

Literature review on articles studying adhd



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This work is done to summarize two articles extracted from scientific experiments.

I chose is Attention-Deficit/Hyperactivity Disorder (ADHD) and Anxiety, two of the most common psychiatric disorders in children and adolescents.

The first article discussed ADHD currently used to describe children with a relatively stable behavioral profile characterized by developmental inappropriate difficulties regulating impulse control and attention, causing impaired functioning at both home and school. It defined properties of an ideal ADHD drug treatment from the patient and parents' perspective.

The second article discussed anxiety disorder. Anxiety is apprehension or excessive fear about real or imagined circumstances, the central characteristic of anxiety is worry, which is excessive concern about situations with uncertain outcomes. Excessive worry is unproductive, it interfere with the ability to take action to solve a problem. Symptoms of anxiety are reflected in thinking, behavior, or physical reactions. The experiment done in this article is to examine whether perceptions of anxiety prompt downward shifts in predictions.

In an age when the focus of psychological treatment has become pharmacological, with patients being rushed to take pills rather than engage in talk therapy, *Nonmedication Treatments for Adult ADHD, Evaluating Impact on Daily Functioning and Well-Being* is a much-needed resource for practitioners seeking to understand all available options.

Several different approaches must be considered to treating children with

ADHD although the symptom relief is provided by medication, adequate treatment requires more than mere symptom reduction.

Left untreated, ADHD may thwart the individual's ability to handle the common demands of daily life and to pursue reasonable goals.

Nonmedication Treatments for Adult ADHD illuminates the negative effects of untreated ADHD by pointing out the cumulative and corrosive psychological effects of living with the disorder.

Anxiety usually comes with or results from of untreated ADHD. Anxiety impairs functioning in most, if not all, activities of adult life and results in a heightened sense of hopelessness, self-denigration, shame, pessimism, and failure. IT corrodes one's sense of confidence in managing many essential domains of life, such as work, school, and relationships; it impairs confidence, industriousness, and connection with others.

At present, the assessment of medicinal products by physicians and other decision-makers is primarily based on the results of studies on clinical efficacy and safety. The patients' perspective and the needs and values of those concerned remain largely unknown and consequently play a rather subordinate role. This is mainly due to the lack of adequate studies, as is the case with drug treatment in attention-deficit hyperactivity disorder (ADHD). ADHD is one of the most common psychiatric disorders in children and adolescents. The core symptoms of ADHD consist in abnormal impulsive behavior, a deficit in attention, and hyperactivity. They are relevant not only because of their

prevalence, but also because of their consequences in the short, medium and long term, which far exceed the immediate concerns of the healthcare system . In addition to family stress and problems, disturbed social behavior, problems at school and at work and the attendant impaired quality of life, numerous significant long-term pathological developmental defects are known. This condition is usually treated by using a multimodal therapeutic concept, consisting of a combination or series of different approaches to treatment that should be tailored to the individual needs of the patient. Standard approaches include psychosocial and behavioral, as well as psychopharmacological therapies. Different drug treatments, in different pharmaceutical forms and with different therapeutic time frames, are available for patients.

The objective of this study is to define properties of an ideal ADHD drug treatment from the patient and parents' perspective. In addition to " classic" medical outcomes, other aspects important to the patient, e. g. quality of life and social behavior, were included. A Discrete Choice Experiments (DCE) was performed in 2007 as a method to elicit preferences and making them accessible for physicians and other health care professionals.

Methods

A social science survey study was divided into two parts: a qualitative part to collect relevant attributes and a quantitative main study to elicit the patients' preferences. The qualitative pre-investigation

determined the desires and expectations of patients and their relatives with regard to the drug treatment of ADHD. In the principal investigation phase,

these were then used as a basis for assessing the previously defined pools of characteristics with regard to their individual degree of relevance.

Qualitative study A qualitative study with four focus groups consisting of five to eleven ADHD-patients each was conducted.

