

# [A sociological perspective on adhd](https://assignbuster.com/a-sociological-perspective-on-adhd/)

in educational and specialization communication. According to Ideus this is not only due to the politicisation and medicalisation of the condition, but also due to the current cultural respect to medical and psychiatric subjects. She argues that more and more popular belief is polarised in the United States by the advocacy groups and the media into ADHD group and ADHD sceptics. She argues that it is not that sociologically conscious and scientifically sceptical ADHD cliques do not exist, but their efforts have been marginalised as counterproductive to ADHD activism welfare (Myers, 2007).

The problem with those who use sociological approach to ADHD is that they fail to accept the biological determinism and pseudo-objectivity of the main approach. Major works have attributed the origin and the growth of ADHD with the cultural imperatives than it is related to neutral science. Schachar established that the origins of ADHD lie in the specific political and economic climate of the United Kingdom as the century turns. According to him, ADHD had its basis in the values of Social Darwinism which had dominated the United States by then.

According to Conrad established that cultural and political factors were significant in the appreciating and defining of Social Darwinism which was a forerunner to ADHD. According to his investigation, the growth of ADHD can be associated with the theories of children medical treatment through the 50′ and 60’s, the development in boldness of pharmaceutical businesses in the sixties, and the US government’s initiatives to control drug treatment. He further noted that while the classification existed and developed from, both the medical label and treatment were not extensively used until the finalization of the social factors. This implies as per him, this condition worsened due to particular needs and forces in the United States’ society.

The sociological perspective on ADHD shows the significance of cultural, political and economic priorities in the reception of the group in different national and cultural environments. A research by Yelich and Salamone has showed that as the procedures and knowledge in treating this disorder have improved it has continued to grow rapidly as compared to other disorders. They hypothesize that this raises major issues about the position of the situation as a purpose medical group. Additionally, they also note that problems occur mainly on entering the school environment and for distinct disorder there is a huge disparity in problems across diverse sites. They also argue that, ADHD pervasiveness and severity has significant associations with inferior socio-economic class. Zametkin study, which employed the use of brain mapping techniques shows the inadequacies in the initial study but it also claim that the outcomes did not implicitly provide a proof of inexistence of the biological basis of ADHD (Zametkin, 1989).

They also disprove opinions for making ADHD a kind of disability in education on the grounds since it cannot be clearly be diagnosed, that it is not considerably dissimilar from other conditions at present getting services, and there is no irrefutable proof of its natural basis. In reaction they reiterate that while a practical medical category its stress on shortage does not inevitably transform well into professional schooling environments. The latest review by Du Paul and Eckert in the year 1997 shows that less than ten percent of studies accomplished on ADHD concentrated on the area in which the preponderance of difficulties are experienced, that is the school.

## Biological perspective

Biologically the cause of ADHD is the brain structures. According to a research which was performed using advanced imaging techniques shows that there exists dissimilarity in the size of some parts of the brain in children with the ADHD disorder as compared to those who do not inhabit the disorder. In their prefrontal cortex, found in the front part of the brain is less active. It controls the ability of the brain to block some responses. The caudate nucleus and the globus pallidus, which is found at the centre part of the brain and which is known for its ability to increase the speed or to stop the orders emanating from the front part of the brain has been found to be smaller in the children who happens to be victims of ADHD but it seems to get back to normal as the age of the child increases. These abnormalities usually impair a child’s ability to discontinue some actions and hence impulsivity in the people with the disorder. In the area above the stem of the brain which is referred to as the cerebellum, it is found to be smaller in children with the disorder. This part enables the control of the muscle tone and their balance and also synchronizes the activity of the muscle (Ellenberger, 1970).

This disorder is mostly found with the boy child but as per the statistics it is also underdiagonised in girls. But the ongoing research has enough evidence to show that both genders are in the same position in getting the disorder. Although this disorder is common in children ADHD in adults has also been noted. Ritalin was administered for about 800, 000 adults in America in 1997 which is about three times the figure in 1992. As of 2005, experts expected that ADHD affects about 4. 1% of adults ages 18 – 44 years in a specified year.

Research shows that ADHD affects 2 – 6% of population of the adults, taking assumptions that that 1-2/3 of cases continue into adulthood. ADHD in adults mostly occurs as an extension of the childhood condition. Adult-onset symptoms are probable to be because of other factors. Since hyperactivity typically wanes as children get older, it can be a difficult to diagnose it in adults. It is therefore evident that the number or the percentage of the adults with this disorder is underestimated. The following are some signs of adults with this disorder: inattentiveness and problems with the memory which includes: failing to finishing things, judging time wrongly, diverting from projects when nearly completion, being absent minded, and easily forgetting things (Conrad, The Sociology of Health and Illness, 2008).

