Consistency and the Will to Act: Children with ADHD

Observations from 103 clinical cases • Sylvia Langford • Chile, 2008-2009

Eighty-five percent of them were aggressive.

Between 2008 and 2009, Sylvia Langford reviewed her clinical experience with 103 patients, aged 2 to 25, who had been diagnosed with ADHD by a neurologist or psychiatrist and referred to her for psychological intervention. Most were between 4 and 13. And roughly 85% of them showed aggressive behaviours - even though aggression isn't a diagnostic criterion for ADHD.

That number caught her attention. If so many of these children were showing behaviours that fell outside their diagnosis, were all their difficulties necessarily linked to ADHD? Or were there other factors at play - factors that could be addressed through psychological work with the families?

What she noticed about consistency

Sylvia had observed that children sometimes responded differently to expectations depending on the situation. Clear, predictable rules - the kind that apply on an aircraft or when obtaining a driving licence - tended to produce different behaviour than the shifting expectations many children encountered at home and school.

She wasn't arguing that structured environments could override ADHD. She was interested in something more specific: what happened when adults followed through on what they said.

At home, she often saw a pattern. Adults responded to difficulties with negotiation, rewards, threats, shouting, or punishment. Expectations changed. Follow-through was inconsistent. She began exploring whether greater adult consistency could help children follow instructions and take more responsibility for their own behaviour.

For her, consistency had a simple definition: adults did what they said they would do.

The clinical work

Detail	Information
Period	2008-2009
Location	Santiago, Chile
Patients	103
Age range	2-25 years (88% aged 4-13)
Aggressive behaviours observed	Approximately 85%
Outcome	102 discharged; 1 referred to another specialist

Sylvia worked primarily with the parents of younger children. During preliminary consultations, she examined how expectations and responsibilities were established and maintained within the family.

Her guidance centred on four things: setting clear household rules and age-appropriate responsibilities (including regular bedtimes and chores); deciding in advance how adults would respond when rules were broken; applying expectations consistently without falling back on

negotiation, rewards, shouting, or threats; and addressing inappropriate behaviours like physical or verbal aggression, self-harm, and dishonesty.

For adolescents aged 13 and older, the work focused more directly on the young people themselves and usually took more sessions.

What happened

Of the 103 patients, 102 were discharged from Sylvia's psychological care. One was referred to another specialist. About 80% completed their intervention within two to five sessions.

According to Sylvia's clinical observations, many patients showed improvements in the behaviours that had originally concerned their families. She also observed greater willingness to follow instructions, take on responsibilities, concentrate on activities, and regulate emotional responses.

These experiences shaped what she came to describe as the Will to Act - the willingness to undertake an expected action and follow it through. For Sylvia, this went beyond compliance on a single occasion. It was about children gradually becoming capable of assuming responsibility with less dependence on repeated adult intervention.

An important distinction about discharge

The children had been diagnosed with ADHD by neurologists or psychiatrists before being referred to Sylvia. After her psychological intervention, they returned to those same specialists.

Discharge from Sylvia's care didn't mean the ADHD diagnosis had been removed or that medical follow-up was unnecessary. Her intervention addressed particular behavioural difficulties, expectations, and responsibilities within the wider context of each patient's clinical care.

Limits of this work

This is a retrospective account of clinical practice. The patients weren't randomly selected, there was no comparison group, and there were no standardised behavioural measures or independent assessments. The observations can't demonstrate that parental inconsistency caused the behavioural difficulties or that the intervention treated ADHD itself. ADHD is a neurodevelopmental condition, and individual patients may continue to require specialist assessment, treatment, and support.

What the experience did produce was a set of questions worth taking seriously. In the cases Sylvia reviewed, changes in the expectations and responses of adults were accompanied by reported improvements in children's behaviour. Some of the difficulties families experienced appeared to be influenced by modifiable aspects of their daily interactions and routines.

The purpose of this work was never about getting immediate compliance. It was about helping children progressively develop the capacity to handle their responsibilities themselves.

Source: Sylvia Langford's retrospective clinical observations from 2008-2009. These findings describe her psychological practice and should not be interpreted as evidence of a treatment for ADHD.