On the basis of literature research and the results of these focus groups 23 aspects were selected for the main study. In a pretest, the questionnaire was tested for comprehensibility by parents of patients

and adolescent patients (n = 14). Based on the results of the pretest the questionnaire was finalized.

Quantitative Main study

An anonymous survey, started in early November 2007 was conducted using either online or paper questionnaires. Family members (mostly parents) and patients (> 14 years) , n= 219, were contacted either in writing and distributing the paper-based questionnaire

version with stamped addressed envelopes, or via email/ internet. Patient advocacy groups helped in distributing paper-based questionnaires and the link to the online version. No personal data such as addresses, names or phone numbers were collected.

The questionnaire encompassed three main domains:

- Part A: Sociodemographic characteristics (gender, educational level, previous therapy, and member of patient advocacy group)

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- Part B: Current health status (questions concerning utilization of medical services)

- Part C: Assessment of importance of ADHS-therapy characteristics. Both methods are based on a multiattributive method to analyse preferences and assess

combinations of characteristics.

C1: A direct assessment in order to analyse the

relevance of therapy characteristics was conducted. Respondents

had to rate the importance of 23 therapy characteristics

using a five-point Likert-Scale, ranging from “ very

important” to “ not important”. For subsequent evaluation,

the ratings were transformed into a numerical range

from 0 (“ not important”) to 100 (“ very important”). However

rating scales do not

incorporate the trade-offs inherent in real-life decision making, so to draw a valid conclusion , a Discrete Choice Experiment was conducted.

C2:

Discrete Choice Experiment (DCE)was done to study patient’s preference.

Preferences refer to the individual evaluation of dimensions of health

outcomes. Patient preferences are statements made by individuals regarding their needs, values and expectations and the relative importance of treatment

properties.

The DCE was built up with eight pairs (choices) each consisting of six dichotomous aspects. All the six characteristics chosen were of high importance in the direct measurement and in the qualitative study: duration of effect, side effects, dosage, discretion, emotional state, and social situation. To achieve maximum differentiation between the two alternatives a fold-over design was used:

each of the eight pairs was presented to the subjects as alternatives A and B, with A being the exact “ mirror image” of B. This approach created varying decision options: some

choices were relatively simple because one alternative was in almost all aspects apparently better than the other. On the contrary, in difficult decisions the advantages and disadvantages were mostly equally distributed which made the alternatives more equivalent and the choice more difficult.

Results

Patient Characteristics (Part A and B)

The majority of patients had first been diagnosed with ADHD at an age of 6 to 9 years; most were 6 years old. The first part of the questionnaire contained a total of 7 questions regarding the use of facilities available to parents: two-thirds (67%) of respondents belonged to a patient advocacy

group at the time of the survey, 18% had previously been active in a patient advocacy group, and 15% had never belonged to such a group. A similar picture emerged for the use of psycho-educational facilities: 70% were using such facilities in the period of the survey, 17% had done so previously, and 14% had never made use of them. Much lower proportions had made use of parental training or coaching. Only 26% made use of parental training, and 22% preferred parental coaching. The vast majority had no experience of the following educational opportunities: 5% made use of systematic family therapy, 10% family assistance, and 8% therapeutic day centers.

The health status of the child or adolescent concerned was classed as “ very good” or “ good” by 53% of respondents, “ satisfactory” by 33%, “ not so good” by 11%, and “ bad” by 5%. With regard to changes in health status over the past 12 months, a marked improvement had been seen by 42%; 14% had noticed deterioration, and the remaining 44% had seen no change. The subjects were presented with a total of 10 treatment schemes to be assessed; information on their past experience was also relevant in this context. The vast majority of 91% professed to have had experience with drug therapy, and 76% were currently using it. About 50% had used ergo therapy and behavioural therapy before, while only

10% and 18%, respectively, were using them at the time of responding. About one-third (36%) had experience with therapy for the treatment of co-morbid disturbances. At the time of responding, 13% of subjects were still being treated for such problems. When asked about the current extent of their medication, 40% stated that they were using an “ all-day drug treatment”, on all days of the week. 17% used medication on school days,

but less at weekends and in school holidays. 26% of respondents treated the disorder on a half-daily basis; 18% of these discontinued their treatment on weekends or during school holidays. A total of 17% professed to prefer non-drug methods.

