Childhood ADHD and Negative Self-Statements: Important Differences Associated With Subtype and Anxiety Symptoms

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The current study examined the role negative self-statements have on the comorbidity between anxious symptomatology and ADHD-combined presentation (ADHD-C) and ADHD-predominantly inattentive (ADHD-I). A total of 114 children and adolescents with ADHD (M age = 10.15; SD = 2.30; range = 7–16) from a clinic-referred sample were grouped based on a semistructured diagnostic interview and consensus approach (ADHD-C, n = 62; ADHD-I, n = 52). Negative self-statements were measured using the Children’s Automatic Thoughts Scale and the total score from the Multidimensional Anxiety Scale for Children was used to measure anxious symptomatology. Findings indicated youth diagnosed with ADHD-C, compared to those diagnosed with ADHD-I, had more frequent personal failure (Cohen’s d = .40) and hostile intent negative self-statements (Cohen’s d = .47). The association of ADHD subtype and negative self-statements was moderated by anxiety; negativeself-statements of personal failure were highest in anxious ADHD-C children (β = .31). A second sample of 137 children and adolescents (M age = 10.61; SD = 2.26; range = 7–16) from a larger clinic-referred sample was utilized to replicate our results dimensionally. Results indicated that both hyperactivity/impulsivity (β = .23, p < .01) and the interaction of hyperactivity/impulsivity and anxiety (β = .17, p < .05) were significant predictors of negative self-statements regarding personal failure, while holding child age, child gender, oppositional symptoms, and inattention constant. In all, negative self-statements should be considered in the treatment and assessment of ADHD with particular attention paid to ADHD subtype and internalizing comorbidity.

Keywords: ADHD; negative self-statements; anxiety

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) is a neuropsychiatric developmental disorder characterized by inattention, impulsivity, and hyperactivity (American Psychiatric Association, 2013). ADHD emerges in childhood, affecting anywhere between 5% and 11% of children (American Psychiatric Association, 2013; Center for Disease Control, 2011; Mangeot, 2001). Childhood ADHD is impairing and associated with impairment in academic achievement (Wilson & Marcotte, 1996), family interaction, peer relationships (DuPaul, McGoey, Eckert, & VanBrakle, 2001), self-esteem (Harpin, Mazzone, Raynaud, Kahle, & Hodgkins, 2016), and health-related quality of life (Klassen, Miller, & Fine, 2004). Moreover, ADHD is commonly comorbid with externalizing as well as internalizing disorders (Jensen et al., 2001). In particular, ADHD with comorbid anxiety is associated with lower self-esteem (Brown, 2000) and more stressful life events (Brown, 2000; Pliszka, Carlson, & Swanson, 1999). Although children with noncomorbid ADHD and anxiety have been shown to have similar levels of worry (Perrin & Last, 1997), research has yet to fully explore other types of maladaptive thoughts, such as negative self-statements or automatic thoughts, in children with ADHD and comorbid anxiety.

ANXIETY AND ADHD

Like ADHD, child anxiety disorders are also highly prevalent, with estimates ranging from 3% to 32% depending on the disorders included, sample, methodology, and time period (Cartwright-Hatton,
McNicol, & Doubleday, 2006; Merikangas et al., 2010). Anxiety disorders in childhood and adolescence can cause psychosocial impairment, and, if left untreated, predict increased risk for other mental disorders and substance use problems in adulthood (Kendall, Safford, Flannery-Schroeder, & Webb, 2004; Pine, Cohen, Gurley, Brook, & Ma, 1998; Silverman & Treffers, 2001). Overall, childhood anxiety has a moderate to high impact on functioning (Demyttenaere et al., 2004) with the largest impact being on the child’s family processes (i.e., increased discord with parents and siblings; Ezpeleta, Keeler, Erkanli, Costello, Angold, 2001). Moreover, research has found that anxiety disorders also affect children’s functioning in peer relations, school, and recreation (e.g., Davis, Ollendick, & Nebel-Schwalm, 2008; Essau, Conradt, & Petermann, 2000; Strauss, Frame, & Forehand, 1987). Longitudinal research suggests that the functioning of children with anxiety disorders continues to decrease from childhood into early adulthood (Casp, Elder, & Bem, 1988; Last, Hansen, & Franco, 1997; Woodward & Fergusson, 2001).

