turn (Criterion A2h), ar of causing difficulties in soci may complain that they can typically make comments ou inappropriate times, interru others, touch things they are lead to accidents (e.g., knoc and to engagement in poten consequences (e.g., riding a

Behavioral manifestatio school, work, and social situ present in at least two setting the same level of dysfuncti Symptoms typically worsen or that lack intrinsic appeal assignments, listening to o repetitive tasks). Signs of th under very strict control, i activities, is in a one-to-one experiences frequent reward

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the task are often scattered, lost, or carelessly handled and damaged (Criterion A1g). Individuals with this disorder are easily distracted by irrelevant stimuli and frequently interrupt ongoing tasks to attend to trivial noises or events that are usually and easily ignored by others (e.g., a car honking, a background conversation) (Criterion A1h). They are often forgetful in daily activities (e.g., missing appointments, forgetting to bring lunch) (Criterion A1i). In social situations, inattention may be expressed as frequent shifts in conversation, not listening to others, not keeping one's mind on conversations, and not following details or rules of games or activities.

Hyperactivity may be manifested by fidgetiness or squirming in one's seat (Criterion A2a), by not remaining seated when expected to do so (Criterion A2b), by excessive running or climbing in situations where it is inappropriate (Criterion A2c), by having difficulty playing or engaging quietly in leisure activities (Criterion A2d), by appearing to be often "on the go" or as if "driven by a motor" (Criterion A2e), or by talking excessively (Criterion A2f). Hyperactivity may vary with the individual's age and developmental level, and the diagnosis should be made cautiously in young children. Toddlers and preschoolers with this disorder differ from normally active young children by being constantly on the go and into everything; they dart back and forth, are "out of the door before their coat is on," jump or climb on furniture, run through the house, and have difficulty participating in sedentary group activities in preschool classes (e.g., listening to a story). School-age children display similar behaviors but usually with less frequency or intensity than toddlers and preschoolers. They have difficulty remaining seated, get up frequently, and squirm in, or hang on to the edge of, their seat. They fidget with objects, tap their hands, and shake their feet or legs excessively. They often get up from the table during meals, while watching television, or while doing homework; they talk excessively; and they make excessive noise during quiet activities. In adolescents and adults, symptoms of hyperactivity take the form of feelings of restlessness and difficulty engaging in quiet sedentary activities.

Impulsivity manifests itself as impatience, difficulty in delaying responses, blurting out answers before questions have been completed (Criterion A2g), difficulty awaiting one's turn (Criterion A2h), and frequently interrupting or intruding on others to the point of causing difficulties in social, academic, or occupational settings (Criterion A2i). Others may complain that they cannot get a word in edgewise. Individuals with this disorder typically make comments out of turn, fail to listen to directions, initiate conversations at inappropriate times, interrupt others excessively, intrude on others, grab objects from others, touch things they are not supposed to touch, and clown around. Impulsivity may lead to accidents (e.g., knocking over objects, banging into people, grabbing a hot pan) and to engagement in potentially dangerous activities without consideration of possible consequences (e.g., riding a skateboard over extremely rough terrain).

Behavioral manifestations usually appear in multiple contexts, including home, school, work, and social situations. To make the diagnosis, some impairment must be present in at least two settings (Criterion C). It is very unusual for an individual to display the same level of dysfunction in all settings or within the same setting at all times. Symptoms typically worsen in situations that require sustained attention or mental effort or that lack intrinsic appeal or novelty (e.g., listening to classroom teachers, doing class assignments, listening to or reading lengthy materials, or working on monotonous, repetitive tasks). Signs of the disorder may be minimal or absent when the person is under very strict control, is in a novel setting, is engaged in especially interesting activities, is in a one-to-one situation (e.g., the clinician's office), or while the person experiences frequent rewards for appropriate behavior. The symptoms are more likely

to occur in group situations (e.g., in playgroups, classrooms, or work environments). The clinician should therefore inquire about the individual's behavior in a variety of situations within each setting.

Subtypes

Although most individuals have symptoms of both inattention and hyperactivity-impulsivity, there are some individuals in whom one or the other pattern is predominant. The appropriate subtype (for a current diagnosis) should be indicated based on the predominant symptom pattern for the past 6 months.

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type. This subtype should be used if six (or more) symptoms of inattention and six (or more) symptoms of hyperactivity-impulsivity have persisted for at least 6 months. Most children and adolescents with the disorder have the Combined Type. It is not known whether the same is true of adults with the disorder.

314.00 Attention Deficit/Hyperactivity Disorder, Predominantly Inattentive Type. This subtype should be used if six (or more) symptoms of inattention (but fewer than six symptoms of hyperactivity-impulsivity) have persisted for at least 6 months.

314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type. This subtype should be used if six (or more) symptoms of hyperactivity-impulsivity (but fewer than six symptoms of inattention) have persisted for at least 6 months. Inattention may often still be a significant clinical feature in such cases.

Recording Procedures

Individuals who at an earlier stage of the disorder had the Predominantly Inattentive Type or the Predominantly Hyperactive-Impulsive Type may go on to develop the Combined Type and vice versa. The appropriate subtype (for a current diagnosis) should be indicated based on the predominant symptom pattern for the past 6 months. If clinically significant symptoms remain but criteria are no longer met for any of the subtypes, the appropriate diagnosis is Attention-Deficit/Hyperactivity Disorder, In Partial Remission. When an individual's symptoms do not currently meet full criteria for the disorder and it is unclear whether criteria for the disorder have previously been met, Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified should be diagnosed.

Associated Features and Disorders

Associated descriptive features and mental disorders. Associated features vary depending on age and developmental stage and may include low frustration tolerance, temper outbursts, bossiness, stubbornness, excessive and frequent insistence that requests be met, mood lability, demoralization, dysphoria, rejection by peers, and poor self-esteem. Academic achievement is often impaired and devalued, typically leading to conflict with the family and school authorities. Inadequate self-application to tasks that require sustained effort is often interpreted by others as indicating laziness, a poor sense of responsibility, and oppositional behavior. Family relationships are often characterized by resentment and antagonism, especially because variability in the individual's symp-

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tomatic status often leads parents to believe that all the troublesome behavior is willful. Individuals with Attention-Deficit/Hyperactivity Disorder may obtain less schooling than their peers and have poorer vocational achievement. Intellectual development, as assessed by individual IQ tests, appears to be somewhat lower in children with this disorder. In its severe form, the disorder is very impairing, affecting social, familial, and scholastic adjustment. A substantial proportion of children referred to clinics with Attention-Deficit/Hyperactivity Disorder also have Oppositional Defiant Disorder or Conduct Disorder. There may be a higher prevalence of Mood Disorders, Anxiety Disorders, Learning Disorders, and Communication Disorders in children with Attention-Deficit/Hyperactivity Disorder. This disorder is not infrequent among individuals with Tourette's Disorder; when the two disorders coexist, the onset of Attention-Deficit/Hyperactivity Disorder often precedes the onset of the Tourette's Disorder. There may be a history of child abuse or neglect, multiple foster placements, neurotoxin exposure (e.g., lead poisoning), infections (e.g., encephalitis), drug exposure in utero, low birth weight, and Mental Retardation.

Associated laboratory findings. There are no laboratory tests that have been established as diagnostic in the clinical assessment of Attention-Deficit/Hyperactivity Disorder. Tests that require effortful mental processing have been noted to be abnormal in groups of individuals with Attention-Deficit/Hyperactivity Disorder compared with control subjects, but it is not yet entirely clear what fundamental cognitive deficit is responsible for this.

Associated physical examination findings and general medical conditions. There are no specific physical features associated with Attention-Deficit/Hyperactivity Disorder, although minor physical anomalies (e.g., hypertelorism, highly arched palate, low-set ears) may occur at a higher rate than in the general population. There may also be a higher rate of physical injury.

Specific Culture, Age, and Gender Features

Attention-Deficit/Hyperactivity Disorder is known to occur in various cultures, with variations in reported prevalence among Western countries probably arising more from different diagnostic practices than from differences in clinical presentation.

It is especially difficult to establish this diagnosis in children younger than age 4 or 5 years, because their characteristic behavior is much more variable than that of older children and may include features that are similar to symptoms of Attention-Deficit/Hyperactivity Disorder. Furthermore, symptoms of inattention in toddlers or preschool children are often not readily observed because young children typically experience few demands for sustained attention. However, even the attention of toddlers can be held in a variety of situations (e.g., the average 2- or 3-year-old child can typically sit with an adult looking through picture books). In contrast, young children with Attention-Deficit/Hyperactivity Disorder move excessively and typically are difficult to contain. Inquiring about a wide variety of behaviors in a young child may be helpful in ensuring that a full clinical picture has been obtained. As children mature, symptoms usually become less conspicuous. By late childhood and early adolescence, signs of excessive gross motor activity (e.g., excessive running and climbing, not remaining seated) are less common, and hyperactivity symptoms may be confined to fidgetiness or an inner

feeling of jitteriness or restlessness. In school-age children, symptoms of inattention affect classroom work and academic performance. Impulsive symptoms may also lead to the breaking of familial, interpersonal, and educational rules, especially in adolescence. In adulthood, restlessness may lead to difficulty in participating in sedentary activities and to avoiding pastimes or occupations that provide limited opportunity for spontaneous movement (e.g., desk jobs).

