

Stimulants in treating children with adhd psychology essay



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Over the last two decades, Attention Deficit Hyperactivity Disorder has taken the title of being the most commonly diagnosed disorder in school-aged children. During the 1990's, the rate of kids seeing physicians for stimulant pharmacotherapy for ADHD increased fivefold (Mayes et al., 2008). By just the year 2000, America's classrooms had on average two students already being treated for the disorder (Mayes et al., 2008). Stimulant medications are rapidly becoming the most common and preferred method of treatment, despite the knowledge of how exactly these treatments are affecting children. These stimulants are critically acclaimed because they are effective in treating most of the symptoms of ADHD relatively quickly, however even short term use has shown a number of negative side-effects such as heart palpitations, mood swings, migraines, seizures and others (Ryan, Katsiyannis, Hughes, 2011). As for the long term effects, there is little knowledge, and what few studies have been done reveal that lasting damage to mood receptors can also come with chronic use (Berman et al., 2009). Cognitive-Behavioral therapy has been shown to be a much safer alternative while being relatively effective to boot. Because of the legitimate health concerns found with stimulants, cognitive-behavioral therapy should be more widely used as an alternative treatment for ADHD, and its effects when used in combination with pharmacotherapy further studied.

Attention-Deficit Hyperactivity Disorder can affect just about every area of one's life including things such as social interaction, education, and work environment. The Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV) details the core symptoms of ADHD in three main areas: inattention and hyperactivity/impulsivity. An individual is then sorted into

one of three subtypes based on their lean in one of the particular categories (predominately inattentive, hyperactive/impulsive or combined subtype).

This is also part of the reason for the controversy surrounding a diagnosis of ADHD. Many people would consider the symptoms of ADHD normal behaviors in young children, and as a result are not sure if the symptoms being exhibited are because they are a child or because they legitimately have the disorder.

So why do nearly half of the children seen in child psychiatry clinics end up getting diagnosed with ADHD? The number is staggering. Part of the reason there has been an increase in diagnoses may be due to the fact that the DSM-IV by itself is not the most accurate way to gauge a child's mental or physical inattention. Many children are diagnosed at even the preschool age, where being inattentive and hyperactive is their full-time job (Mayes et al., 2008). This makes it quite easy to see the controversy that is stirred up when children at such a young age are diagnosed with a mental disorder and prescribed psychotropic drugs. The symptoms are sometimes indistinguishable from normal behavior and are not symptoms at all but just kids being kids (Mayes et al., 2008). Taking into account where the child's symptoms are most prevalent (home, school) is important, as well as things like whether or not the symptoms only come up in certain situations, or how much they are affecting their life in aspects such as relationships with peers (Mayes et al., 2008). For a truly correct diagnosis of ADHD, psychologists need to dig deeper; these other factors need to be considered. Sometimes they are, but often the DSM-IV is the sole factor in deciding whether or not a child has ADHD.

Clearly a new solution is necessary-one that relies less on psychotropic drugs and more on the actual management of the symptoms themselves.

Cognitive-Behavioral Therapy (CBT) is a less common, yet highly underrated alternative compared to stimulants. In younger children, CBT focusing on behavioral aspects has been shown to be the most effective. As a child gets older though, cognitive interventions and exercises in perception, memory, and judgment produce more long term results that allow the child to better independently control their symptoms (Schultz et al., 2011). School-based settings provide a place to practice new thought processes and evaluate internal emotional and behavioral change. Through cooperation of teachers and parents, there are several procedures that are fairly easy to implement which address many of the behavioral symptoms associated with ADHD.

These procedures vary depending on the age of the child in question, with behavioral therapy working better on elementary-aged children and cognitive intervention showing better results on adolescents and adults. According to Pelham & Fabiano, in the elementary classroom setting: simple things like reinforcing positive behavior, providing specific instructions, creating stringent classroom policies/routines, and providing appropriate reprimands and prompts for behavior have been shown to be “ effective in reducing disruptive classroom behavior of children with ADHD” (qtd. in Schultz et al., 2011). Individualized behavior programs are also an option, one major example being the Daily Report Card (DRC). The DRC entails selecting certain behaviors that are exhibited in the child and then having the teacher rate these behaviors on a regular basis. These behaviors may be things like raising one’s hand before responding to a question, or staying in

one's seat. The child then takes the DRC home at the end of the day and, based on how well his or her behavior was, is given a small reward such as watching a favorite TV show before bed. Owens tells us that the DRC has been shown to produce “ positive changes in teacher-rated symptoms of ADHD and conduct problems, parent-rated daily functioning across several domains, and teacher-rated classroom functioning” (qtd. in Schultz et al., 2011). These methods have shown considerable progress in maintaining the symptoms of a child's ADHD, yet stimulants are still a knee-jerk reaction for most doctors.

