A WALK THROUGH THE DSM 5: Attention-Deficit/Hyperactivity Disorder (ADHD) & Externalizing Disorders (ODD)

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Disclosures

• Dr. Hill has a contract with IHS for neuropsychological assessment of children through her private practice.

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Overview of Neurodevelopmental Series

• **Session 1:** Intellectual Disabilities

• **Session 2:** Communication Disorders

• **Session 3:** ADHD/Externalizing Disorders

• **Session 4:** Specific Learning Disorders

• **Session 5:** Motor Disorders

• **Session 6:** Special Topics
Session 3 Goals

• Identify children with ADHD and/or ODD.
• Recognize differential diagnoses of ADHD and/or ODD.
• Provide families with directions to accessing resources and interventions for ADHD and/or ODD.
Attention-Deficit/Hyperactivity Disorder (ADHD)

- Oppositional Defiant Disorder (ODD)
ADHD
Diagnostic Criteria

• A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development

Subtypes:

• ADHD Predominantly Inattentive Presentation
• ADHD Predominantly Hyperactive/Impulsive Presentation
• ADHD – Combined Presentation
ADHD – Inattentive Type Diagnostic Criteria

• Six or more symptoms that have persisted for at least 6 months in a degree inconsistent with developmental level and negatively impacts functioning
  • Fails to give close attention to details/careless mistakes
  • Difficulty sustaining attention
  • Doesn’t seem to listen when spoken to directly
  • Doesn’t follow through on instructions/fails to complete tasks
  • Difficulty organizing tasks/activities
  • Avoids/dislikes tasks that require sustained mental effort
  • Often loses things
  • Easily distracted by extraneous stimuli
  • Often forgetful in daily activities
ADHD – Hyperactive/Impulsive Diagnostic Criteria

- Six or more symptoms that have persisted for at least 6 months in a degree inconsistent with developmental level and negatively impacts functioning
  - Often fidgets
  - Leaves seat when expected to be seated
  - Runs about/climbs in inappropriate situations
  - Unable to play/engage in leisure activities quietly
  - Is often “on the go” acts as if “driven by a motor”
  - Talks excessively
  - Blurts out answers
  - Difficulty waiting turn/waiting in line
  - Interrupts others/intrudes on others
ADHD
Diagnostic Criteria

• B. Several symptoms prior to age 12
• C. Several symptoms present in two or more settings
• D. Clear evidence that symptoms interfere with or reduce quality
• E. Not occurring exclusively during a psychotic d/o and not better explained by other mental d/o
ADHD
Comparison DSM-IV & DSM-5

• ADHD now be found in the “Neuro-developmental Disorders” chapter to reflect brain developmental correlates with ADHD.

• Examples have been added to the criterion items to facilitate application across the life span

• The onset criterion has been changed from “symptoms that caused impairment were present before age 7 years” to “several inattentive or hyperactive-impulsive symptoms were present prior to age 12”
ADHD
Comparison DSM-IV & DSM-5

• Subtypes have been replaced with presentation specifiers that map directly to the prior subtypes

• A co-morbid diagnosis with autism spectrum disorder is now allowed

• A symptom threshold change has been made for adults
ADHD
Demographics

• Population surveys suggest that ADHD occurs in most cultures in about 5% of children and about 2.5% of adults.

• Prevalence by Race
  • White: 9.6%
  • Black: 10.5%
  • American Indian/Alaska Native: 6.4%
  • Asian: 1.4%
  • Multiple Race: 11.6%
ADHD
Etiology & Risk Factors

• Very low birth weight conveys a two-to-threefold risk for ADHD
• Smoking during pregnancy
• History of child abuse, neglect, neurotoxin exposure (e.g., lead), infections (e.g., encephalitis), or alcohol exposure in utero.
• ADHD is elevated in the first-degree biological relatives of individuals with ADHD.
• Visual/hearing impairments, metabolic abnormalities, sleep disorders, nutritional deficiencies, and epilepsy should be considered as possible influences on ADHD symptoms.
ADHD
Development & Course: Childhood

• May first observe excessive motor activity when the child is a toddler, but symptoms are difficult to distinguish from highly variable normative behaviors before age 4 years.

• In preschool, the main manifestation is hyperactivity.

• ADHD is most often identified during elementary school and inattention becomes more prominent and impairing
ADHD
Development/Course: Adolescence & Adulthood

• The disorder is relatively stable through early adolescence, but some have develop antisocial behaviors.

• In most with ADHD, symptoms of hyper-activity become less obvious but difficulties with restlessness, inattention, poor planning, and impulsivity persist.