The disorder is much more frequent in males than in females, with male-to-female ratios ranging from 4:1 to 9:1, depending on the setting (i.e., general population or clinics).

Prevalence

The prevalence of Attention-Deficit/Hyperactivity Disorder is estimated at 3%–5% in school-age children. Data on prevalence in adolescence and adulthood are limited.

Course

Most parents first observe excessive motor activity when the children are toddlers, frequently coinciding with the development of independent locomotion. However, because many overactive toddlers will not go on to develop Attention-Deficit/Hyperactivity Disorder, caution should be exercised in making this diagnosis in early years. Usually, the disorder is first diagnosed during elementary school years, when school adjustment is compromised. In the majority of cases seen in clinical settings, the disorder is relatively stable through early adolescence. In most individuals, symptoms attenuate during late adolescence and adulthood, although a minority experience the full complement of symptoms of Attention-Deficit/Hyperactivity Disorder into mid-adulthood. Other adults may retain only some of the symptoms, in which case the diagnosis of Attention-Deficit/Hyperactivity Disorder, In Partial Remission, should be used. This diagnosis applies to individuals who no longer have the full disorder but still retain some symptoms that cause functional impairment.

Familial Pattern

Attention-Deficit/Hyperactivity Disorder has been found to be more common in the first-degree biological relatives of children with Attention-Deficit/Hyperactivity Disorder. Studies also suggest that there is a higher prevalence of Mood and Anxiety Disorders, Learning Disorders, Substance-Related Disorders, and Antisocial Personality Disorder in family members of individuals with Attention-Deficit/Hyperactivity Disorder.

Differential Diagnosis

In early childhood, it may be difficult to distinguish symptoms of Attention-Deficit/Hyperactivity Disorder from **age-appropriate behaviors in active children** (e.g., running around or being noisy).

Symptoms of inattention are common among children with low IQ who are placed in academic settings that are inappropriate to their intellectual ability. These behaviors must be distinguished from similar signs in children with Attention-Deficit/Hyperactivity Disorder. In children with **Mental Retardation,** an additional diagnosis of Attention-

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Deficit/Hyperactivity Disorder should be made only if the symptoms of inattention or hyperactivity are excessive for the child's mental age. Inattention in the classroom may also occur when children with high intelligence are placed in academically **understimulating environments.** Attention-Deficit/Hyperactivity Disorder must also be distinguished from difficulty in goal-directed behavior in children from inadequate, disorganized, or chaotic environments. Reports from multiple informants (e.g., babysitters, grandparents, or parents of playmates) are helpful in providing a confluence of observations concerning the child's inattention, hyperactivity, and capacity for developmentally appropriate self-regulation in various settings.

Individuals with **oppositional behavior** may resist work or school tasks that require self-application because of an unwillingness to conform to others' demands. These symptoms must be differentiated from the avoidance of school tasks seen in individuals with Attention-Deficit/Hyperactivity Disorder. Complicating the differential diagnosis is the fact that some individuals with Attention-Deficit/Hyperactivity Disorder develop secondary oppositional attitudes toward such tasks and devalue their importance, often as a rationalization for their failure.

Attention-Deficit/Hyperactivity Disorder is not diagnosed if the symptoms are better accounted for by **another mental disorder** (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, Personality Disorder, Personality Change Due to a General Medical Condition, or a Substance-Related Disorder). In all these disorders, the symptoms of inattention typically have an onset after age 7 years, and the childhood history of school adjustment generally is not characterized by disruptive behavior or teacher complaints concerning inattentive, hyperactive, or impulsive behavior. When a Mood Disorder or Anxiety Disorder co-occurs with Attention-Deficit/Hyperactivity Disorder, each should be diagnosed. Attention-Deficit/Hyperactivity Disorder is not diagnosed if the symptoms of inattention and hyperactivity occur exclusively during the course of a **Pervasive Developmental Disorder** or a **Psychotic Disorder.** Symptoms of inattention, hyperactivity, or impulsivity related to the use of medication (e.g., bronchodilators, isoniazid, akathisia from neuroleptics) in children before age 7 years are not diagnosed as Attention-Deficit/Hyperactivity Disorder but instead are diagnosed as **Other Substance-Related Disorder Not Otherwise Specified.**

Diagnostic criteria for Attention-Deficit/ Hyperactivity Disorder

A. Either (1) or (2):

(1) six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

(b) often has difficulty sustaining attention in tasks or play activities

(continued)

☐ **Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder** (*continued*)

(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
(e) often has difficulty organizing tasks and activities
(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(2) six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity
(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively

Impulsivity
(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

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☐ **Diagnostic c**
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Hyperactive
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Coding note: I
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314.9 Att

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Diagnostic Featu

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(Criterion B). Conduct
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(Criterion C). The beh
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☐ **Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder** (*continued*)

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Code based on type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months

314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months

314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

314.9 Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified

This category is for disorders with prominent symptoms of inattention or hyperactivity-impulsivity that do not meet criteria for Attention-Deficit/Hyperactivity Disorder.

312.8 Conduct Disorder

Diagnostic Features

The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated (Criterion A). These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals (Criteria A1–A7), nonaggressive conduct that causes property loss or damage (Criteria A8–A9), deceitfulness or theft (Criteria A10–A12), and serious violations of rules (Criteria A13–A15). Three (or more) characteristic behaviors must have been present during the past 12 months, with at least one behavior present in the past 6 months. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning (Criterion B). Conduct Disorder may be diagnosed in individuals who are older than age 18 years, but only if the criteria for Antisocial Personality Disorder are not met (Criterion C). The behavior pattern is usually present in a variety of settings such as home, school, or the community. Because individuals with Conduct Disorder are likely

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

In the Matter of	)	
NATURAL ORGANICS, INC., a corporation, and	)	DOCKET NO. 9294
GERALD A. KESSLER, individually and as an officer of the corporation.	)	

TO: The Honorable James P. Timony
Chief Administrative Law Judge

DECLARATION OF CRAIG KAUFFMAN

I, Craig Kauffman, hereby affirm as follows:

1. I am a citizen of the United States, over 21 years of age. I have personal knowledge of the facts stated herein, and if called to testify, I could and would competently testify to the facts set forth below.

2. I am employed by the Federal Trade Commission as an investigator. My business address is 901 Market Street, Suite 570, San Francisco, CA 94103.

3. On or about December 27, 2000, I accessed the Internet on my office computer. I typed in the URL for Google, http://www.google.com. Google is a prominent Internet search engine. I typed in the search term "ADD". Google responded with a listing at the top of the search results page "Category: Health>Mental Health>Disorders>ADD and ADHD." A true and correct copy of this search result page, consisting of two pages, is identified as Kauffman Exhibit 1.

4. I then clicked on the link described in the previous paragraph, "Category: Health>Mental

Health>Disorders>ADD and ADHD." Google then presented me with a listing headed, "ADD and ADHD." A true and correct copy of this listing, consisting of four pages, is identified as Kauffman Exhibit 2. Included were Web pages for the National Attention Deficit Disorder Association, an Attention Deficit Disorder archive; an ADD Helpline; ADD/ADHD Resources Catalog, etc.

5. I then performed an on-line search on Lexis-Nexis for ADD articles. One article found was from the February 9, 2000 Chicago Tribune entitled, "Girls Also Have ADD." A true and correct copy of this article, consisting of three pages, is identified as Kauffman Exhibit 3. A second article found on my "ADD" search was a September 26, 2000 New York Times article entitled, "Some See Hope in Biofeedback for Attention Disorder." A true and correct copy of this article, consisting of six pages, is identified as Kauffman Exhibit 4. Another article located on my "ADD" search was a July 17, 2000 Capital Times (Madison, Wisconsin) article entitled, "Docs Issue ADHD Rules." A true and correct copy of this article, consisting of three pages, is identified as Kauffman Exhibit 5. I also found a transcript from the Good Morning America show from August 31, 2000, headlined, "Schools Pressuring Parents to Put Children With Behavioral Problems on Ritalin." A true and correct copy of this transcript, consisting of four pages, is identified as Kauffman Exhibit 6.

6. I accessed the Web site http://www.chadd.org. A true and correct copy of this Web page, consisting of two pages, is identified as Kauffman Exhibit 7.

