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Prevalence, Diagnosis and Treatment of ADHD in Children

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Abstract:

This article strives to emphasize the need for detailed examination and strict criteria when diagnosing children with attention deficit and hyperactivity disorder. ADHD (short for attention deficit and hyperactivity disorder), is one of the most widely spread mental development disorders. It affects individuals since childhood and may continue to be present even during adulthood depending on the patient's disorder gravity. This disorder consists of a short attention span, being loud and excessive in motion. ADHD would be diagnosed as such only if some other disorder influencing the patient would not be a better explanation for his/her behavior. What is crucial for the identification of a pattern of behavior as a disorder is that all of the above manifestations can be evidently acknowledged as disrupting the person's life and being conflictual to his/her well-being. Different spheres of life are affected when suffering with ADHD. ADHD has a lot of impact on schoolwork. Children with ADHD seem to have more complications in school as they are unable to focus.

Key words: Symptoms, Oppositional Defiant Disorder, Conduct Disorder, Treatment

WHAT IS KNOWN ABOUT THE CONDITION

ADHD is a mental disorder resulting of consistent inattention and hyperactivity that interferes with the individual's normal functioning. For a person to be classified as having ADHD a

mental health professional has to examine several symptoms. These symptoms must've been present before the age of 12 and persist in various settings, not just one. The endurance of the ADHD characteristic manifestation has to be over six months for the condition to be labeled as a disorder. 6 is the minimum number of symptoms for the identification of ADHD in people of 16 years or younger while it is 5 for 17 year olds and adults. This disorder has different forms of presentation. Combined ADHD presentation is where the patient demonstrates symptoms of both attention deficit and hyperactivity. Predominantly inattentive presentation and predominantly hyperactive-impulsive presentation are kinds where the symptoms of one part or another do not manifest themselves. However inattentive presentation and hyperactive-impulsive presentation are considered kinds of the same disorder as the manifestation of symptoms during ADHD is very likely to change and become mixed. Both parts of the disorder (attention deficit and hyperactivity consist in a variety of expressions. The inattention can be displayed in different ways, for example, being indifferent to details in a task or having trouble holding attention to a chore. People with ADHD often seem to be unaware and not listening to a direct speaker. They will often not listen to questions they have been asked and tend to be distracted quite easily. Another essential indicator is being absent minded and sloppy; also repeatedly losing things. Attention deficit can be demonstrated in situations where the person is required to put effort on things he/she does not enjoy doing as a person with ADHD would be unwilling to do so. It is often for this reason that they are unable to finish a job, they lack concentration. The deficiency of attention causes a shortage of organizing skills. Hyperactivity or impulsivity has its own symptoms, e.g., moving around restlessly such as tapping feet. Individuals cannot remain rested therefore they abandon situations that require a certain calm and persistent attitude. They run at improper times as if they are constantly

"on the go". Hyperactivity interferes with the person's communication skills. These people exaggerate it when talking, their speech is excessive, and especially cannot remain silent in activities enjoyable to them. They can be unfit for conversing as they are impatient to wait for their turn. Bothering other people by engaging on activities/discussions that go beyond their social circle or competence is another feature of hyperactivity. It can appear as sudden impatient exclamations, for example, answering before the question has been asked. ADHD would be diagnosed as such only if some other disorder influencing the patient would not be a better explanation for his/her behavior. ADHD symptoms are sometimes the consequences of other disorders, however it happens vice versa too, ADHD can be their cause. ¼ of children experiencing ADHD develop behavior disorders, such as, Oppositional Defiant Disorder or Conduct Disorder. Oppositional Defiant Disorder mostly affects ages 8 to 18. Children and adolescents with ODD would have various losses of temper and would be more rebelling to rules compared to another peer of theirs. They develop anger and hurting people as means of coping. Symptoms include refusal, arguing and putting the burden of fault onto other people. Conduct Disorder is similar to ODD as it is about being aggressively defensive but in more extreme ways. Adolescents with CD demonstrate behavior concerning themselves and the people around them, for example, running away from home, bullying, theft, animal cruelty, etc. These children/adolescents can become outlaws and end up in jail risking their lives and futures. It is harder than usual to control ADHD in children when it is combined with disorders. Apart from the ones mentioned above, 1 in 5 children develop anxiety while 1 in 7 develop depression in addition. Anxiety would cause these children to be afraid of certain situations, such as, separation from family or familiar places or avoiding meeting new people. It could also generally make them distressed about the future, stopping them from achieving their true potential or