Relevance of therapy characteristics: Direct assessment

(Part C1)

In this part, it emerged that all but 2 of these items reached relatively high scores, meaning that patients consider most of them to be very important with regard to the quality of a therapy approach. This is not surprising, since only aspects were presented, that were rated as important according to the literature and the qualitative study/focus groups.

The greatest relevance (100 – 90) was attributed to “improving the child’s emotional state” (mean value = 94), “little or no addictive potential” (94), and “improved ability to concentrate” (93). Response styles are a source of contamination in questionnaire ratings.

Preferences in the Discrete-Choice-Experiment (Part C2)

From the patient’s point of view, the 6 aspects presented influenced the choice of the best therapy to different degrees. The greatest importance was attributed to “enabling

social contacts” (Item 6; 3, 162 coefficient). This was followed by two items with almost the same degree of importance: by “emotional state: no mood swings” (Item 5; 1, 644 coefficient) and “duration of effect: long (all day)” (Item 1; 1, 437 coefficient). If one of these characteristics

was present, this treatment alternative was very likely to be selected. These were followed at a considerable distance by “discretion” (Item 4; 0, 727 coefficient), “dosage”

(Item 3; 0, 468 coefficient), and “side effects” (Item 2; 0, 470 coefficient). A supplementary (partial) log-likelihood analysis yielded to the same hierarchy as the interpretation based on the six item-coefficients. All 6 aspects were statistically significant, with a level of $p < 0.001$ for Items 1, 4, 5 and 6, and $p < 0.01$ for Items 2 and 3.

At the end of the questionnaire, subjects were asked about

their degree of satisfaction with their present treatment. In total, 58% were “satisfied” or “very satisfied”, while about one-third chose the category “yes and no”, and 11% expressed a negative opinion of their present therapy.

Anxiety and Outcome Predictions

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The traditional approach of viewing mental health involved relatively accurate perceptions of the self. Perceptions that were overly optimistic or overly pessimistic were generally regarded as evidence of poor functioning. More recently, researchers have proposed that mental health is best characterized by positive illusions and that healthy people have an overly positive view of the self, exaggerated perceptions of control, and unrealistically optimistic expectations for the future (S. E. Taylor & Brown, 1988). Numerous theorists have proposed that normal social perception

systems have a variety of social and cognitive filters in place that serve to screen and distort information in self-serving ways. Most notable of the various positive illusions is perhaps unrealistic optimism whereby people maintain that their future is bright and getting brighter. Optimism have been linked it to a variety of emotional, social, and health benefits the benefits of an optimistic outlook draw from related outcomes such as greater motivation, persistence, and goal-directed behavior or at the very least, the capacity for optimism to generate positive

affect. However, when events are more concrete or immediate, the benefits of an optimistic outlook may diminish, and evidence suggests that people will sometimes shelve their optimism for a more realistic or even pessimistic outlook.

A study was done on students predicted their score on a classroom exam on four occasions

(Shepperd, Ouellette, & Fernandez, 1996). This studies suggest that as events draw near and pass

and people move from awaiting the “ test” to awaiting news of the outcome, people will often trade their optimism for a more grim prognostication .

The cause behind Fluctuations in Future Outlooks, shifting from optimism in personal prediction across time, is that People are responding to new information.

bearing on the accuracy of personal predictions, such as information about the difficulty of the material , how much time they have to study. A greater

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clarity on existing information either in response to accountability pressures or in response to a shift in the construal of the event from abstract to concrete , reduce biases in perception and decision processes as well (Tetlock&Kim, 1987). Anxiety is also a source of information. Specifically, as feedback draws near, people note their increasing anxiety and infer that if they feel anxious, it must be because they did poorly. people interpret their anxiety as important information about the status of their outcome (Gilovich et al., 1993).

Another reason for the downward shift in prediction is that people are bracing for possible undesired news (Shepperd et al., in press).