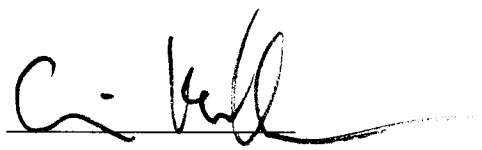
7. I accessed the Internet search site Yahoo, http://www.yahoo.com. I typed in the search term "ADD". A true and correct copy of the results, consisting of three pages, is identified as Kauffman Exhibit 8.

8. I then clicked on the first link at the top of the first page described in the previous paragraph: "Health: Find information about Attention Deficit Disorder on Yahoo! Health". A true and correct copy of that link, consisting of three pages, is identified as Kauffman Exhibit 9.

9. I then returned to the Yahoo search results page described in paragraph 7, and clicked on "Health > Diseases and Conditions - Attention Deficit Disorder (ADD)". A true and correct copy of the resulting Web page, consisting of three pages, is identified as Kauffman Exhibit 10.

10. I then clicked on the category "Companies" shown on the Web page described in paragraph 9. A true and correct copy of the resulting Web page, consisting of three pages, is identified as Kauffman Exhibit 11.

I swear under penalty of perjury and the foregoing is true and correct. Executed at San Francisco, California, this 29th day of December, 2000.



Craig Kauffman

Google™ Advanced Search Preferences Search Tips

ADD Google Search I'm Feeling Lucky

Searched the web for **ADD**. Results **1 - 10** of about **37,700,000**. Search took **0.06** seconds.

Category: Health > Mental Health > Disorders > ADD and ADHD

Untitled
home.netscape.com/misc/nav_redir/addsite.html - 1k - Cached - Similar pages

Add Me, FREE Site Promotion and Submission!
... To bookmark this website, press the keys Ctrl D. You can also drag this **Add** Me! bullet to your Desktop. Free Search Engine Submission You have a great website ...
Description: Submission to 34 popular search engines.
Category: Computers > Internet > ... > Submitting Services > Free
www.addme.com/ - 22k - Cached - Similar pages

Excite Info: **Add** URL
... Questions? Visit the LookSmart Submit FAQ or LookSmart Customer Service. Click here to **add** your site to the Excite Search Index only. This option is still free ...
www.excite.com/info/add_url - 18k - Cached - Similar pages

WebCrawler Info: **Add** URL
Home : Info : **Add** URL, -- Choose a Channel --. ...
www.webcrawler.com/Help/GetListed/AddURLS.html - 8k - Cached - Similar pages

Magellan Info: **Add** URL
... Questions? Visit the LookSmart Submit FAQ or LookSmart Customer Service. Click here to **add** your site to the Excite Search Index only. This option is still free ...
magellan.excite.com/info/add_url - 8k - Cached - Similar pages

FindLaw: **Add** URL
... FindLaw: FindLaw Information Center: **Add** URL. **Add** to FindLaw. ... FindLaw provides a listing of law firms. To **add** a law firm, please fill in the following fields. ...
www.findlaw.com/info/write/addurl.html - 38k - Cached - Similar pages

Geocrawler.com - **Add** A List
... **Add** a list to Geocrawler. Please Provide Geocrawler With... List Name: List Email Address: List ...
www.geocrawler.com/add/ - 6k - Cached - Similar pages

AnyWho: Telephone Number, Email, Home Page URL, FAX, Toll ...
FREE,FREE,FREE!!! **Add** detailed info to your Business or Personal listing. White Pages, Yellow Pages, Toll Free, E-Mail, Web Sites. ...
www.anywho.com/add.html - 18k - Cached - Similar pages

What's in YOUR Name? demo -- **ADD** MY NAME!!!
500,000 baby names What's in Your name? demo -- **ADD** MY NAME!!! Adding Names. We **add** ...
www.kabalarians.com/html/add-name.htm - 5k - Cached - Similar pages

add xrefer it! to your browser
... If you are using a Macintosh, don't despair. We are currently working on

Kauffman Ex. 1
Page 1 of 2

ways to support Sherlock, so you won't be left out in the cold! ...
www.xrefer.com/xreferit.jsp - 10k - Cached - Similar pages

New! Get the Google Toolbar for your browser:

Gooooooooogle ▶
Result Page: 1 2 3 4 5 6 7 8 9 10 **Next**

ADD Google Search Search within results
Try your query on: AltaVista Deja Excite HotBot Infoseek Lycos Yahoo!

Google Web Directory - Cool Jobs - Advertise with Us! - Add Google to your Site - Google in your Language - **All About Google**

Kaufman Ex. 1
P. 2 of 2

Google Web Directory

Search Directory Help

Search only in ADD and ADHD Search the Web

ADD and ADHD

Health > Mental Health > Disorders > ADD and ADHD

Go to Directory Home

Categories

Alternative Treatments (24)
Articles and Research (8)
Health Professionals (21)
Personal Pages (29)
Products and Services (49)
Regional (10)
Support

Related Categories:

Home > Family > Parenting > Resources > Health And Challenges (25)
Reference > Education > Special Education > Learning Disabilities > Attention Deficit Disorder (11)

Web Pages **Viewing in Google PageRank order** **View in alphabetical order**

- National Attention Deficit Disorder Association - http://www.add.org/
  A site with everything from the ABC's of ADD to Work & Career.
- All About ADHD/ADD - http://adhd.mentalhelp.net/
  Comprehensive guide to online resources, support, treatment information, and symptoms of ADHD/ADD.
- ADD/ADHD and Optometric Eye Care - http://www.add-adhd.org
  Articles by optometrists and educators on attention deficits and vision.
- NINDS Attention Deficit-Hyperactivity Disorder Information - http://www.ninds.nih.gov/health_and_medical/disorders/adhd.htm
  Attention Deficit-Hyperactivity Disorder (ADHD) information sheet compiled by NINDS, the National Institute of Neurological Disorders and Stroke.
- Attention-Deficit Hyperactivity Disorder - http://www.mentalhealth.com/dis/p20-ch01.html
  This site includes information on diagnosis, treatment, and research, and includeds links to booklets and magazine articles.
- ADDitude: The Happy Healthy Lifestyle Magazine for People With ADD - http://www.additudemag.com/
  The online issue of a new print magazine.
- Attention Deficit (Hyperactivity) Disorder - http://www.mhsanctuary.com/add/
  Information on DSM-IV Criteria, articles, resources, chat, bulletin board, family bulletin board, clinician's forum, and more.
- ADHDNews - http://www.adhdnews.com
  Information on the research and treatment of ADD with emphasis on special education, behavior issues and advocacy. Includes free monthly newsletter and discussion groups.
- ASK - Adults Seeking Knowledge about ADD - http://www.azstarnet.com/~ask/
  A large collection of information on ADD. Information of use to the individual learning about ADD, as well as for those experienced with ADD.
- Born to Explore! The Other Side of ADD - http://borntoexplore.org/
  A noncommercial clearinghouse for positive and alternative information which explores creativity, nutrition, giftedness, allergies, temperament, and more.
- Effective Parenting - http://www.jameswindell.com/
  Professional parenting advice from James Windell on children with behavior problems and ADD/ADHD.
- ADHD Owner's Manual - http://www.edutechsbs.com/adhd/

Kaufman Ex. 7, p. 1 of 4

This site, created by a medical doctor, includes information on educational and behavioral interventions, medication, and tips for teachers.

