

Are different  
treatment approaches  
to managing children



**ASSIGN  
BUSTER**

Attention Deficit Hyperactivity Disorder (ADHD) is a recently established syndrome to describe one to seven percent of the population (Hinshaw, 1994), currently remaining one of the most common chronic disorders in childhood. The disorder arises in early childhood between the ages three and four and it often presents itself across the lifespan (Gittelman et al. , 1985). The disturbance manifests itself in emotional and behavioural deficits (EBD) with cardinal symptoms of inattention, hyperactivity and impulsivity (Safren et al. , 1994).

The disorder specifically interferes with the child's ability to inhibit or delay inappropriate behavioural responses to stimuli. This poor inhibitory control is commonly associated with executive function difficulties. In addition, ADHD is accompanied by many other disorders. These comorbid disorders include oppositional defiant disorder, conduct disorder (Moffitt and Silva, 1988), anxiety and depression (Biederman et al. , 1990; Livingston et al. , 1990; Anderson et al. , 1987). In fact, more than fifty percent of children with ADHD endure comorbid disorders (Biederman et al. 1992; Sprich-Buckminster et al. , 1993).

These children display difficulties in social interaction and as a result, have poor family and peer relationships. They tend to be far more vulnerable and susceptible to academic failure and exclusion from school with possible consequences including low self-esteem, delinquency and substance abuse (Barkley, 1998). Treatment for this unique population has varied considerably and is surrounded by controversy in terms of potentially competing or complementary approaches.

Considering the pervasive nature of this disorder, it is imperative that the most effective interventions are administered to this population. The causes of ADHD remains controversial but provide significant indications as to what the best forms of treatment should be employed to treat these children.

There is good evidence to support the theory that ADHD indicates a " within-child" model in that the difficulties the child presents to the world stem from biochemical disturbances in the brain's frontal lobe.

Recent brain imaging research has found significant abnormalities in the lobes of the brain, specifically in the location of the brain where attention is regulated (Cooper and O'Regan, 2001). Additional studies have demonstrated insufficient neurotransmitter production (Train, 1996; Levy and Swanson, 2001). These neurotransmitters are responsible for transmitting information among various parts of the brain and employ the role of regulating impulse control, concentration and motor regulation.

This biological-based theory has much supporting evidence since the primary deficits of the disorder are inattention, impulsivity and hyperactivity (Safren et al. , 2004). These disturbances can potentially result from brain injury, disease, lead ingestion, alcohol and drug abuse but it is generally recognized, for the most part, that this disorder is genetically inherited (Cooper and Ideus, 1996). Since there is strong evidence for a biological dysfunction in the brain, it seems only pertinent that any form of treatment will take this biological element into consideration.

Treatment has been widely administered in the form of stimulant medication such as methlphenidate (Ritalin), and dexophetamine (Dexedrine) (Cooper

and Ideus, 1996). Methylphenidate remains the most common and popular form of treatment and is now the most well-studied therapy in childhood psychiatry (Barkley, 1990). There is evidence to suggest that medication stimulates incessantly low levels of activity in particular areas of the brain and regulates the neurotransmitter underproduction in children with ADHD (Cooper and Ideus, 1996). Nevertheless, social and cultural influences cannot be so easily extracted out of the equation.

The children's external environment undoubtedly has an effect on the way in which their ADHD manifests itself. In fact, their social environment, family and relationships all play a fundamental part in shaping their current behaviours. Sameroff and Chandler (1975) in their transactional model examined the influences of social context and the family upon developing children and their behaviour. He demonstrated that the parental and social environment continuously related to and modified the way in which children develop and played an intrinsic part in shaping and managing their conduct.

There is an abundance of research to suggest that there is a difference in the brains of people with the disorder which leads to certain specific cognitive differences. However, the extent to which these cognitive characteristics are a problem/disorder depends entirely on the way in which that particular individual reacts to life's experiences (Cooper and O'Regan, 2001). The central implication of this is that interventions need to recognize that ADHD is inevitably a product of the interaction between nature and nurture (Train, 1996).