They are also hypersensitive and being restless examples of this is: they are risk takers they have also been found to be less impulsive and their emotions are instable by interrupting others, are easily frustrated, mostly drive recklessly, and have unpredictable moods. These adults have a problem with their self worth such that they do not entertain the occurrence of fresh challenges and mostly they seem to place so much confidence in other people that in themselves

In treatment of adults doctors normally revisit their childhood reports on their conducts and experiences. Amusingly, the disorder appears to be equally distributed among adult men and women. Supplementary emotional, personality, and learning disorders have it that amid 19 – 37% of adults with ADHD has dejection disorder. Between 25 – 50% have an anxiety disorder. In learning disorder, about 20% of adults with ADHD have dyslexia and auditory dispensation problems which must be considered in which ever plan of treatment to be employed. The adults with the disorder do not mostly attain high academic levels; they earn less money, and have higher chances of being fired in their work places. It has been noted that by the age of approximately 30 most of them are self employed (Conrad, The Changing Social Reality of ADHD, 2009).

Research also has it that about 32 to 53% of alcoholics are the ADHD victims. 8 – 32% are marijuana smokers or cocaine takers. A study in year 2003 shows that the adults and the young people who are at the risk of drug abuse are the ones with the ADHD disorders or those who had had behavioural problems in their childhood days. Both adults and children with this disorder seems to lack sleep with a disorder commonly called restless legs syndrome and sleep apnea. In the sleep apnea one is unable to breath for temporal period when a sleep. Most people do not recognize but the victim wakes and start grasping for breath. This is usually coupled with snoring. It has been known that treatment of sleep apnea reduces the symptoms of ADHD by 50%. ADHD in adults is treated with the Atomoxetine which is not a stimulant. It reduces the symptoms as hyperactivity, inability to concentrate, and inclination in adult victims. This treatment is normally discontinued in early signs of liver problems. It is therefore advisable to be used in adults compared to the adolescents and children since they can trigger suicidal thoughts.

Bupropion may be a chiefly good quality option for some ADHD adults, as well as those who also have bipolar disorder or a history of drug abuse. Tricyclic antidepressants are also effective with both depression and ADHD disorders. The standard psycho stimulants, methylphenidate (Ritalin) and Adder all are also good in the same. These patients can also be treated by nicotine replacement. This improves ADHD symptoms and seems to have special effects in the brain that similarly to those of stimulants.

It is also difficult to identify presence of this disorder in children since there exists no laboratory or imaging for perfect diagnosis of ADHD as it majorly depends on the symptoms of behaviours and the process of discriminating other disorders. Many professionals believe that is under and over diagnosed in most cases. The difficulty is due to: misconception of parents who ends up to pressurizing the doctors to administer methylphenidate to their children who seem to perform poorly in school and who are usually aggressive which as per the statistics shows that out of the 18% and 20% of Caucasian boys treated with Ritalin only 11% were ADHD victims.

In other cases most children were young for their level of grades which shows that they may be immature intellectually and socially. It is also known that children from poor backgrounds and those who have grown up in single parent households are likely to have behaviour and emotional problems which has increased in the level of the victims of the ADHD victims.

In treatment the doctor will need the history of the behaviour of the child and he/ she will compare the behaviours with the standardized list which outlines the symptoms of the ADHD.

Parent must provide the following information to the physician: the particular problems from as early as they can remember in their child growth more so the report from school, relationship between the child and other siblings, changes that have occurred of late, information on whether the family have had a history of ADHD, the eating habits of the child, the sleeping patterns, speech and the language development, and any other problem the mother experienced during delivery or during the pregnancy. The mother should also include any other history of allergies, terminal ear problems, and hearing problems. Finally it is crucial that the doctor understand how the parent6 handle the child when interacting with the child.

There are various tests that may be administered to a child in order to test any signs of ADHD. These include CPT which is a test referred to as continuous performance test where a child is sat before a computer and he/she is asked to press some keys and not to press others as per certain images in the screen. Some other tests may be done in order to test the neural, emotional and intellectual growth. They mostly include studying and problem solving assignments with the aim of determining the disabling areas. Tests of blood samples may be taken in the situations of doctors suspecting presence of lead toxics in the blood of the child.

Research has shown that ADHD does not in most cases exist alone but it is accompanied by other disorders. Scientists have it that it is only 1/3 only pure ADHD that exist. The following disorders also exist parallel to it. Attention-Deficit Disorder without Hyperactivity. In this type of disorder, the child’s initial signs are inability to persist in assignments and the ability to be distracted is very high. Oppositional-Defiant Disorder (ODD): statistics shows that about 36% of the ADHD children also have ODD. The child is defiant, hostile towards authoritative people lasting for about six months and they have a negative pattern of life. Additionally, they are aggressive and have frequent tempers tantrums and in most cases they display antisocial manners. ODD patients have other phobia disorders which must be treated disjointedly (Leo, 2009.).