even from going through the routine of daily life. Children should be treated by such disorders as they may develop suicidal thoughts during depression because of feelings of uselessness or sadness. It has been proven that suicide is the number one cause of death for the age group 10-24. However, diagnosing depression is a delicate process because sometimes fake symptoms come from the use of medications during ADHD treatment.

STATISTICS IN CHILDREN

Figures of ADHD diagnosis are particularly interesting. From 1997 to 2006 they have been increasing on average 3% per year, while from 2003 to 2011 this average percent increase per year has escalated to 5%. In 2003, 7.8% of the overall population of children aged 4 to 17 was diagnosed with ADHD and in 2011 it became 11%. These percentages are immense numbers when calculated on a general scale of the whole world population. It results in 6.4 million people. Even though according to the APA Guideline the first line treatment is behavior therapy, the number of children receiving behavior therapy is substantially low. Only half of 4-5 year olds diagnosed do receive it. The numbers decrease for children ages 6 and up where only 1 in 3 individuals gets the first line treatment. What is concerning is that significant proportions not only do receive behavior treatment but are directly put on medication. 3/4 of the group age from 2 to 5 are given drug prescriptions by health clinicians although not receiving talking sessions of therapy. There has been an overall increase of medication take in for a period of 4 years only (2007-2011) of 1.3%. However, the disagreeable fact is that this impressive use of medication has occurred in ages that are not recommended drugs at all. Side effects and medication consequences are enhanced in juvenile individuals and what's more is that their long term effects are yet unknown.

CRUCIAL IDENTIFIERS OF ADHD

What is crucial for the identification of a pattern of behavior as a disorder is that all of the above manifestations can be evidently acknowledged as disrupting the person's life and being conflictual to his/her well-being. Different spheres of life are affected when suffering with ADHD. Social relationships get more difficult. As children with ADHD have difficulty in communicating properly by respecting social norms, they might be problematic and cause conflicts with other children. Behaving properly in circumstances involving simple acquaintances or peers is three times more challenging to ADHD children compared to another child of their age. The more intimate the relationship is, the tougher it gets for them to behave suitably. Maintaining friendships make these children go through 10 times the difficulty, something that a non-ADHD child would find perfectly natural as they get along more smoothly to peers. Health is another issue tackled by ADHD. These children demonstrate careless behavior that can, in many cases, cause them their physical injuries. Young cases end up in a hospitalization state because of taking random drugs when experimenting and trying things around the house. Impulsivity and the excessive motion are factors that influence the creation of injuries that lead to disabilities. In older cases, such as, adolescents an example of an ADHD injury is accidents caused by negligence during driving (drinking and driving, forgetting to put the seatbelt on, etc.). People struggling with ADHD are four times more prone to severe accidents than other individuals. ADHD has a lot of impact on schoolwork too. Children with ADHD seem to have more complications in school as they are unable to focus. They face dilemmas with assignments and teachers, especially regular schools do not provide special attention to ADHD. To overcome this everyone should be included in a process of observing and looking after these children (teachers, school counselors, etc.) as they help

keep an updated report of the child's condition to better understand and control it.

DIAGNOSIS

ADHD is often misdiagnosed due several misinterpretations. One of them is taking school setting into consideration a lot. It has to be said that not only ADHD can be the consequence of anxiety, depression or another mental disorder but also the child might be facing dyslexia, dyscalculia or dysgraphia that are interfering with his or her school progress. Further on, statistics show that healthcare providers tend to diagnose with ADHD children that are at a younger age compared to their older classmates. This is a vast indicator of a misconception of immaturity as ADHD. One-year difference is huge when taking into account ages 5 and 6. The responsibility level increases gradually and of course a 5-year-old wouldn't bear the same amount of obligation put on a 6 year olds in an equivalent way. They would slightly disobey. School systems are made up of a diversity of teachers, some of which are rigid and more conservative in their method. They would be prone to classifying these children as problems to their classrooms as they have no experience with atypical behavior.

