ATTENTION DEFICIT HYPERACTIVITY DISORDER: A CASE STUDY

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ABSTRACT: Attention Deficit Hyperactivity Disorder (ADHD), is a severe public health issue that affects a huge number of youngsters. Attention deficit hyperactivity disorder (ADHD) is a complex disorder, which can be seen as a disorder of life time, developing in preschool years and manifesting symptoms (full and/or partial) throughout the adulthood. The aim of this paper is to examined the overview of ADHD in children in relation to its demographic profile, precipitating factor, history of present illness, history of present illness, history of present illness and diagnosis.

INTRODUCTION :

ADHD is a severe public health issue that affects a large number of children (Wilens & Spencer, 2010). ADHD is a well-known pediatric psychiatric illness with substantial genetic, neurobiological, and neurochemical underpinnings (Curatolo & Moavero, 2010). It is characterized by symptoms of inattention and/or impulsivity and hyperactivity which can significantly impact many aspects of behavior as well as performance, both at school and at home (Wilens & Spencer, 2010). ADHD is characterized by pervasive and impairing symptoms of inattention, hyperactivity, and impulsivity according to DSM-V (Gnanavel, Sharma, Kaushal & Hussain, 2019). The World Health Organization (WHO) uses a different name hyperkinetic disorder (HD)-but lists similar operational criteria for the disorder (Kessler & Üstün, 2004). Regardless of name used, ADHD is one of the most thoroughly researched disorders in medicine. The DSM diagnostic criteria for ADHD were based on reviews of existing research and a field trial in which alternative diagnostic criteria were evaluated (Cabral, Liu, & Soares , 2020).

Classification of what constitutes ADHD has changed dramatically over the last 32 years, with each successive revision of the Diagnostic and Statistical Manual, the diagnostic criteria used to describe the disorder (Mahone & Denckla, 2017). Current classification for combined type ADHD requires a minimum of six out of nine symptoms of inattention of hyperactivity/impulsivity. In addition there must be some impairment from symptoms in two or more settings (*e.g.* home and school) and clear evidence of significant impairment in social, school or work functioning (Epstein & Loren, 2013).

The DSM also allows the classification of two sub-type disorders:

i) Predominantly inattentive where the child only meets criteria for inattention; and

ii) Predominantly hyperactive-impulsive where only the hyperactive-impulsive criteria are met.

DEMOGRAPHIC PROFILE OF CASE

- **Name** : MS " G"
- **Age** : 13
- **Sex** : Male
- **Place of birth** : Jammu
- **Education** : 1st
- **Religion** : Hindu
- **Socio economic status** : Middle class
- **Domicile** : Rural
- **Informants** : Parents
- **Chief complaints** :
  - Poor retention
  - Low concentration
  - Distraction
  - Aggressive
  - Does not want to study
  - Disturbed sleep
  - Restless

PRECIPITATING FACTOR:- Mother was suffering extreme stress during this pregnancy. Relationship with the in laws and money problem was the root cause of extreme stress during pregnancy.

HISTORY OF PRESENT ILLNESS: - The child's milestones developed late, his speech developed at the age of "4". He started walking at the age of 'one year'(normal development in walking).He was quiet normal but Development was delay.

The fist doctor to whom parents consulted labeled him a patient of ADHD (ATTENTION DEFICIT HYPERACTIVITY DISORDER) IN JAMMU; according to DSM IV.

The dr "A" (NEUROPSYCHIATRIST) was consulted. He recommended the medicines

- tab Adderall 0.5 mg ½
- syp. Methylin

Then dr j was consulted . He recommended

- 1 cognitive behavior therapy
- 2 sports (30 minutes running in morning & evening time)

At present the child is improving slowly and steady. However the patient is quiet normal but because of ADHD, he is categorized as middle ordered.

HISTORY OF PAST ILLNESS:- no case of mental and physical illness in the family.

- **Personal history**:-
  - ✓ **Birth :** full term (9 month) normal delivery.
  - ✓ **Development: -** normal development in milestones (walking at 1 year) and delayed development in milestones (speech at 4 yrs).
- **Family history:** joint family – grandfather, grand mother, father, mother and 1 sister. No case of mental retardation in the family. The patient relates best to his mother.
- **Educational history: -** later admitted to Sahara; then his school was changed, he was admitted to other school which is also basically for the mental retarded children contain good education facilities eg computer, drawing. The child is able to write and read.
- **Marital status: -** unmarried.
- **Sexual history: -** normal development of primary and secondary sexual characteristics.
- **Religious:-** normally indulge in prayers like taking name of god like to dance on the bhajans . He also learn fall "hanuman chalisa".