People are not simply recalibrating their predictions in response to new information.

Rather, they are readying themselves or bracing for the possibility of an undesired outcome-the possibility that things may not turn out as hoped.

The author spots light on the common thread in several of the explanations that the downward shift in predictions reflects a response to mounting anxiety. The source of anxiety may be from some unrelated source, from gearing up to perform , from mental simulations of how things could go wrong, or from thoughts about the prospect of disappointment.

Regardless of its source, the anxiety often produces a downward shift in outlook. For instance, people interpret the rising anxiety they experience in anticipation of feedback as information that the outcome will be undesirable. The anticipation of performance and feedback prompts thoughts about the

possibility of disappointment, and anxiety over the prospect of disappointment prompts less optimistic predictions. In both cases, anxiety serves as a signal to make less optimistic predictions.

Studies show that as feedback draws near, anxiety reports increase and predictions become less optimistic (Shepperd, Ouellette, et al., 1996; K. M. Taylor & Shepperd, 1998).

In preparing this article we asked undergraduates (N = 136) enrolled in a psychology class whether they had ever predicted their grade after taking an exam, yet revised their prediction downward as the professor returned the exams. Participants who indicated they had done so then described why they lowered their prediction.

Of the participants, 30 reported never having done this, 3 said that they had but provided no reason, and 7 provided reasons suggesting that they misunderstood the question.

Of the remaining 96 participants, the two most common reasons offered by participants were to

avoid disappointment (37%) and because of anxiety, nervousness, or insecurity about their score (26%). The remaining participants offered a smattering of other reasons such as learning new information (11%), experiencing doubts (10%), second-guessing themselves (10%), and correcting for initial overconfidence (5%).

If anxiety serves as a signal to shift from optimism, then inducing people to believe that any anxiety they are experiencing is actually due to some other cause should reduce or eliminate the

decline in optimism. They must isolate the role of emotion in judgment.

Participants

reported their confidence in their ability to perform well on a forthcoming task. They made their predictions while ostensibly listening to subliminal noise. Some participants believed the subliminal noise would make them anxious, whereas others believed it would have no physical effects.

Participants induced to misattribute their anxiety to the subliminal noise were more confident about their ability on the upcoming task than were participants who believed the noise would have no effect (Savitsky et al., 1998).

An experiment was made to examine whether perceptions of anxiety prompt downward

shifts in predictions

Experiment:

In our study we examined the predictions people make after a performance and prior to receiving feedback. Participants took a test and learned they would receive the results in a few days or in a few moments. Participants learned either that a cup of coffee they had consumed earlier was highly caffeinated and would produce feelings of arousal or was decaffeinated and would thus produce no effects.

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Method:

Participants : Introductory psychology students (N = 108) participated as part of a course requirement were randomly assigned to conditions in a 2 (misattribution vs.

control) , 2 (immediate vs. delayed feedback) factorial design. Data from 7 participants were discarded

A total of 101 participants was left. Participants were not allowed to drink any caffeinated beverages for 12 hours before the experiment.

Procedure:

On their arrival, the experimenter escorted participants to separate compartments and explained that they were participating in two unrelated experiments. The first experiment would ostensibly establish local norms for a measure of intelligence. The second experiment ostensibly examined the effects of caffeinated coffee on motor performance. The experimenter explained that the American Coffee Importers Association funded the second experiment to know whether caffeinated coffee affects motor performance.

After these instructions, participants consumed a 6- ounce cup decaffeinated coffee. 20 min after , The experimenter administered the 1st exam (V-RAT), which was for 12 min.

12 minutes later, the experimenter collected the tests and took them down the hall for scoring, stating that participants would receive their scores in the mail in 3 days.

On returning, the experimenter introduced the feedback timing and attribution manipulations. Participants in the immediate feedback condition were told that the person who scored the test was unexpectedly available and that they would receive their test scores before the end of the experiment. Participants in the delayed feedback condition received no such information .