Overall, ADHD is highly comorbid with anxiety disorders in childhood (for reviews, see Jarrett & Ollendick, 2008, and Schatz & Rostain, 2006), with 30% to 40% of clinically referred children with ADHD meeting criteria for a comorbid internalizing disorder (MTA Cooperative Group, 1999; Tannock, 2009). There is some evidence that the prevalence of ADHD and comorbid anxiety, specifically, is as high as 50% (Mancini, Van Ameringen, Oakman, & Figueiredo, 1999), with 27% meeting criteria for more than one anxiety disorder (Spencer, Biederman, & Wilens, 1999). The low frequency of ADHD without a comorbid diagnosis has led some researchers to support distinct comorbid diagnostic subtypes of ADHD (Barkley, 2006; Jensen et al., 2001).

PHENOTYPIC DIFFERENCES IN YOUTH WITH ADHD AND COMORBID ANXIETY

Pliszka et al. (1999) suggested that children with ADHD and comorbid anxiety are phenotypically different from those without the comorbid presentation. However, as Tannock (2009) notes, the effects of ADHD and comorbid anxiety on ADHD symptomatology have been inconsistent. For example, although there is some evidence that the presence of anxiety is associated with greater inattention relative to impulsivity (Jensen et al., 2001; Newcorn et al., 2001), this has not always been found (Abikoff et al., 2002; Davis et al., 2008; Vloet, Konrad, Herpetz-Dahlmann, Polier, & Gunther, 2010). Similarly, some researchers have found that ADHD and comorbid anxiety improves response inhibition (Manassis, Tannock, & Barbosa, 2000; Oosterlaan, 1998; Pliszka, 1992; Pliszka, Hatch, Borcherding, & Rogeness, 1993; Yurtbaș, et al., 2015), but a meta-analysis of clinical literature did not find evidence for this association (Oosterlaan & Sergeant, 1998). As well, some researchers have found ADHD with comorbid anxiety is associated with greater ADHD severity (Tsang et al., 2015), whereas others have not (Jarrett et al., 2016). These discrepancies may reflect differences in community versus clinical samples or inconsistencies in how the research groups are measuring inattention, impulsivity, and symptom severity (e.g., self-report, performance measures, parent reports, etc.). However, research on increased working memory deficits (Jarrett, Wolff, Davis, Cowart, & Ollendick, 2016; Pliszka, 1989; Skirbekk, Hansen, Oerbeck, & Kristensen, 2011; Tannock, Ickowicz, & Schachar, 1995) and reduced emotion recognition (Manassis et al., 2000; Manassis, Tannock, Young, & Francis-John, 2007) in children with ADHD and comorbid anxiety has been more consistent.

NEGATIVE SELF-STATEMENTS IN YOUTH

Differences in maladaptive cognitions, such as negative self-statements, have seldom been explored in children with ADHD and comorbid anxiety. However, negative self-statements have been found to be a critical factor in the development and maintenance of mood dysregulation in children, with changes in cognition seen as vital for treatment (Beck, 1967; Kendall, 1984; Kendall & MacDonald, 1993; Rapee, Wignall, Hudson, & Schniering, 2000; Treadwell & Kendall, 1996). Drawing on Beck’s theory, negative emotional states typically involve self-statements (i.e., internal dialogue) that often have particular themes (Beck, 1967, 1976). This internal dialogue can involve voluntary cognitions, automatic thoughts, self-statements, and images. Beck, Brown, Steer, Eidelson, and Riskind (1987) posited that negative self-statements, or automatic thoughts, are crucial in delineating affective states. Further, it is suggested that each disorder is characterized by self-statements with unique cognitive content. As well, Beck’s cognitive theory hypothesizes that negative self-statements reflect content of maladaptive schemas (Beck, 1967, 1996). For instance, anxiety is thought to be associated with thoughts of perceived vulnerability, physical or psychological threat. In contrast, depression is associated with negative self-statements of negativity, personal loss and failure (Beck, 1967, 1976; Beck, Rysh, Shaw, & Emery, 1979). Negative self-statements underlying conduct problems likely correspond to perceptions of being wronged, and provide the justification for aggressive behavior (Beck, 1999). Cognitive theorists have translated this model to youth, which is described in more detail below.
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