MENTAL STATUS EXAMINATION

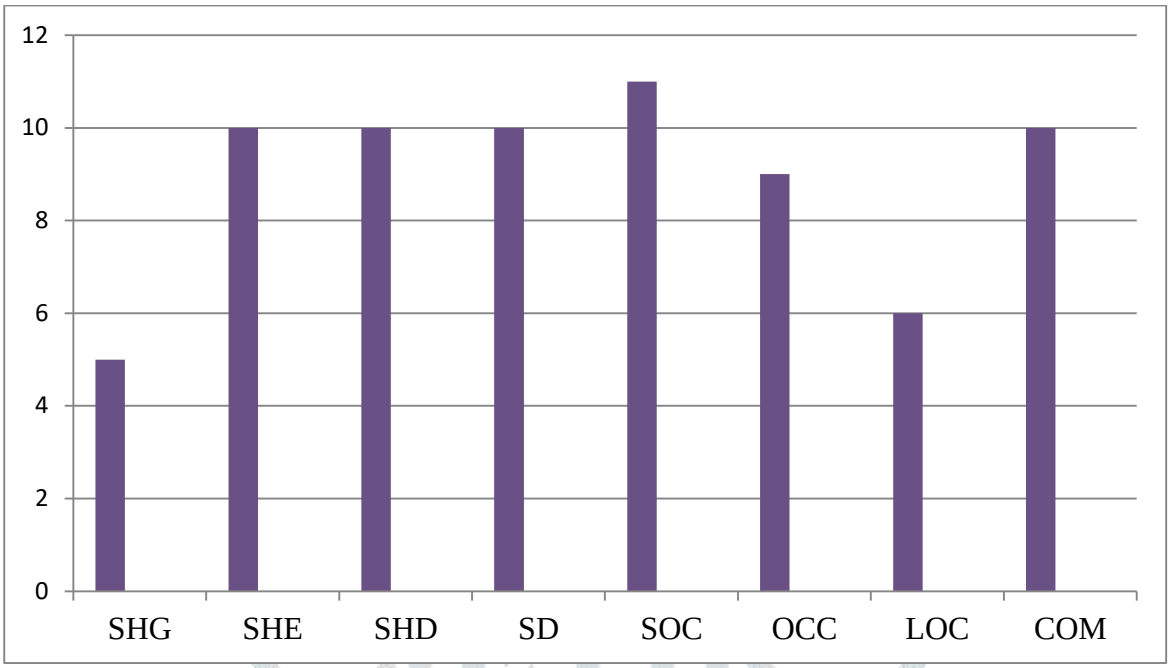
- **GENERAL APPEARANCE:-** he sat comfortably, he is also able to make full eye contact, he is always properly dressed. Gender- tall, dark complexion, healthy.
- **ATTITUDE:-** he is open frank and also a help and attention seeking.
- **PSYCHOMOTOR ACTIVITIES**:- Normal , ability to write and draw.
- **SPEECH**:- Fast speech, while talking he don't make eye contact because he is busy to attend the other stimulus.
- ➢ Pitch:- high

- Volume:- Normal
- Tone:- Normal

- **MOOD**:- No Predominant effective state
- **THINKING**:- Flow Normal
    - Contact : Normal
- **PERCEPTION**:- No abnormality in perception.
- **ATTENTION AND CONCENTRATION**:- present
- **MEMORY**:- inadequate information
- **INTELLIGENCE**:-
    - ✓ Arithmetic ability:- he is average in arithmetic ability. He knows that table till five and able to solve single digit addition seems.
- **JUDGEMENT:**- Inadequate information
- **INSIGHT**:- the patient has insight of level – I , complete denial of illness.

- **DIAGNOSIS:**-Test Administrated VIMELAND SOCIAL MATURITY SCALE (VSMS) was used to assess the level of retardation and to measure the development in Eight areas.
    - Self Help General (SHG)
    - Self Help Eating(SHE)
    - She Help Dressing(SHD)
    - Self Direction(SD)
    - Socialization(SOC)
    - Locomotion(LOC)
    - Occupation(OCC)
    - Communication(COM)
- **TEST FINDING**:- The SQ came out to be 62 which shows that the patient is " mild mental retardation"

PROFILE ANALYSIS



GRAPH SHOWING SOCIAL AND ADAPTIVE FUNCTIONING OF THE PARTICIPANT

TREATMENT:- Specific treatment (BT) behavioral therapy was given to patient was recommended.

Currently the patient takes medicine and counseling also.

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