The experimenter next told participants in the misattribution condition that the coffee they consumed was highly caffeinated and that they may experience a slight trembling, a fluttering of the heart, increased perspiration, and some slight anxiety feelings. These instructions were delivered roughly 20 minutes after participants had consumed the cup of coffee and were intended to lead participants to attribute any anxiety feelings they might have about the intelligence test to the coffee. The experimenter told participants in the control condition that the coffee they consumed was decaffeinated and was unlikely to produce any effects.

Participants then completed a survey regarding their daily caffeine consumption.

Immediate feedback participants then learned that their test was scored. However,

for privacy reasons, the experimenter was not permitted to see the scores. The experimenter then produced envelopes for each immediate feedback participant with a test score ostensibly sealed inside but informed them that they must complete two brief questionnaires, one for the coffee study and one for the intelligence test study, before opening their envelopes.

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Delayed feedback participants completed the same two questionnaires but continued to believe that they would receive their feedback in several days.

The first questionnaire comprised 10 adjectives (calm, tense, nervous, at ease, anxious, self-confident, jittery, relaxed, worried, joyful). Instructions for participants to indicate how they "felt right now, at this moment." Each item was followed by a 4-point response scale (1 = not at all, 2 = somewhat, 3 = moderately so, 4 = very much so). These items were summed (Grand M = 19.2, SD = 4.80, Cronbach's $\alpha = .83$). At the bottom of the questionnaire was a single item asking participants the extent to which their responses were the result of the coffee they drank. Participants responded using a 9-point scale (1 = not all, 9 = very much). The second questionnaire comprised four items asking about the V-RAT. The instructions reminded participants that there were 40 items on the V-RAT. Participants then indicated on a scale of 1 to 40 (a) the highest score they thought they would receive, (b) the lowest score that would fall within their expectations, (c) the score they thought the average person would get, and (d) the exact score they thought they would receive.

The interest was exclusively in participants' exact prediction, which when viewed relative to participants' actual score provided the best test of our hypothesis.

subtracting the score participants

Participants were optimistic or pessimistic was tested by subtracting actual score received from predicted score. A negative score indicates pessimistic

participants, a positive score indicated optimistic participants. This testing was done to address the question about if misattributing their arousal to the coffee eliminate bracing among participants anticipating immediate test feedback

Results:

Before seeing the results, the experimenter predicted that: In the no caffeine (control) condition,

participants predicted a higher score when they

anticipated (predicted) test feedback in a few days than when they

anticipated test feedback immediately (downward shift).

By contrast, in the caffeine (misattribution) condition where people

could attribute any arousal to the coffee, we predicted

that immediate feedback participants would be just as

optimistic as delayed feedback participants in their

predictions.

The results of the experiment were:

Immediate, Misattribution: Predicted score (27. 9), Actual score (25. 5)

Immediate, Control: Predicted score (25. 0) , Actual score(25. 4)

Delayed, misattribution: Predicted score(27. 4), Actual score(24. 9)

Delayed, Control: Predicted score (28. 2), Actual score(25. 3)

Participants reported experiencing greater anxiety in the misattribution condition than in the control condition.

Participants in the control condition were optimistic in their predictions when they anticipated learning their score in 3 days but not when they anticipated learning their score immediately. In the misattribution condition, where any anxiety feelings could be attributed to the coffee, participants were optimistic regardless of whether they anticipated learning their scores immediately or later.

Control/immediate feedback participants displayed less optimism than did control/delayed feedback and misattribution/ immediate feedback participants . Misattribution/

immediate feedback participants did not differ from misattribution/delayed feedback participants in their optimism.

Conclusion & discussion:

Participants significantly overestimated their scores in the misattribution/delayed feedback

condition, the misattribution/immediate feedback condition , and the control/delayed feedback condition. In the control/immediate feedback condition, participants' predicted and actual scores did not differ. So although participants were generally optimistic, they abandoned their optimism when they anticipated immediate feedback and could not attribute their anxious feelings to the coffee.