- ADDHelpline - http://go.to/addhelpline
  Support Group and Resource Center for parents raising children with ADD/ADHD. Monthly newsletter, chat room, message board, links to other ADD sites.
- ADD on AOL - Main Menu - http://members.aol.com/jimams/index.html
  Information and support group for Attention Deficit Disorder forming on the Internet with a core of AOL users.
- Correcting dyslexia, dyspraxia, ADD, ADHD and coordination problems. - http://www.inpp.org.uk
  Factors in early development, for the majority, often underlie learning difficulties such as dyslexia, dyspraxia, ADD, ADHD and coordination problems. Find out about the primitive reflexes and how early development sets the scene for later learning.
- ADHD Assessment and Information Services - http://www.helpforadd.com
  Information and services to help parents and professionals promote the healthy development of children with ADHD or Attention Deficit Disorder.
- Attention Deficit Disorder Archive - http://www.realtime.net/~cyanosis/add/
  Attention Deficit Disorder WWW Archive
- The WWW Attention Deficit Disorder (ADD/ADHD) FAQ Site - http://www3.sympatico.ca/frankk/
  A site designed as a resource for parents, teachers and adults interested in information about ADD.
- ADD/ADHD Diagnosis and Treatment Info - http://www.addclinic.com/
  Comprehensive, detailed and current information to the medical and lay community about ADD, ADHD, OCD, and TS.
- KidAccess, Inc. - http://www.kidaccess.com
  Customizable visual materials for children who need visual cueing for organization, sequencing, staying on-task, and managing transitions.
- Resources on ADD and ADHD - http://www.focusas.com/AttentionalDisorders.html
  Resources and information on ADD and ADHD, including schools and programs and the new guidelines for the diagnosis of ADHD from the American Academy of Pediatrics.
- ADD, ADHD Community - HealthyPlace.com - http://www.healthyplace.com/Communities/Add/site/index.htm
  Comprehensive expert and peer ADD/ADHD information, ADD support groups, ADD chat, journals-diaries, and buddy lists.
- A.D.D. F.A.Q. - http://www3.sympatico.ca/frankk/contents.html
  Faqs divided into major categories, background, treatment, sources, miscellaneous, updates and news, and adult tests.
- LD OnLine: Preventing Antisocial Behavior in Disabled and At-Risk Students - http://www.ldonline.org/ld_indepth/add_adhd/ael_behavior.html
  Information on learning disabilities, learning disorders, attention deficit disorder, ADD, ADHD, dyslexia, dysgraphia, dysnomia, speech disorder, reading difficulties, special education, parenting, and teaching.
- ADD/ADHD Resources Catalog - http://www.the-add-clinic.com/title.htm
  Offers over 180 products for parents, teachers, and clinicians who must deal with the bhavior of children with ADD/ ADHD and related conditions. Books, Videos, audiotapes, games, behavior forms, and training resources are available. A new item being introduced is the Homewrok Skills Improvement Kit.
- ADD-Holistic Resource Center - http://www.holisticmed.com/add/
  Resources provided by the 19 of the world's top Holistic Medicine practitioners on treating and understanding Attention Deficit Disorder (ADD). Access to the ADD-Holistic Internet discussion group.
- AfraidToAsk.com's ADHD Online Guide - http://www.afraidtoask.com/ADHD/index.html
  Free guide to ADHD/ADD, including interactive questionnaire, signs and symptoms, treatment, and other resources.
- Brain.com - http://www.brain.com/about/content.cfm?ID=21
  Information and education for ADD.
- Adult ADD/ADHD - http://www.learnfree.com/vb/health/adult-add.html

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A brief overview of Adult Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder, including diagnosis, treatment and management options.

- ADHD On-line Community - http://www.adhd.com/
  ADHD.com offers information and support on Attention Deficit Hyperactivity Disorder. There are forums, articles of interest, editorials, links, and submission areas.
- Advice For Parents - http://www.adviceforparents.com
  Advice for raising children and a form to submit questions answered by parenting professionals.
- The Whole Child/Adolescent Center - http://wholechild.net/addadhd.htm
  Introductory description of the terms, causes, and treatment.
- Attention Deficit Hyperactivity Disorder (ADHD or ADD) on Medbroadcast.com - http://www.medbroadcast.com/health_topics/kids_teen/adhd/index.shtml
  Find out about ADHD on medbroadcast.com.
- Chat Room For Parents - http://addhelpline.homestead.com/index.html
  Chat Room for parents raising children with ADD/ADHD
- The ADD Page - http://www.adult-add.org/
  This site seeks to promote a discussion between students in college with learning disabilities and those who are about to enter college, including study tips for students with ADD and ADHD.
- About Attention Deficit Disorder - http://www.cdipage.com/adhd.htm
  Provides comprehensive information and practical solutions for kids and teens with ADHD.
- ADDHelpline - http://addhelpline2.homestead.com/newsletter.html
  Monthly interactive ezine for parents raising children with ADD/ADHD.
- ADHD - Understanding the Problem - http://telosnet.com/review/adhd_1.html
  A three-part article describing ADHD. An extensive overview is supplemented with information on effective alternative treatments.
- ADD/ADHD Information Library - http://www.newideas.net/p0000374.htm
  Information for parents on ADD/ADHD, including description of ADD/ADHD, diagnosis, treatment options, classroom interventions, etc. About 80 pages of information.
- Outside the Box - Helping Misunderstood Kids - http://adhd.kids.tripod.com/
  Provides research, original articles, personal testimonies and support in order to better help ADHD/special needs kids succeed in school and in life.
- Behavioral Treatment for ADHD: An Overview - http://www.athealth.com/Consumer/farticles/Rabiner.html
  Behavioral treatment for ADHD.
- The Parent Guide - http://www.theparentguide.com
  Help for parents wanting education/training about ADD/ADHD.
- Adult Attention Deficit Disorder: Diagnosis, Coping and Mastery - http://www.ncpamd.com/Adult_ADD.htm
  Articles on diagnosis, new medications, coping strategies, and reviewed links to selected ADHD web sites.
- Attention Deficit Disorder Resources - http://www.robinsnest.com/articles/adds.html
  Includes links to a variety of ADD Internet resources.
- Attention Deficit Information Network - http://addinfonetwork.com
  A non-profit,volunteer orgaization which offers support,diseminates information, and lists resources for parents, professionals, and adult who deals with Attention Deficit Disorder. Has conferences, one on one telephone info.
- Information Site for Deaf and Hard of Hearing Students with ADHD - http://www.golden.net/~emor/
  A site for those students with a hearing disability.
- Attention Deficit Disorder: Treatment, Prevention, Cure - http://www.healthlinkusa.com/Attention_Deficit_Disorder.htm
  A wide range of helpful Attention Deficit Disorder information concerning treatment, prevention, diagnosis, email groups, support groups, personal stories and much more. Updated regularly.
- ADD/ADHD Resources @ ParentPatch.com -

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http://www.parentpatch.com/SpecialNeeds/AddAdhd/index.htm
Links to information on ADD/ADHD, such as articles, education, advocacy, medical news and research, support groups, books,message boards, and more.

- ADD Focus - http://www.healthyplace.com/Communities/add/addfocus/index.html
  Useful ADD, ADHD information on diagnosis, treatment, medications, diet supplements and practical solutions to help students improve concentration, learning, and study habits.
- Neurological Issues with ADD/ADHD - http://www.newideas.net/p0000627.htm
  A discussion of the involvement of the reticular activating system.
- Classroom strategy for students with ADD and ADHD - http://allsands.com/Kids/addadhdclass_rei_gn.htm
  Students with ADD/ADHD require more time and attention to stay on-task and focused. A reinforcement schedule of tangible rewards often help this challenge.
- ADD and ADHD - http://athealth.com/FPN_2_36.html
  ADD and ADHD information for mental health professionals and their patients.
- About Attention Deficit Disorder and Treatment - http://www.healthfoundation.com/add.html
  Information pertaining to causes and issues of ADD/ADHD, as well as treatments.
- ADD/ADHD - http://attentiondeficit.50megs.com/
  Includes articles, news items, books, letters and FAQs.

Special Education, ADD, ADHD, OCD, ODD - http://www.channel21.com/Biz/bozak/index.html
Find help here selecting an educational program for your child at risk. Boarding schools and other program for kids who need help.

Attention Deficit Disorder - http://www.dyslexiaonline.com/info_add.html
Dr. Levinson was the first to discover that Dyslexia or LD and ADD all stem from one and the same inner-ear cerebellar-vestibular) dysfunction.

MedicineNet - http://www.medicinenet.com/art.asp?li=MNI&ArticleKey=258
Symptoms, causes, diagnosis, treatments, and links.

The Dove's Nest - http://home.talkcity.com/CarpoolLn/lilwhitedove/
Here you can learn all about Attention Deficiet Disorder, both with and without hyperactivity, and what that means to the millions who have this disorder.

Mediconsult.com : Attention Deficit, ADD Health Information - http://www.mediconsult.com/mc/mcsite.nsf/conditionnav/add~sectionintroduction
Attention Deficit, ADD health resources from Mediconsult.com for patients, professionals and parents with educational material, news, drug information, journal articles, community support.

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20TH STORY of Level 1 printed in FULL format.

Chicago Tribune

February 9, 2000 Wednesday, EVENING UPDATE EDITION

SECTION: NEWS; Pg. 7; ZONE: C; EVENING. Health.

LENGTH: 760 words

HEADLINE: GIRLS ALSO HAVE ADD

BYLINE: By Donna Gehrke White, Miami Herald.

BODY:

Teachers thought Karina Aspillaga, now 12, was lovely and sweet.

In Miami schools she was polite and vivacious, so the teachers were willing to overlook that Karina couldn't sit still, had trouble concentrating and ignored directions.

Not her mother, Irma. She was convinced Karina needed help--the help that Irma herself didn't get years ago as she struggled to get through college.

So she took Karina to a neurologist who found that Karina is highly intelligent but, like millions of other American children, is "wired" differently. She has attention-deficit disorder (ADD), a neurobiological condition that until recently was thought of mostly as a boy's malady--especially if they were hyperactive and difficult to control in the classroom.