Therefore, children should be put side by side to another peer of theirs, not just one of their classmates. A single setting would not be enough, the Guideline itself requires for the ADHD behavior to happen in 2 or more places. However, a difficult child at home, a nuisance to parents does not necessarily mean abnormal behavior. Sometimes, it is natural for children to not follow every instruction and not behave as responsible adults by doing what has been told to do. Hence, setting is not the only important feature of diagnosis, but frequency too. Does the behavior have a pattern? Are these actions done again and again? Has the child been spoken to and in spite of the parents' efforts he has failed to understand the

basics? These are all questions that should be asked when dealing with a potential child with ADHD.

A clear ADHD case would be one in which the child's impulsivity is evidently causing him/her a threat to his health by making the child be a physical danger to himself/herself. Other diagnoses where the child's behavior is unclear or suspicious should have a wait and see approach. Wanting to play outside is not enough evidence for the child to be found as with attention deficit hyperactivity disorder. Before 1992, ages 8-18, children used to spend double the amount of time in external environments. The causes of this disorder are probably genetic but modern day strictness has made normal behavior seem as ADHD symptoms. It is hard for a typical child to adapt sitting still for long hours. Consequent actions could result in behavior that mimics ADHD but is not a disorder. This misunderstanding is partially why it is the most commonly over diagnosed disorder. Psychologist Laura Batstra of the University of Groningen in the Netherlands and psychiatrist Allen Frances of Duke University in a commentary in 2012 articulated apprehensions that these modifications will result in erroneous increases in ADHD diagnoses. Whether or not their forecast is correct, this next chapter of ADHD diagnosis will almost surely guide in a new wind of controversy regarding the classification and treatment of the disorder.

TREATMENT OF ADHD

There are many ways in which ADHD can be managed. Attention should be paid to the children by overlooking their behavior step by step. Behavior therapy is half of the work when dealing with such a disorder. In young ages especially it is as effective as medication. Behavior therapy also known as psychosocial non-medical behavioral treatment consists of turning negative thoughts into positive ones to influence the patient's performance. It is critical for the therapy to begin the

earliest possible before the lack of success has effect on the individual's self-esteem. For young children, parenting is crucial. Family behavior therapy is the most effective as young ages are remarkably influenced by their parents. Thus they must learn and actualize theoretical strategies into their child's daily life. The same goes for teachers if they want to increase their success in academic results and peer interrelations.

Peer program has shown to be more efficacious compared to one-person therapy. People of the same age group practice together to improve their interaction skills and self-restraint. What has proven to be non-effective are: one to one therapy, cognitive therapy, treatment for balance problems and office-based "play therapy". Usually, for children older than 6 years old, a combination of both behavior therapy and modification stimulant medication is the optimal choice. However, medication does not alter the parts of the brain that increase concentration, only temporarily put them in a state of focus. Its effects are short-term only. Behavior therapy, on the other hand aims to find ways to improve the current situation by gradual but consistent, permanent change. Its goal is not to eliminate ADHD symptoms (like medication's goal is) but control the response. Medication has to be implemented gradually in the child's life so that the lowest dose that operates can be found. "When I first diagnose a child with ADHD, I tell the parents they need to learn behaviour techniques, whether I'm prescribing medication or not," says doctor Patricia Quinn. Furthermore, The Agency for Health Care Research and Quality has found enough evidence to support that for younger than 6, behavior treatment is enough to help the children recover therefore medicine is not needed. ADHD is a chronic issue therefore a plan must be devised for the treatment of a child. Impairment is the problem that must be interfered with so that there can be lasting results and for consequences to be enduring to the distant future. Dealing with impairment is what the therapy aims. The initial step for designing a