As a child gets older, cognitive interventions become more effective in maintaining results. Different approaches are used when compared with a younger child, as the reward system can only remain age-appropriate for so long. Interventions include the student as well as the parents and teacher, and include things like discussing homework management, note-taking and school engagement (Schultz et al., 2011). Sitting down and talking about things seems to be a simple solution, student and parents agreeing on academic expectations and communicating. Interventions targeting organizational aspects have also revealed promising results; techniques as simple as keeping materials in a binder or establishing a system for tracking and filing assignments (Schultz et al., 2011). Consistent monitoring of this system by teachers can lead the student to independent mastery of the skill in as little as 2-4 months of biweekly intervention sessions (Schultz et al., 2011). Some investigators are even figuring out that certain areas of academic impairment, such as homework completion, are more effectively

treated with cognitive-behavioral therapy rather than medication (Schultz et al., 2011).

Unfortunately, some schools simply do not have the resources to be able to implement these programs (Allen, 2011), which is an understandable concern. Consequently, one might think that these practices could be hard to implement into schools reliably-however, Pelham & Fabiano show us that for the most part, teachers find these strategies relatively easy to implement in the classroom (qtd. in Schultz et al., 2011). A recent survey done by Chafouleas, Riley-Tillman, & Sassu also shows that nearly two-thirds of teachers have used a version of the DRC in their classroom at some point (qtd. in Schultz et al., 2011). The concept of cognitive-behavioral therapy is not entirely foreign, it just needs to be more widely implemented. Another concern is the fact that CBT is more time-consuming than simply taking a pill that lasts throughout the primary schooling hours. Parents, teachers and children alike have to put in more effort which isn't always the most convenient option; parents have jobs, children might not always cooperate and teachers sometimes have to go above and beyond. Despite this, cognitive-behavioral therapy is grossly underused while stimulant use is skyrocketing.

There is some merit to another approach: using a combination of CBT and medication therapy. Doctors are discovering that, when medication therapy and CBT are used in tandem, results are often better than either could have produced alone. In the aforementioned MTA study, after 14 months, the combined treatment of CBT and medication therapy outperformed

behavioral treatment on over six factors, while straight medication therapy

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outperformed straight behavioral therapy on just three (qtd. in Foltz, 2010). In the same study, after 36 months the medication was continued and CBT ceased; the results showed that all of the initial gains provided by the medications had stopped while the positive effects provided by CBT were sustained (Foltz, 2010). Using a combination of the two methods also allows more flexibility for time-constraints when it comes to the parents, and eases up the amount of effort necessary on their part to maintain control over the symptoms. It would seem as if the ideal approach is using both medication and cognitive-behavioral therapy as a pair, at least until more tests are done to show the long term side-effects of stimulants or the efficacy of CBT.

So what's the verdict? The rise in ADHD diagnoses and stimulant usage over the years and the controversy that inevitably follows is very understandable. On one side there are the supporters who claim stimulants as a miracle medication, because it is a direct fix to the symptoms of ADHD. On the other side there are the skeptics who, while they know stimulants are an almost for-sure fix for the disorders, are still wary of giving a psychotropic drug to their children daily because of the potential risks, which is also completely understandable. There might not be a black and white answer for all children; it is situational with each child and while more may respond positively to the medication, some may not, or be better suited for another method of treatment such as cognitive-behavioral therapy (CBT). As long as the child receives a correct diagnosis, their doctor will help decide which method of treatment (or a combination of the two) might be more effective. Regardless, Cognitive-Behavioral Therapy has certainly shown some promise and should be used more often in the treatment of ADHD.