New research is suggesting that there are a lot more Karinas out there. They just aren't getting help.

Thanks to her mom's persistence and a doctor's help, Karina is flourishing today--both in class and after school, as a cheerleader.

"She's very athletic," says her mom.

Research among adults shows an equal number of men and women have ADD. Yet six boys to every girl is clinically treated, with only one girl to every three boys being diagnosed, says Harvey Parker, a clinical psychologist in Plantation, Fla., who started the A.D.D. Warehouse and co-founded the national organization, Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD).

Technically called attention-deficit/hyperactivity disorder,it is divided into categories of inattention or hyperactivity or a combination of both.

Boys get diagnosed early in school because their fidgeting, interrupting and hyperactivity disrupts classes and home life, Parker believes.

In contrast, a girl who simply daydreams and doesn't pay attention gets overlooked.

"The girls with ADD (without hyperactivity) are especially underdiagnosed," Parker says, because "their problem doesn't cause a problem to anyone else

Kaufman Ex. 3
P. 1 of 3

than themselves."

Some doctors argue that girls actually are lucky to escape the diagnosis. They note that rambunctious boys get stuck with the label and are dosed with Ritalin and other medications.

Dr. Richard Rubin, a child psychiatrist and past president of the South Florida Psychiatric Society, agrees there is a problem with some children being given Ritalin before they have had thorough evaluations. But that doesn't mean ADD should be ignored, he says.

Alan Delamater, director of clinical psychology at the Department of Pediatrics at the University of Miami, says he has seen how girls "with a long history of struggles" turn their lives around once they are diagnosed with ADD. With drugs and behavior modification, they can focus on their studies for the first time, he says.

"Their turnaround can be remarkable," he says.

"Most women with ADD were able to seek help only as adults, after many years of feeling frustrated, inadequate and misunderstood," according to the recent book, "Understanding Girls With Attentio-Deficit/Hyperactivity Disorder" (Advantage Books).

One of the authors, Kathleen G. Nadeau, a Baltimore psychologist, understands firsthand: She has ADD.

"It runs in my family. I have a brother and uncle with it," says Nadeau, who feels so strongly about girls and women not getting ignored that she and coauthor, Patricia Quinn, also started ADDvance: A Magazine for Women with Attention-Deficit Disorder.

Nadeau says girls' symptoms may appear as problems not usually linked with attention- deficit disorder: Poor organization skills or messiness, sleep problems, shyness, poor social skills, disheveled appearance or grooming problems. They often are highly intelligent and creative, but it doesn't show in their grades. They also may work long hours at homework but aren't able to finish it. Their parents may accuse them of laziness but they really are trying, Nadeau says.

Many girls with attention problems seek to hide the fact they are "different." They avoid participation in the classroom to the point where some even develop a phobia about going to school.

Because their attention is scattered, they don't always learn to get along with others. They may cling to one special pal or have trouble making any friends.

Many adults with attention problems can find it hard to hold jobs and relationships. Most, according to CHADD, are restless, easily distracted, impatient and impulsive. They experience mood swings, short tempers and have trouble planning ahead and staying organized. Many women with ADD have messy homes that they are embarrassed to show.

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p. 2 of 3

Chicago Tribune, February 9, 2000

GRAPHIC: PHOTOPHOTO: Irma Aspillaga (left) was convinced her daughter, Karina, 12, needed help. Knight Ridder/Tribune photo by Jon Kral.

LANGUAGE: ENGLISH

LOAD-DATE: February 10, 2000

Kanthan Ex. 3
p. 3 of 3

September 26, 2000, Tuesday, Late Edition - Final

SECTION: Section F; Page 7; Column 2; Health & Fitness

LENGTH: 1130 words

HEADLINE: Some See Hope in Biofeedback for Attention Disorder

BYLINE: By JIM ROBBINS

BODY:

If a child at the Enrico Fermi School in Yonkers is found to have attention deficit disorder, parents can choose an unusual alternative to medication: neurofeedback, a computerized biofeedback system that some say strengthens the brain.

Linda Vergara, the school's principal, said she decided to try the approach when doctors diagnosed the disorder in her son in 1992. "They told me I needed to give him something to calm him down," she said.

Ms. Vergara decided not to give her son Ritalin, the drug frequently used to treat the ailment, and instead took him to see Dr. Mary Jo Sabo, a psychologist in Suffern, N.Y., to try neurofeedback.

Ms. Vergara said she saw her son become calmer, and he began doing his homework without being asked. She and Dr. Sabo brought the technique to Fermi, a public elementary school with 900 children.

Now, five years after the program began, nearly 300 children have been treated at no charge with neurofeedback at Fermi and two other public schools in Yonkers for a variety of problems, including A.D.D., learning disabilities and depression.

"There are children who see tremendous gains and some who see minimal changes," said Ms. Vergara. "Over all, the kids can focus better and have better self-esteem. There are fewer suspensions, better attendance and fewer late kids."

Generally relegated to the fringes by mainstream scientists when it was introduced in the 1970's, brain wave biofeedback -- now called neurofeedback or neuro therapy -- has returned. Its effectiveness boosted by computers, it has made its way into mainstream health care, largely as a treatment for attention deficit disorder, but also for depression, head injuries, sleep disorders and other problems.

Critics say that not enough research has been conducted on the technique to justify any claims for its effectiveness. Critics say that improvements in the patients probably stem from a placebo response and that parents should be aware that the technique is highly experimental.

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"If you give a child four extra hours a week of one-on-one attention you'll see some improvement," said Dr. Larry B. Silver, who has been treating attention deficit disorder in the Washington area since 1964. "But will it last a week or a month later? There has been no follow-up."

The disorder, Dr. Silver said, is "a neurochemical deficiency." He added: "And the only thing that will raise the levels of neurochemicals is medication. We've found no alternatives."

One of the hundreds of clinics in the United States offering the treatment is Connecticut Educational Services in Middletown, Conn., which specializes in treating A.D.D., hyperactivity and traumatic brain injury. Dr. Robert Reynolds, the psychologist who operates the clinic, said the technique brought about long-term changes in the brain's functions.

"About half the children we treat get off medication completely," Dr. Reynolds said. "The other half reduce their medication."

Brain wave training, he said, is part of a package of treatments that includes family counseling and behavioral therapy. But the brain wave training, he said, is key.

"We did all these things without the neurofeedback and they didn't work as well," Dr. Reynolds said. A testing and treatment package costs around $4,500 at the clinic.

Most neurofeedback systems use one or two dime-size sensors placed on the scalp. The sensors read the subtle electrical frequencies of the brain. The signal is amplified and displayed on a computer, and a clinician can see where the client needs to alter the range of frequencies.

The patients sit at computers playing video games, which respond to their brain waves to challenge them. Their success at the game is tied to their ability to expand the range of their brain waves. After 20 to 40 sessions the brain changes are set in place, practitioners say.

"It's brain exercise," said Dr. Alan J. Strohmeyer, chief of the Biofeedback Section of the Department of Neurology at North Shore University Hospital in Manhasset, N.Y., and an assistant professor of neuroscience and neurology at the New York University School of Medicine. "There's a direct correlation between neurofeedback and getting in shape physically at a gym. Neurofeedback helps the brain grow and develop normally."

Neurofeedback is a carry-over from the behavioral school of psychology. In the 1970's, a researcher at the Veterans Administration Hospital in Sepulveda, Calif., accidentally discovered that neurofeedback could help some people control epileptic seizures.

The researcher, Dr. M. Barry Sterman, now a professor emeritus at the University of California at Los Angeles School of Medicine, had conditioned cats' brain waves for a sleep study. Coincidentally, he used some of those cats in a study of the hazards of rocket fuel for the Defense Department. Most of the cats exposed to the rocket fuel went into seizures, except those that had received brain wave training. Dr. Sterman then tried the technique on people with epilepsy.

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Mr. Sterman concluded that those cats had increased their resistance to seizures by strengthening their brain. In several controlled, randomized studies he tested the technique on epileptic patients and reported that they had far fewer seizures. The results were published in journals and replicated in other studies.

Although it appeared effective, the technique was put aside in favor of new drugs. Later, Dr. Joel Lubar, a psychologist at the University of Tennessee, adapted the technique to treat attention deficit disorder.

But Dr. Edward Hallowell, a psychiatrist who teaches at Harvard Medical School, has criticized the costs. It is not that neurofeedback does not work, said Dr. Hallowell, who wrote "Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood Through Adulthood."

The treatment, he said, does work well for some people. He even refers some patients for the treatment. "The problem," he said, "is that it's time consuming and it's expensive. Those are real obstacles."

A full course of testing and treatment ranges from $1,500 to $5,000 or more. While some insurance companies pay for the treatment, most do not.