## Psychological perspective

Attention Deficit Hyperactivity Disorder (ADHD) is a universal neurodevelopment psychiatric problem the greatest part of research in this field has focused on genetics and neuropsychological or the behavioural signs for the disorder. It exists as the most genetic psychiatric disorders, with genetical inheritance being approximately 77%. Despite of the scientific research that various genes can be associated with ADHD their impacts are minimal and hence the cause of this disorder cannot be pegged entirety on gene theory. Today research is expanding in order to investigate the role of environmental factors and their association with some genes and epigenetic processes in the expansion of the ADHD’s symptoms. The analysis of ADHD is founded on the assemblage of symptom arrangement (impulsivity-hyperactivity and lack of attentiveness) and provides room for three subtypes – impulsive-hyperactive, lacking concentration and combined-type. These subtypes may have diverse aetiologies and behavioural profiles. Psychiatrists and Psychologists have come up with a variety of theories to give details of the behaviour of patients of ADHD. It should be clearly noted that any key psychological theory of ADHD ought to be able to explain these analytical symptoms. The psychological perspective takes into account four theories to explain the existence and the development of ADHD. Below is the outline of the same.

The Delay Aversion theory which was introduced in 1990 argues that children who harbor this disorder are capable of waiting but they don’t want to. Its earlier version stated that ADHD children aren’t impulsive in terms of opting for an instant reward at the expense of the overall reward but it happens when there is a shorter delay. Inattentiveness and hyperactivity are well thought-out to show trials to decrease prejudiced knowledge of delay in situations when it can’t be avoided.

The Dynamic Developmental Theory (DDT) of ADHD was developed for the past 20 years and which has raised different views amongst various psychologists. This complete theory tries to elucidate the behavioural manifestations of ADHD from a neurotransmitter up to a community level and aims to give details about all symptoms of ADHD. This theory argues that there exist two major behavioural mechanisms reinforcing a lot of symptoms of ADHD: altered reinforcement of original behaviour and poor extermination of insufficient behaviour.

The State Regulation hypothesis suggests that a non-optimal vigorous situation can clarify performance lack in children with ADHD. It is founded on a study using the Cognitive vigorous model of Sanders. In this model, the competence with which a duty is done is considered to be a creation of elementary cognitive stage and their energy allotment. The basic stages are spur encoding, memory hunt, binary choice and motor training and may be viewed as structural computational in sequence processes. The accessibility of these processes is connected to the stimulation and launching levels of the subject. Stimulation is defined as a time-locked phasic physiological answer to effort, whereas launching refers to a long-lasting intentional preparedness for action

The Executive Dysfunction theory of ADHD argues that the symptoms of ADHD occur entirely due to a decrease in executive power, caused by abnormalities in the arrangement, purpose and biochemical process of the fronto-parietal and fronto-striatal neural networks Neuropsychological tests that are susceptible to the mechanism of the decision-making purpose system have been used to evaluate children with ADHD. The outcomes of these tests have been unswervingly and ultimately linked back to the physiological, anatomical and biochemical dysfunctions in the frontal cortex, the fronto-parietal and fronto-striatal circuits in ADHD.

## Summary and Conclusions:

It is evident that the three disciplines concerning the issue of ADHD communicate the same thing or they tend to explain the same concept but they use different approaches. According to the discussion above, the biological cause of ADHD is the deformation in the brain structures. It implies that children and adults with ADHD disorder have either small brain size or even deformed brains as compared to the normal adults and children. This approach cannot be ignored since it bases its facts on a practical example i. e. on an experiment that has been done by medical professionals. This can be objected on the basis that the experiment that was done just happened to be a coincidence and for those who do not believe to believe in scientists, they may find this perspective not fulfilling like the sociological perspective

The sociological perspective rotates about the education factor as a determinant of whether the chid is suffering from ADHD disorder. Children who fail to perform well or those who conduct their selves in abnormal manners tend to be judged to have the ADHD disorder and in most cases as I discussed earlier they form about 11% while there are others who perform poorly in class not because they have these disorders but they are poor learners. Maximum investigation must be performed in order to differentiate between a disorder and inability to learn. As earlier discussed, sociologists fails to recognise the biological perspective and pseudo-objectivity of the biological approach as they object the origin theory provided by the neural scientists. They normally attribute the growth and the origin of this disorder with the environment around the child. This environment is the: cultural, political and the immediate society of the child. It also depends on the economic status of the family of the child.

The psychological perspective on the other hand focuses on the key psychological theories which include: the Executive Dysfunction theory, the State Regulation model, the Dynamic Developmental Theory (DDT), and the Delay Aversion theory. These theories only try to explain this disorder in just but a theoretical way without providing actual practical examples on the application of the same. Therefore these theories have the same definition but they sound differently depending on the field of study (Erkulwater, 2009. ).