treatment for the child is assessing his or her everyday symptoms. There should also be an evaluation of how well the child can adjust to circumstances. The central idea of analyzing the condition is that out of an assessment it is easier to conclude on the best fit objectives that will be followed during the treatment. Also a diagnostic baseline that will be acted upon has to be decided. To be prepared at all times and manage ADHD in their children, parents can train skills in programs that offer the basics on daily therapy. Shaping behavior has to be made an ongoing process that does not end when the child gets out of the therapist's office, but rather persists in other environments, such as, home and school too. The main three letters of the Behavior Therapy that need to be remembered are A, B and C. A is for antecedents. Things that happen prior to the behavior should be modified (requests for example). B is for behavior. The child's response to something can be adjusted through shaping. C is for Consequences. Parents have to adapt the feedback they give to their child varying on how they find their behavior. For example, for a disobedient response they want to change they must react negatively. Alternatively, when their child responds properly, they have to acknowledge it by giving positive feedback such as a reward. A reward system has to be used to shape the child's behavior in order to get actions they want more of. Reinforcing behavior is the most important thing to modifying it. To minimize their work, parents can clear away anything that provokes detrimental behavior.

POSITIVE WAYS TO DEAL WITH ADHD

Demanding children can be just as efficient as typical ones. They can be managed socially through extra care. Not only children with ADHD, but children in general require a level of flexibility from parents and teachers. For example, children with ADHD, or showing ADHD-like behavior are prone to making trouble and noise in classrooms however, they can do

very good outdoors. It can be a push for teachers to lead activity outdoors or prepare breaks for physical activity and exercise.

The school's role concerning children with ADHD used to be almost irrelevant but through training programs for the staff, teachers can be brought in touch with skills requested to help these children grow in a positive environment. Tips for teachers would be to minimize the distractions in class (any background music, television, etc.). This is an angle efficient for parents too, as television is a way of drawing the child's attention away from the task and makes him/her lose focus. Assignments have to be made clear and children be reminded of them as young ages are often forgetful and can't be held accountable of finishing tasks. They should be sensitive to their issues and engage the school psychologist as a third party to mediate in delicate situations. Exchanging information with parents and reporting the child's behavior is necessary so both groups can have a full evaluation of the child and see what he or she is missing in order to later provide for that. Parents are the initial key to the child's mental health. It is important for them to be gentle and not yell when their child does not act reasonably as that can cause trauma, and the rise of manipulative behavior. Instead, they can talk quietly to the child and use removal of privilege as means of discipline. Routine and a healthy lifestyle are helpful to children, not just because they aid their parents keep track of them, but because repetition helps the child lay a foundation for independence. What can also be helpful to avoid children getting overly enthusiastic is confine the number of choices so that the child won't get overwhelmed. A high priority should be put to positive reinforcement. Parents can set goals for the child and reward them for their performance. This kind of reinforcement makes it more likely for the child to improve his/her behavior in the course of time.

CONCLUSION

The early identification of ADHD and potential classification of children in the spectrum should be a primary concern within the educational and public health environment. There are consistent implications of a finding of ADHD for the early educational and school community experience of these children. These children tend not to adapt positively to their school environment which has implications for their academic, social, confidence-building or future satisfaction and integration into societal roles. There is a reasonable amount of controversy about the definition of the concept which has implications about the diagnosis, methods of treatment or management or diagnosis of the disorder. An individual diagnose will determine the type of therapy (both medical and behavioral) that will best benefit a particular child. An undetailed diagnosis based on cursory observation is imprecise and unfit to establish the proper therapy suitable for the fragile physical and mental state of children. Thus the first step when in doubt of identifying a child with ADHD is to have a pause of several months to a year to observe and examine the child more closely in their natural settings to permit a valid diagnosis. Lastly, any successful therapy or treatment must address the notion that ADHD is predominantly an expression of a child's biology in interaction with his social environment. The collective expression of behaviors observed in a child with ADHD is generally the result of his/her relationship within his family and social environment developed over time. The impact of this interaction on the lives of children, parents, and educators would benefit from future research in this area.

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