No one knows precisely how the brain responds to the neurofeedback training, though recent research on the brain's ability to change offers some explanation.

Dr. Henry Markram, a professor and senior scientist at the Weizmann Institute of Science in Israel and an expert in neuroplasticity, took his 9-year-old daughter to a psychologist in Toronto who treats A.D.D. with neurofeedback. "It was very effective," he said. "I'm very pleased with the effects."

"The brain is incredibly plastic and incredibly responsive," Dr. Markram said. "Neurofeedback is in keeping with that."

http://www.nytimes.com

GRAPHIC: Photos: Dr. Mary Jo Sabo, a psychologist, with Nicole Zingone, demonstrating a computerized biofeedback system. It is used at the Enrico Fermi School in Yonkers to treat children with attention deficit disorder and other conditions. (G. Paul Burnett/The New York Times)

LANGUAGE: ENGLISH

LOAD-DATE: September 26, 2000

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2ND STORY of Focus printed in FULL format.

Capital Times (Madison, WI.)

July 17, 2000, Monday, ALL EDITIONS

SECTION: Lifestyle, Pg. 1B

LENGTH: 853 words

HEADLINE: DOCS ISSUE ADHD RULES

BYLINE: By Debra Carr-Elsing The Capital Times

BODY:

Short-term memory loss isn't just a problem for the elderly. Children with attention deficit/hyperactivity disorder often appear to have similar losses. That's because they have trouble remembering what they worked on the day before in school, for example.

Other behaviors associated with ADHD include physical restlessness, distractibility and impulsiveness. Children with ADHD tend to have a difficult time standing in line and sitting still. They do things like jump up and down in class andtake jabs at their friends.

''People are much more educated about ADHD nowadays, but they still need to recognize that children can show the behaviors that look like ADHD without having the underlying neurobiological disorder,'' says Jocelyn Miller, a child psychologist with Dean Medical Center-Sun Prairie.

To help primary care doctors screen for ADHD, the American Academy of Pediatrics issued new guidelines earlier this year to help distinguish ADHD from other problems among children ages 6 to 12. The guidelines were developed by educators and a panel of medical and mental health experts with training in psychiatry, psychology, neurology, epidemiology, pediatrics and child development. They say:

Doctors should routinely pursue an evaluation of ADHD in school-age children who show signs of a short attention span, hyperactivity, impulsiveness and academic underachievement.

A diagnosis of ADHD requires the child's symptoms to occur in at least two settings, such as home and school.

Evidence needs to be established -- before diagnosing ADHD -- that the child's academic or social functioning is impaired.

About a third of children with ADHD have a coexisting condition, so an assessment also should be made for learning and language problems, aggression, disruptive behavior, depression or anxiety.

Other diagnostic tests, such as lead screening, brain imaging and thyroid hormone tests, do little to diagnose it.

''The guidelines are very straightforward and basic,'' Miller says. ''But they're not anything new for anyone who's been in this field.''

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The guidelines, however, are indicative of the trend in the medical community for more standardization and clarification.

Studies indicate that about 8 percent of school-age children have ADHD. Diagnoses among boys outnumber those among girls by a ratio of 5-1.

''ADHD is so much more in the public consciousness nowadays that people think it's being overdiagnosed,'' Miller says. ''But there were tremendous numbers of kids who simply were not diagnosed in the past and left to flounder in our schools.''

Granted, the number of kids being treated for ADHD has skyrocketed, says Dr. Hugh Johnston, director of child and adolescent psychiatry training at the University of Wisconsin Medical School.

''But we're sure the prevalence of ADHD hasn't changed much -- we're just recognizing the syndrome more accurately,'' he adds.

An increase in treatment can be viewed as a positive thing for ADHD children who are getting the help they need.

''On the other hand, it's also an indication that there's a problem out there in our schools and in our homes,'' Johnston says.

Well-meaning teachers and parents often have lives so taxed and harried, for example, that they struggle to take care of challenging kids, Johnston says, ''and one way to get around that problem is to make fewer challenging kids.''

This isn't a bad thing, he adds, ''but this huge increase in ADHD treatment can be seen as a warning sign to evaluate what we're doing as a society to meet the needs of our children.''

In recent years, the main thing that's changed about ADHD has been its names.

''The syndrome has been called 'minimal brain dysfunction,' 'minimal brain damage' and simply 'ADD,' '' Johnston says.

Since the early 1900s, however, the syndrome's hallmark has included three features: a short attention span, hyperactivity and impulsivity.

''When it comes to treatment, research has shown that stimulants, such as Ritalin or Dexadrine, are the most effective to improve the academic achievement part of ADHD,'' Miller says.

Significant side effects of these medications are uncommon, Johnston says. Besides that, the commonly held belief that children are ''slowed down'' in school and that they don't do as well academically with stimulants is not true.

''These aren't sedative drugs,'' Johnston says. ''Most people, even those without ADHD, will perform somewhat better on most academic tasks with these medications on board.''

Still, drug therapy isn't always the best option, especially if it goes against a family's value system.

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''Another approach is to modify the environment in a way that this kind of child will have less impairment and a better chance for success,'' Johnston says.

This kind of intervention is time-consuming, difficult and expensive, he adds, because children with ADHD are particularly sensitive to class size.

They do better with fewer students in the classroom, Johnston says. And the process of getting class size down to five or 10 students also goes against the grain nowadays.

GRAPHIC: HENRY A. KOSHOLLEK/THE CAPITAL TIMES

Jocelyn Miller, a child psychologist at Dean Clinic-Sun Prairie, says the newguidelines for diagnosing attention deficit/hyperactivity disorder will help primary care physicians screen more effectively for it.

LOAD-DATE: July 18, 2000

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31ST STORY of Focus printed in FULL format.

SHOW: GOOD MORNING AMERICA (7:00 AM ET)

August 31, 2000, Thursday

TYPE: Profile

LENGTH: 1537 words

HEADLINE: SCHOOLS PRESSURING PARENTS TO PUT CHILDREN WITH BEHAVIORAL PROBLEMS ON RITALIN; NYU CHILD STUDY CENTER'S DR. HAROLD KOPLEWICZ AND BEHAVIORAL PEDIATRICIAN DR. LAWRENCE DILLER DEBATE THE ISSUE

ANCHORS: ROBIN ROBERTS

BODY:
ROBIN ROBERTS, co-host:

When America's children return to the classroom, nearly four million of them will have been diagnosed with some form of attention deficit disorder, which can cause learning and behavioral problems. And some two million of those kids will be treated with the prescription drug Ritalin. But what happens when schools pressure or even force parents to put their child on Ritalin?

As children head back to school, it is a scene that will play out over and over. Kids being given drugs like Ritalin, Dexadrine, drugs that are supposed to help treat behavioral problems and make learning easier. Ten-year-old Michael Mozer was one of those kids. In the first grade, he was fidgety, distracted.

Ms. PATTY WEATHERS (Michael's Mother): I was called in the principal's office a few times. He was being disruptive, impulsive, touching things that he shouldn't have touched.

ROBERTS: Michael's mother, Patty Weathers, at first resisted medicating her son, but under what she describes as intense pressure from his school, she finally gave in.

Ms. WEATHERS: That's a nice one. Perfect.

I went about a year before I finally broke down and medicated, at the second to last week of first grade.

ROBERTS: At first, it seemed like the solution. Academically, Michael began to thrive. But over time, the once active little boy became lethargic, withdrawn, a loner.

Mr. MICHAEL MOZER: I felt like a zombie. Like a walking dead person.

ROBERTS: And by the time Michael entered the third grade, there were other problems.

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Ms. WEATHERS: He was chewing excessively. The kids--he wouldn't eat lunch. The children thought he was a freak.

ROBERTS: Patty says, on the advice of the school psychologist, she took her son to a psychiatrist who prescribed the drug Paxil. The results were devastating.

Ms. WEATHERS: He would pace, he would act frantic, he would fly off the handle. He did not know what was wrong with him. He said, 'Mom, I can't control myself. Make it stop.'

Mr. MOZER: I felt very, very mean. I would want to--I screamed at my mom a lot, and I would just scream and scream, and it was like I could do anything I want when I was on Paxil. There was nothing to stop me.

ROBERTS: So Patty took her son off drugs, and she says when she told his school of her decision, Michael was dismissed.

Ms. WEATHERS: The school principal basically told me that he had nothing left in the school to offer for Michael, that Michael lived in a world all his own.

ROBERTS: And the school took it one step further. They reported Patty to Child Protective Services for medically neglecting her child and failing to send Michael to the special education school they recommended.

Ms. WEATHERS: It's an intimidation tactic to get parents--to coerce parents to medicate and to do what the school district wants, and it's wrong. And other parents, I know it's happened to, and I know that they've got to speak up. They've got to come forward because this is the only way we're going to make school districts accountable for what they're doing in this country.