• A substantial proportion of children with ADHD remain relatively impaired into adulthood.
ADHD
Functional Consequences

• Reduced school performance/academic attainment
• Impaired peer relationships
• More likely to develop conduct disorder in adolescence and antisocial personality disorder in adulthood,
• Increased likelihood for substance use disorders and incarceration
• More likely than peers to be injured.
ADHD
Functional Consequences

- On average, individuals with ADHD obtain less schooling, have poorer vocational achievement, and have reduced intellectual scores than their peers, although there is great variability. In its severe form, the disorder is markedly impairing, affecting social, familial, and scholastic/occupational adjustment.
ADHD
Co-Morbid Conditions

• Oppositional Defiant Disorder (ODD)
• Other Externalizing Disorders
• Mood disorders/Anxiety Disorders
• Specific Learning Disorders
• Substance Use Disorders
• Autism Spectrum Disorders
ADHD
Differential Diagnosis

• Externalizing Disorders
• Autism Spectrum Disorder
• Motor Disorders
• Learning Disorders/Intellectual Disabilities/Language Disorders
• Reactive Attachment Disorders
• Mood/Anxiety Disorders
• Medication-Induced ADHD Sx
• Neurocognitive Disorders
ADHD
Screening & Evaluation

• Screening can occur in a variety of settings
• Screening Tools: free/available online, does not result in diagnosis
• Evaluation Guidelines
ADHD Interventions/Treatment

• Evidence-based psychosocial interventions
• Evidence-based medication interventions
• Interventions not supported
ADHD and Medication Intervention

- The main medications used to treat ADHD are stimulants and nonstimulants. Sometimes antidepressants are also used.
Stimulant medications

• Methylphenidate Dexmethylphenidate

• Amphetamine Amphetamine/dextroamphetamine
  Dextroamphetamine Lisdexamfetamine
Nonstimulant Medication

• These non-stimulants are FDA-approved for ADHD in children and teens:
  • Atomoxetine
  • Clonidine ER
  • Guanfacine ER
ADHD
Cultural Considerations for Diagnosis, Intervention, Health Information Exchange

• ADHD in American Indian/Alaska Native children
• Medical home for individuals with ADHD
• Role of PCP in ADHD
• Impact of ADHD on health information exchange
Oppositional Defiant Disorder (ODD) Diagnostic Criteria

- Includes at least four symptoms
  - Angry/irritable mood
  - Argumentative/defiant behavior
  - Vindictiveness
- Occurs with at least one individual who is not a sibling
- Causes functional impairments
- Occurs on its own, rather than as part of the course of another mental health problem
- Lasts at least six months
ODD
DSM-4 versus DSM-5

• Disruptive, Impulse-Control, & Conduct Disorders Category
• Symptoms are grouped into three types
• Removal exclusion criteria for conduct disorder
• Frequency needed for a behavior to be symptomatic of the disorder
• Severity rating has been added reflecting pervasiveness
ODD
Demographics

• Prevalence: average 3.3% (range: 1% - 16%)
• Rate varies depending on age/sex
• More prevalent in males than females (1.4 to 1) prior to adolescence
• Consistent across race/ethnicity
ODD
Etiology/Risk Factors

• Biological Factors
  • Genetic
  • Brain injury
  • Prenatal exposure
  • Poor nutrition

• Psychological Factors
  • Parental relationships
  • Social relationships

• Social Factors
  • Poverty
  • Chaotic environment
  • Abuse/Neglect
ODD
Development and Course

• First symptoms usually seen in preschool years, rarely later than early adolescence

• ODD often preceded Conduct Disorder

• Increased risk for problems in adulthood
ODD
Assessment & Interventions

• Diagnostic Evaluation

• Treatment:
  • Parent-Management Training Programs/Family Tx
    (Triple P-Positive Parenting Program: www.5.triplep.net)
  • Cognitive Problem-Solving Skills Training
  • Social Skills Programs/School-Based Programs
  • Motivational Interviewing
  • Collaborative Problem Solving (www.explosivechild.com)
  • Medications
  • Therapies not shown to work
ODD
Cultural Considerations for Diagnosis, Interventions, & Health Information Exchange

• Different cultures/different families have different thresholds of tolerating externalizing behaviors

• Medical Home roles
  • Identifying the clinical concern for ODD/CD
  • Ensuring referral and treatment by a psychologist
  • Ensuring the parents know how to access appropriate school services
  • Ensuring family-centered team collaboration
  • Supporting parents in advocating for needed supports
  • Prescribing medication or consulting with a psychiatrist when indicated

• Impact of ODD on health information exchange