It cannot be disputed that stimulant medication does alleviate the core symptoms of ADHD to a huge degree and is effective in seventy to eighty percent of children (Train, 1996). Specifically, Ritalin has produced affirmative results in many studies impacting positively on concentration, general behaviour (Gadow et al. , 2002), academic performance, self-esteem (Frankel et al. , 1999) and ultimately reducing interfamilial tension (Hechtman, 1996). Medication primarily increases concentration and improves the ability to apply mastered tasks and skills (Gittelman et al. , 1983).

It does not directly improve academic skills or social and conduct performance (Kelly, 2003). It merely paves the way for these neurologically disabled children to be present " cognitively" and for teacher-learning type experiences amongst teachers and parents to have maximum impact. These teacher-learning type experiences come in the form of educational and behavioural interventions and parent training combined. In addition, there are a small but significant percentage of those inattentive children who do not respond to medication. These " non-responders" need appropriate interventions without the contribution of stimulant medication.

It has been established that the difficult behaviours that children with ADHD exhibit are not only the result of biological elements. Social and psychological factors influence these difficult behaviours and these factors need to be the focus of interventions to manage this pervasive disorder.

There is some support for nonpharmacological interventions but more often than not, there are inconsistencies in findings from such interventions. One such nonpharmacological intervention includes behavioural therapy and <https://assignbuster.com/are-different-treatment-approaches-to-managing-children/>

researchers have specifically focused upon training desirable behaviours and reducing the number of undesirable behaviours.

Behaviour management concentrates on increasing on-task behaviour, task completion, self-control and social skills while reducing off-task behaviour, hyperactivity and disruptive behaviour (Fiore et al. , 1993). The consistent use of token systems can also help to reduce socially unaccepted behaviour in children with ADHD and conduct disorder [Kelly, 2003 and NIMH, (2003 rev)]. Maximum effects of behavioural therapy are found when precise rules are established and rewards and consequences are provided on a regular and long-term basis (AAP, 2001).

Behaviour management strategies can be provided in the form of individual and family counselling, tailored to the needs of the child and family with ADHD. These sessions can serve in strengthening the child's low self-esteem, educating parents about the disorder and enhancing daily coping skills (Call-Schmidt and Maharaj, 2004). Educational interventions commonly use behavioural therapy. However, they are set apart from behavioural therapy in that the educators modify the circumstances presented to the child in order to inhibit the undesired behaviour.

The educators are to ensure that the child is preoccupied in worthwhile activities (Alban-Metcalfe and Alban-Metcalfe, 2001). In addition, there is significant evidence to support the theory that stress is a potent influence on these children's behaviour. Barkley (1997) emphasized the influence of stress in his cognitive model which is based on the hypothesis that the

organic etiology of individuals with ADHD leads to reduced efficiency in executive function which can be affected by stress and anxiety.

According to Barkley, this would inevitably mean that these problems with executive functions would be intensified when placed in stressful situations, such as when under social or emotional pressure. Educational interventions need to focus on children avoiding possibly stressful situations. Furthermore, evidence has demonstrated that these children are in fact capable of maintaining "normal" levels of concentration and attention on task if the task is sufficiently stimulating and equally structured and controlled.

A specific problem children suffering from ADHD have is maintaining attention and concentration after being distracted from a task (Sergeant, 1995, Van der Meere, 1996 and Borger and Van der Meere, 2000). This has significant implications for educational interventions and signifies the importance of producing every-day tasks in the classroom which minimize opportunities for children to become distracted. These theories represent the possible detrimental influence of situational factors on the cognitive characteristics that these children find themselves with.

There is an abundance of evidence, though not without its inconsistencies, that interventions such as educational and behavioural are maximally effective when combined with medication therapy (Hinshaw et al. , 1998; Kewley, 1999 and Pelham et al. , 1980). Essentially, medication therapy is a vital component in treatment of this disorder as it enhances fundamentally low cognitive functioning in children with ADHD and thus, allows nonpharmacological treatments to be maximally effective.

Nevertheless, it has been advocated that medication should never be applied as the sole intervention and treatment should be in the form of complementary interventions (Cooper and Ideus, 1996). The behaviours these affected children represent to their parents, teachers and peers are not only a consequence of their physical make-up but are also demonstrative of the quality of their compensatory and adaptive skills. Cognitive-behavioural interventions combine behavioural techniques with cognitive strategies to help parents and teachers develop strategies for children with this condition to provide effective learning and self-regulation.

