

Attention-deficit hyperactive disorder



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Attention-deficit hyperactive disorder, otherwise known as ADHD is a common and often relentless disorder in children. Nearly 3%-5% of elementary aged children are diagnosed with this disorder. Children with ADHD have behavioral problems including being hyperactive, easily distracted and impulsive, causing problems emotionally, academically, and socially. Being one of the most common disorders in childhood, ADHD has more studies published on it and its variations than any other childhood disorder. Much is still unknown about ADHD.

The proper classification of ADHD is still undecided, however, over the past 60 years there have been any different terms used to describe the disorder. A few include: minimal brain dysfunction, Attention deficit Disorder and Hyperkinetic Impulse Disorder. ADHD's classification can become complicated when scientific research suggests that different behaviors are directly connected to ADHD, yet different research suggests that these behaviors need to be classified independently as ADHD. The defining characteristics of ADHD are inattention, hyperactivity and impulsivity.

Inattention means lacking attention. A child with symptoms of inattention may have trouble listening and following directions or staying organized. Hyperactivity describes when a child is unusually and effortlessly excited. Short attention span and strong emotions describe a person who is hyperactive. And finally, impulsivity is when a person carries out a behavior without prior thought of the consequences. Impulsivity can be behavior, as in the things a person does, or cognitive, as in the way a person thinks and makes choices.

A child with ADHD may experience difficulties at home, school, and with friends. At home a child may have trouble following the rules or completing homework. Conflict may occur at bedtime or mealtime. At school the child may be disruptive, and may have trouble concentrating and following class routines. “ Children with ADHD perform like younger children in tests of executive functions” (Gustafsson et al, 233).

Also, children with ADHD are often avoided by others, this could be because the child provokes fights, or draws disregard from other children. Low ‘ social preference — defined as the difference between the degree of acceptance of the child by the peer group and the degree of rejection—can be considered both as an outcome of maladaptive adjustment and as a predictor of future difficulties, including psychiatric risk and antisocial behavior (Bacchini, Dario, Gaetana Affuso, and Teresa Trotta, 447). There is a psycho-social risk with the amount of rejection or approval a child receives. Based on the Diagnostic and Statistical Manual (DSM), ADHD is classified with having 3 symptoms of impulsivity, 6 symptoms of hyperactivity, and 9 symptoms of inattention.

The DSM divides ADHD into 3 groups: Predominantly independent type, Predominantly Hyperactive-Impulse type, and combined type. For a child to be classified as predominantly independent, he or she must show at least 6 symptoms of inattention. For predominantly hyperactive-impulsive type the child must show 6 symptoms of hyperactivity and impulsivity. And for a child to be classified as combined type the child has to meet both sets of criteria. A child’s symptoms must be present before the age of 7, and present in two different settings.

Symptoms seen are usually inappropriate for the child's developmental level. These specific diagnosis criteria's are put in place so assure the child is not being misdiagnosed due to any other possible reasons the child is having a behavioral issue. Also, learning disorders have similar symptoms to ADHD, so the specific diagnosis requirements prevent the child from being diagnosed with a learning disorder instead of ADHD. The use of these diagnosis requirements by the DSM instead of previous methods has had an effect on the occurrence of ADHD.

Nearly 3%-5% of elementary aged children are diagnosed with this disorder. The diagnosis of ADHD is usually determined necessary by teachers or parents. Co morbidity is often present in children with ADHD, commonly experiencing one or more other behavioral disorders that can affect the capability to function normally. " The co morbidity of ADHD with other disorders is between 60% and 80%" (Austin 6). Over half the children diagnosed with ADHD also meet criteria for another disorder.

The two most common are conduct disorder (CD): showing a persistent pattern of behavioral problems and oppositional defiant disorder (ODD): showing a pattern of defiant and disobedient behavior towards authority figures. When a child clearly appears to show opposition towards an authority figure, ODD may be present. However, this symptom could also be the child simply trying to interact in his/her environment. Depression and anxiety are 2 less common disorders that show an indication of co morbidity with ADHD.

A less common possibility however is when ADHD occurs in arrangement with another disorder; a new disorder can form, having its own correlates, development course, and set of causes and origin. Learning disorders are common to appear together with the predominantly impulsive type and ODD and conduct disorder are most likely to appear with predominantly hyperactive-impulse type. Researchers are currently studying to see if co morbidity is always the case with ADHD or if ADHD can occur alone. As for the causes of ADHD, it is unknown what exactly causes it however; there are a few theories as to what might be causing the disorder.

One theory is that ADHD is caused by biological factors, mostly involving the central nervous system. There are possible links between children with ADHD and brain structure, function of dopamine and nor epinephrine in the brain, and how the areas of the brain that control impulse and attention function, all are still being studied. Children with ADHD are shown to have a smaller prefrontal cortex, smaller caudate nucleus and globus pallidus. This suggests that there could be less prefrontal corticostriatal fibers and fewer pallidal responses to prefrontal regions of the brain.

Genetic research on ADHD has increased immensely in the past 5 years, looking for certain genes that could possibly be involved in the transmission of ADHD. “ ADHD has a strong genetic basis in the majority of cases, as a child with ADHD is four times as likely to have had a relative who was also diagnosed with attention deficit disorder” (Martin). It was recently discovered that children with ADHD are more likely to have parts of their DNA missing or duplicated than other children, mainly in the genes associated with dopamine transporters.

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The Etiological Factors can be different depending on the type of ADHD. With predominantly impulsive type, central processing might be shown, and with predominantly hyperactive-impulsive type, shortage of deregulation in certain neurotransmitter systems might be shown, or imbalance. There are also environmental risk factors associated with ADHD. There have been more than a few studies undergone showing the association between children and family hardship and its connection with ADHD.

Burt et al, who studied twin pairs, pointed out that although genetic and environmental factors were associated with both, ADHD and externalizing disorders, the largest contributions to comorbid ADHD and CD/ODD were made by shared familial and contextual factors” (363). Poor parenting is one cause, angry and controlling parent’s leads to lack of compliance in the child or vice versa where lack of compliance in the child leads to angry and controlling parents. Divorce or any sort of family dysfunction may cause misbehavior in the child along with poor modeling of behavior from parents.

Both genetic and psychosocial risks provide the context for ADHD. ADHD results from multiple causes including, biological-genetic, family environment, and community factors. Studies have been done that show the developmental course of ADHD and how each course reflects on the different subtypes. Evidence shows that tempered, irritable, and hard to calm babies and often seen as challenging during toddler years. Having an outlook on certain things is a good predictor on the risks possible. Complications during birth and premature births put the baby at high risks of developing ADHD.

A biological cause for maturational factors includes genetic tendencies and environment interacts to establish outcomes. Symptoms are likely to continue into adolescence when they occur with other symptoms like noncompliance and aggression and in circumstance of multiple indicators of family conflict. Also, during adolescence, ADHD children tend to join more anti-social peer groups or just being socially secluded. The drug and alcohol rates are slightly higher with adolescents with ADHD. The lack of co morbidity and family conflict in a child's life tends to help them function better in adolescents. The main subtypes of ADHD are distinct.

Research shows that it is possible they have different etiologies and responses to treatment. Keeping in mind that there is a significant overlap with learning disorders, compliance disorder, and oppositional defiant disorder, ADHD by itself without co morbidity is being studied hoping to provide more information than the co morbid diagnosis. The specific and current definition of ADHD could possibly be unnecessary because of the two distinct disorders that occur with the disorder. Children that show early symptoms of ADHD can have different outcomes depending on the arrangement, age of onset, persistency, and severity of risk factors.

Works Cited

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