ROBERTS: Now Michael's original school declined to comment on his case. Michael now attends a charter school twice a week and receives home tutoring, and his mother is planning to file a lawsuit against the school.

But this is far from an isolated story. Joining us now to debate whether schools should have the right to insist that a child with ADD receive medication are two people on both sides of the issue. Dr. Harold Koplewicz, director of the NYU Child Study Center. He's in favor of giving schools that power. And on the other side, Dr. Lawrence Diller, a behavioral pediatrician and the author of "Running on Ritalin, a Physician Reflects on Children, Society and Performance in a Pill."

And, gentlemen, thank you both very much for joining us.

Dr. HAROLD KOPLEWICZ (New York University Child Study Center): Good being here.

ROBERTS: This is a hot issue.

Dr. LAWRENCE DILLER (Behavioral Pediatrician): Oh, it is.

ROBERTS: Especially with school starting again. Dr. Koplewicz, let me start with you first. Should schools, should states have the right to virtually

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force parents to medicate their children?

Dr. KOPLEWICZ: I think the important part to remember is that attention deficit hyperactivity disorder, ADHD, is a real disorder. Kids who have this and are left untreated drop out of school 10 times more frequently than the average child, they're more likely to get in trouble with the law, they're more likely to have trouble with illicit drugs. And so if it's a real disorder, we need real treatment. And the real treatment means that we have been spending 25 or 30 years studying what is effective treatment. And to date, unfortunately, the only treatments that have been found to be successful and effective are medication treatments. There are over 200 studies, there are follow-up studies of 25 and 30 years after children have been diagnosed and treated. And, unfortunately, even though the National Institute of Mental Health has spent literally millions of dollars looking at psychotherapy for these kids...

ROBERTS: Right.

Dr. KOPLEWICZ: ...the only time psychotherapy has been found to be helpful is when psychotherapy is used together with medicine. Now, if a child had diabetes and a parent said, 'I don't like insulin,' a school would say, 'This is neglectful or abuse' unless you give...

ROBERTS: But that's life-threatening.

Dr. KOPLEWICZ: Well, I have to tell you, if a child had asthma and was wheezing, the school would be told, 'We'd get the Bureau of Child Welfare to say you must take some medication.' Now, they're not saying take the medicine. They're saying the child has to have a better--a better school setting. If he's not going to take the medicine, then he should be in a special school setting.

ROBERTS: Dr. Diller, I know that you have written against states and schools forcing parents to--to medicate their--their children.

Dr. DILLER: Well, I don't think they can legally at this point, despite Dr. Koplewicz's notion that it's a real disorder, and I'm not saying there isn't a core group of children who are severely affected by impulsivity and hyperactivity. But the much larger group of children and the much larger experience for the families in this country is the sense of pressure that is coming from the schools to medicate. And I disagree with Dr. Koplewicz. For that small group--very small group of children...

ROBERTS: Right.

Dr. DILLER: ...the only thing that might make a difference is medication. But for the Tom Sawyers and Pippi Longstockings that I see, helping the parents parent the children differently, especially in terms of discipline and making sure there are no learning problems in these children can make an inordinate difference.

ROBERTS: What are the...

Dr. DILLER: So we're talking about apples and oranges here.

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ROBERTS: ...what are the alternatives?

Dr. DILLER: The alternatives are, basically, parenting strategies, which have been shown to be very effective, particularly in making the parents more effective in their discipline, and making sure there are no learning problems, and there are classrooms run with very hyperactive kids on a behavior mod kind of level, no one's taking medication. So I disagree with Dr. Koplewicz that there are no alternatives here, and I agree with you that this is generally not a life-threatening condition immediately, like meningitis and antibiotics, or Jehovah's Witnesses and blood products. There the courts do step in, but I can't imagine a court upholding a decision to force parents to put their children on Ritalin at this time.

ROBERTS: A question I want to ask both of you that I found very alarming. It said that 90 percent of Ritalin used in the world is used right here in the US. Do we use it too much?

Dr. KOPLEWICZ: Well, you know, I think we should go back to what Larry was saying about whether or not someone has ADHD. Being inattentive is a symptom. In fact, we know that inattention, the number one cause for inattention is boring teachers, not ADHD. So we have to make sure that we're talking about children who have a psychiatric illness or a mental disorder called ADHD.

ROBERTS: Right.

Dr. KOPLEWICZ: And the fact is that when they do have that, then medication is quite effective. There's no doubt, though, that we give more medication, and we identify kids with ADHD more than any other country in the world. In fact, in England, for many, many years, they decided it didn't exist. But if you start looking at our graduation rates for high school, and our demands for kids to graduate, and even to try to get kids into college, the United States is very different than the rest of the world.

ROBERTS: Oh, Dr. Diller, I'm sorry we're not letting you get a chance to respond.

Dr. DILLER: No--we use 80 percent of the world's Ritalin, and I think we ought to be worried about that.

ROBERTS: I agree with you.

We'll have more of GOOD MORNING AMERICA in a moment. Stay with us, everyone.

Thanks so much for joining us, doctors.

(Commercial break)

LANGUAGE: English

LOAD-DATE: August 31, 2000

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- Javascript: Simple Little Things To **Add** To Your Pages

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- Internet Mental Health: Attention Deficit Hyperactivity Disorder
- NIH Consensus Statement 110. Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder

Attention deficit disorder (ADD)

Print this article

Overview | Treatment

Definition

A condition characterized by an attention span that is less than expected for the age of the person; there is often also age-inappropriate hyperactivity and impulsive behavior.

Alternative names

A.D.D.; ADHD; attention deficit hyperactive disorder; childhood hyperkinesis; hyperactive

Causes, incidence, and risk factors

People with attention deficit disorder (A.D.D.) are easily distracted, have difficulty paying attention, and may be unable to focus more than a few moments on mental tasks. They may be physically active and behave impulsively.

There are three sub-categories of attention deficit disorder:

- attention deficit/hyperactivity disorder: combined type
- attention deficit/hyperactivity disorder: predominantly inattentive
- attention deficit/hyperactivity disorder: predominantly hyperactive or impulsive

The cause of attention deficit disorder is unknown. Some contributing factors include prenatal toxic exposure and prematurity. There frequently is a family history of school problems, behavioral disorders, or other psychosocial problems. There is sometimes a history of injuries to the central nervous system. However, there is no scientific evidence that shows conclusively that ANY of these factors directly cause attention deficit disorder. There may be a familial component involved (genetic) in some but not all cases. This may be seen with an increased incidence of

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- National Attention Deficit Disorder Association

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ADHA in children with a first degree relative with ADHD, conduct disorders, antisocial personality, substance abuse and others.
The apparent incidence of A.D.D. has been increasing over the last 15 years, possibly related to better diagnosis, changing expectations, or problems with supportive social structures. There is a wide ranging estimate of the prevalence from 1.5 percent to 10 percent of children. The disorder is 3 to 10 times more common in males than females.

Typically affected children, whether intellectually handicapped or not, perform poorly in school because of the inability to attend to tasks at hand or to sit still during the school day. The diagnosis is generally not considered until school age, although there may be earlier indicators of pending problems.

Prevention

Attention deficit disorder is a complex issue, and many preventive measures have been proposed. None have been proven at this time.

Symptoms

The symptoms typically begin by 3 years of age.

Attention deficit:

- does not pay close attention to details; may make careless mistakes at work, school, or other activities
- failure to complete tasks
- has difficulty maintaining attention in tasks or play activities
- does not listen when spoken to directly
- has difficulty organizing tasks
- is easily distracted
- unable to follow more than one instruction at a time

Hyperactivity:

- fidgeting, squirming in seat, or moving constantly
- wandering, may leave the seat in the classroom when expected to stay
- has trouble participating in "quiet" activities such as reading
- runs and climbs in inappropriate situations
- talks excessively

Impulsivity:

- may blurt out answers before questions have been completed
- has difficulty awaiting turn
- interrupts others

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- disruptive behavior

Other:

- sleep problems
- inability to delay gratification
- social outcasts or loners (possibly inability to play in groups but may perform in one-on-one situation)
- apparent disregard for own safety
- behavior not usually modified by reward or punishment
- may have other specific learning disabilities
- failure to meet normal intellectual developmental milestones

Signs and tests

Clinical evaluation is indicated if A.D.D. is suspected.