Strategies, to name a few, encompass training in organizing and planning, dividing tasks into smaller steps to enable problem solving and teaching skills to reduce distractibility (DuPaul and Stoner, 1994). Research has demonstrated some beneficial effects for cognitive-behavioural therapy (Fehlings et al. , 1991; Meichenbaum and Goodman, 1971) but the majority of studies have failed to affirm these results (Brown et al. , 1986). However, cognitive-behavioural therapy for adults has demonstrated generally positive effects (Safren et al. , 2004).

A possible explanation for such discrepancies in findings with children may be the effects of inconsistent matches between children's cognitive capacities and the level of training tasks. Specifically, the extent to which they can learn and adopt strategies may be affected by their maturational level and in addition, their level of motivation to overcome these difficulties (Safren et al. , 2004). Although medication does significantly reduce the core symptoms of ADHD, it does not ensure children acquire the necessary compensatory strategies to deal with their experiences in the external world.

<https://assignbuster.com/are-different-treatment-approaches-to-managing-children/>



Nonetheless, stimulants have been described as facilitating the learning of appropriate behaviour and effective coping skills by maximizing the child's receptiveness to teacher-learning type experiences (Cooper and O'Regan, 2001). For instance, one study combined medication and cognitive-behavioural therapy and produced results beyond medication alone (Safren et al. , 2004). Clinicians emphasise the need for additional studies, and advocate cognitive-behavioural therapy as an essential component of comprehensive intervention programs (Fiore et al. 1993).

Originally, blame for children's emotional and behavioural difficulties rested in aversive parenting skills. However, these claims proved to be entirely unsubstantiated (Barkley, 1990). Nonetheless, it cannot be disputed that parents play important roles in shaping children's behaviour (Sameroff and Chandler, 1975). In fact, negative feedback in the form of adult criticism continuously damages already fragile self-esteem and tenuous coping skills among affected individuals (Cooper and Ideus, 1996).

Therefore, training of parents to understand the true nature of their child's disorder will undoubtedly be beneficial to the parents and the affected child. However, parent training is another under-evaluated psychosocial intervention. It typically involves parent-training programs whereby parents are taught behavioural strategies. Considering the inconsistencies found in behavioural interventions, it is no surprise that parent training has also demonstrated congruous results (Pelham et al. , 1980; Fierstone et al. , 1981).

However, consistent results have been found in reducing parents' stress levels and increased levels of competence following treatment (Pisterman et al. , 1992). This can indirectly lead not only to increased levels of self-esteem and self-worth among children with ADHD but also strengthened coping skills. Although it appears demonstrable that the cardinal symptoms of ADHD are caused by neurological under-stimulation, it seems ADHD is a multi-faceted problem comprising of interacting biological, psychological and social components.

Thus, it only seems appropriate that complementary interventions be employed to try to manage this special population by the most effective means possible and attend to not only biological, but social and psychological elements also. Stimulant medication is the most common and well-studied form of treatment available for children with ADHD (Barkley, 1990) and yet, nonpharmacological treatments have not been well-evaluated and used in the same way.

The American Academy of Pediatrics (AAP) advocates a multi-modal treatment approach comprising integrated components such as cognitive, behavioural, pharmacologic, psychosocial and educational approaches (Hinshaw and Erhardt, 1991; Train, 1996; AAP, Committee on Quality Improvement, 2000) Indeed, research has demonstrated, though not without its consistencies, that non-medical treatments often maximize the effects of medication alone and in some cases result in reductions in dosage (Hinshaw et al. 1998; NICE, 2000; Stein et al. , 2002; AAP, 2001; Jensen et al. , 2001 and Olfson, 2003).

Finding the appropriate dosage of medication is needed for children to reach their optimal level and similarly, nonpharmacological treatments need to be altered according to the needs of the individual. Thus, there is a strong need for investigators to test the larger issues related to developing comprehensive programmes that specifically target the individual's symptoms (Fiore et al. , 1993; Safren et al. , 2004).