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Participants reported experiencing greater anxiety in the misattribution condition than in the control condition. This effect arises from the instructions making misattribution participants

more sensitive to their internal state or more willing to report feelings of arousal. Participants were more likely to attribute their arousal to the coffee in the misattribution condition than in the control condition.

The present study replicated the effect of temporal proximity of feedback on outcome predictions. Participants in the control condition were less optimistic in their exam score predictions when they anticipated imminent feedback than when they believed that feedback was several days away. The primary interest however was in the role anxiety plays in predictions.

Among control participants, greater anxiety corresponded to lower predictions relative to

performance. In contrast, among misattribution participants, anxiety and predictions were uncorrelated. Also, the more participants in the misattribution condition viewed the coffee as responsible for their anxiety, the more they were optimistic. By contrast, among control participants, the extent to which participants viewed the coffee as responsible for their anxiety was unrelated to optimism. hence anxiety serves as a signal for predictions.

When the coffee provided a reasonable explanation for their anxiety, participants no longer relied on their anxiety as a signal for how they should adjust their predictions. It is note worthy that we found no evidence of

pessimism in participants' predictions, whereas prior studies of exam scores reveal that people will err on the side of pessimism in their exam predictions in the moments prior to receiving their scores. We suspect that the absence of pessimism resulted from participants' general unfamiliarity with the test.

Conclusion

Children with ADHD are thought to have problems with the part of the brain that controls the organization and direction of thought and behavior. It is strongly genetically determined, but like all developmental and health problems, the symptoms are modified by environmental influences.

There are many types of ADHD. One type is characterized by inattentiveness in which the child must show symptoms such as difficulty following instructions, difficulty focusing on tasks, losing things at school and at home, forgetting things often, having difficulty listening, making careless mistakes or being disorganized, failing to complete homework or task.

Another type is characterized by hyperactive or impulsive behavior in which the child must show symptoms such as fidgeting excessively, difficulty staying seated, running or climbing inappropriately, talking excessively, difficulty playing quietly, blurting out answers or frequently interrupting, having trouble waiting his or her turn.

The presence of some symptoms, however, does not confirm a diagnosis of ADHD. Just because a child has a lot of energy or difficulty paying attention in school does not mean the child has ADHD. An accurate diagnosis relies on

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the presence of a range of symptoms and difficulties that prevent the child from performing at an appropriate level for his or her age and intelligence level.

Medication use is not the central issue with our current approach to attention deficit/hyperactivity disorder (ADHD); rather it is the fragmented nature of the service delivery system that often is not able to meet the needs of this vulnerable group of children. The symptoms of ADHD result from an interaction between biological and environmental factors. Stimulant medication is an effective therapy modality used for children with ADHD nowadays, however, a focus on medication is not the most fruitful way to move this field forward. The biggest unmet needs in the care of children with ADHD are family support and school-based services.

Children and adolescents with ADHD are more likely than children without the disorder to suffer from other mental disorders. About one-half of all young people with ADHD have oppositional defiant disorder; about one-quarter have an anxiety disorder; and as many as one-third have depression and one-fifth have bipolar disorder. Adolescents with untreated ADHD are at risk for substance abuse disorders (Mental Health America of Illinois (MHAI), Chicago, IL 60601, 70 E. Lake Street).

At times, anxiety may appear similar to behaviors seen with Attention Deficit Hyperactivity Disorder (ADHD). For example, inattention and concentration difficulties are often seen in children with ADHD and with children who have anxiety. Therefore, the child may have anxiety rather than ADHD. Failing to identify anxiety accurately may explain why some children do not respond as

expected to medications prescribed for ADHD. The age of the child when the behaviors were first observed can be a useful index for determining if anxiety or ADHD is present. The signs of ADHD usually are apparent by age 4 or 5, whereas anxiety may not be seen at a high level until school entry, when children may respond to demands with worry and needs for perfectionism. A thorough psychological and educational evaluation by qualified professionals will help to determine if the problem is ADHD or anxiety.

If evaluation or consultation is needed, developmental information about the problem will be useful to the professional.

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All of us experience anx