Evaluation may include:

- parent and teacher questionnaires (Connors, Burks)
- psychological evaluation of the child AND family including IQ testing and psychological testing
- complete developmental, mental, nutritional, physical, and psychosocial examination

Overview | Treatment

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Most Popular Sites

- Internet Mental Health: Attention Deficit Hyperactivity Disorder - diagnosis, treatment, and research. Includes booklets and magazine articles.
- Born to Explore! The Evolution of ADD and Creativity - ADD genes may exist because they increase creativity, thereby making a population more fit.
- Attention Deficit Disorders, Hyperactivity & Associated Disorders - provides parents, educators and health professionals with knowledge to enable them to help children with ADD and related disorders.
- Attention Deficit Hyperactivity Disorder - National Institute of Mental Health publication which describes symptoms, co-existing conditions, and possible causes, as well as treatment and education options.
- Scientific American: Attention-Deficit Hyperactivity Disorder - a new theory suggests the disorder results from a failure in self-control. ADHD may arise when key brain circuits do not develop properly, perhaps because of an altered gene or genes.
- ADHD News

- ADD in School - features classroom interventions for educators. Also includes resources for parents.
- ADD/ADHD Europe - links to ADD/ADHD sites and information on Attention Deficit Disorder throughout Europe.
- ADDitude - healthy lifestyle magazine for people with ADD.

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- ADDNet UK
- ADHD News
- ADHD Owner's Manual - diagnosis, treatment, intervention strategies and information on medication.
- ADHD Parents Support Group - support for parents of children with ADHD and other learning disorders.
- Attention Deficit Disorder - all about one of the most misunderstood afflictions facing the family unit today.
- Attention Deficit Disorder [Bev Price] - information from an educators perspective.
- Attention Deficit Disorder and Hyperactivity [Charles Robitaille, Ph.D] - Un recueil de textes et de références portant sur le déficit de l'attention et l'hyperactivité. Une information scientifique, à jour et accessible.
- Attention Deficit Disorder and ODD - explains the differences between two commonly regarded disorders.
- Attention Deficit Disorder Resources - writings and links for children and adults.
- Attention Deficit Disorders, Hyperactivity & Associated Disorders - provides parents, educators and health professionals with knowledge to enable them to help children with ADD and related disorders.
- Attention Deficit Hyperactivity Disorder - National Institute of Mental Health publication which describes symptoms, co-existing conditions, and possible causes, as well as treatment and education options.
- Bob's Little Corner of the Web - about ADD from the perspective of one who has it. Information, tips on management, creative writing and links to other resources.
- Born to Explore! The Evolution of ADD and Creativity - ADD genes may exist because they increase creativity, thereby making a population more fit.
- Children Who Can't Pay Attention - ADHD fact sheet from the American Academy of Child and Adolescent Psychiatry.
- Christian ADHD Alternative Treatment List - online support group for the adult or parent of ADHD child who has chosen not to use pharmaceuticals in their treatment of ADD/ADHD.
- Essays on ADHD - personal experiences with ADD and ADHD.
- Fraud of Attention Deficit Hyperactivity Disorder - contains essays and articles relating to the fraud of ADHD and the over prescription of drugs for treatment.
- Fraud of Child Psychiatry, ADD/ADHD, and Ritalin - contains articles and summaries of books that discuss the fraud and myth of Attention Deficit Hyperactivity Disorder and psychiatric treatment.
- gayADD - forum to support members of the gay community affected by Attention Deficit Disorder.
- Internet Mental Health: Attention Deficit Hyperactivity Disorder - diagnosis, treatment, and research. Includes booklets and magazine articles.
- Living with ADD - contains book recommendations, tips, stories, and links.
- NIH Consensus Statement 110. Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder - informs the biomedical research and clinical practice communities of the results of the NIH Consensus Development Conference on Diagnosis and Treatment of ADHD.
- Scientific American: Attention-Deficit Hyperactivity Disorder - a new theory suggests the disorder results from a failure in self-control. ADHD may arise when key brain circuits do not develop properly, perhaps because of an altered gene or genes.
- FAQ - Attention Deficit Disorder (ADD/ADHD)
- Usenet - alt.support.attn-deficit

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- A.D.D World of Gorf - line of A.D.D./A.D.H.D. products for families and schools.
- A.D.D. & A.D.H.D. Info Line - benefit from our personal experience; learn the facts; know the symptoms; where to turn for help.
- A.D.D. Center - comprehensive approach to the treatment of ADD and behavior disorders.
- A.D.D. Coach - Providing systems solutions and support to those with A.D.D. and their partners by telephone anywhere in North America.
- A.D.D. From A To Z - Diagnosis and treatment of Attention Deficit Disorder - with Edward Hallowell, M.D., a leading authority on A.D.D. and author of "Driven to Distraction" and "Answers to Distraction."
- A.D.D. Treatment and Research Center - Provides psychological and psychoeducational assessment and/or therapy and educational treatment of AD/HD and other disorders in children and adults.
- ADD Clinic - assesses and treats ADD behaviors in children and adults. Also offers a summer program, camp, and workshops.
- ADD Medical Treatment Center of Santa Clara Valley - dedicated exclusively to diagnosing and medically treating adults, teenagers and children with ADD/ADHD.
- ADD News for Christian Families - devoted entirely to Attention Deficit Disorder and related topics.
- ADD Warehouse - online catalog of books, videos, training tools, games, and assessment products on Attention Deficit Disorder (ADD, ADHD) and related problems for parents, educators, health professionals, children and adults.
- ADDMed - online information resource for children and adults with attention deficit disorder.
- ADELI Venture Company - investigating a product for rehabilitative treatment of patients suffering from motor, speech and mental disorders of cerebral origin. Asking for financial support to continue the project.
- ADHD Audio Simulation - features an audio simulation product.

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- ADHD: A Path to Success - book offers drug and diet free treatment for ADHD and learning/behavior disabilities.
- Amen Clinic for Behavioral Medicine - Attention Deficit Disorder (ADD) specialists. Offers interactive ADD tests, resources, and more.
- Attention Deficit Disorder - - A New Relief Approach
- Attention Deficit Disorder Diagnostic Kit
- Better Way, Inc. - offers natural products for the treatment of ADHD.
- Checkmate Plus - publishes assessment instruments designed to screen for DSM-IV emotional and behavioral disorders including AD/HD.
- DayBreak Dynamics, Inc. - intensive outpatient programs for children and adolescents with emotional, behavioral and chemical abuse problems. Also offering treatment for Attention Deficit Disorder.
- EduAdvice - provides tutoring services, academic and psychological testing, advocacy, and parent support.
- FACT'R - books, audio and video tapes, and workshop info for parents and teachers of ADD/ADHD children (and adults). Formerly ADD Plus.
- Giler, Janet PhD - therapist specializing in Learning Disorders.
- Goldstein, Sam PhD - speaker and authority on child development provides books and videos online.
- Gordon Systems, Inc. - offers products for Attention Deficit Hyperactivity Disorder (ADD/ADHD).
- Grandma's Pet Wildebeest Ate My Homework - practical guide for parenting and teaching Attention Deficit Hyperactivity Disorder (ADHD) kids by Tom Quinn.
- Innate Knowledge
- Jerry Mills - Programs on Attention Deficit Disorder - An outstanding program/event offering a practical and inspirational first hand look at Attention Deficit Disorders.
- Mary-Julia Stephens - offers workshops on Attention Deficit Disorder. Find schedules and other resources on this site.
- Miller Associates - offers books, workshops, and presentations for treating addictions, attention deficit disorder (ADD), and other compulsive/impulsive disorders.
- Natural Therapies for Attention Deficit Disorder - a workshop in audiotape format on natural and alternative therapies for attention deficit disorder.
- Oaklands Clinic Toronto - specializing in ADD/ADHD including psychological assessment, epilepsy, and sleep disorders including sleep apnea.
- Peter W. Choate, MSW, RSW - ADD counselling; ADD issues along with many related links.
- Play Attention - biofeeback enabled, educational video games to help children increase attention.
- Professional Development Resources, Inc. - private not-for-profit corporation established to provide quality continuing education programs to health professionals on a national level.
- Pycnogenol for Attention Deficit Disorder (ADD)
- Retrain the Brain - handwriting training program as an alternative to Ritalin for treating children with learning disabilities.
- Running on Ritalin - advice, schedule of apprearances, and book exerpts from Lawrence H. Diller, M.D., on medication and ADD/ADHD.
- Spectrum Center - Tomatis auditory training as a sensory stimulation therapy service for children, adolescents, and adults.
- Success Oriented Achievement Realized - adventure programs for LD and ADD preteens, teens and adults.
- Tomatis Centers - help people with learning disabilities, dyslexia, ADD, autism, speech and behavior problems; develop language and musical skills; stimulate creativity, personal growth. Over 200 centers worldwide.

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- Tubman Indicator for Parental Screening - an early indicator for learning disabilites.
- Zan-Pro.com - natural herbal psychostimulant and therapeutic for the symptoms associated with ADD/ADHD.

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CERTIFICATE OF SERVICE

This certifies that a copy of Complaint Counsel's Motion for Partial Summary Decision was served by Federal Express on January 2, 2001, on the following:

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