Applied Psychiatry

OPINION

ADHD as Shifting Disorder Throughout Age and Comorbidities: The Diagnosis Challenge

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Introduction:

Attention-Deficit/Hyperactivity Disorder (ADHD) is a common childhood behavioural disorder, estimated to affect around 3-5% of children [1]. Around 5% of children have significant difficulties with these behaviours, presenting a challenge for detection by meeting the complete diagnostic criteria [2]. ADHD often persists into adulthood and is a risk factor for a wide range of other mental health problems, including defiant, disruptive, and antisocial behaviours, emotional problems, self-harm and substance misuse, as well as broader adverse outcomes such as educational under-achievement and exclusion from school, difficulties with employment and relationships, and criminality [3-5].

Thus, ADHD leads to impairments in essential areas of life such as social relationships, education, family life, professional life, economic independence and compliance with social rules, norms and laws. The patients also suffer more physical injuries and accidental poisoning [6].

ADHD is characterized by a continuous pattern of inattentiveness, overactivity and impulsiveness.

The definitions of the disturbances differ in the two valid classification systems ICD-10 and DSM-V. The most significant difference in this regard is the division into subtypes. While the hyperkinetic syndrome (HKS), according to ICD-10, must have both inattentiveness and overactivity and impulsivity, the DSM-V opens up the possibility to classify subtypes attending only the attention only the hyperactivity/impulsivity, or a combination of both [7].

The "inattentive subtype" described in the DSM-V appears to be a less pronounced variant of the disorder.

In general, the severity can be determined by the intensity of the symptoms, the degree of generalization in different areas of life (family, school, leisure area) and the extension to areas in which the symptoms are not only in externally determined situations (e.g. school, homework) but also in self-determined situations (play).

The prevalence rates of HKS (ICD-10) are estimated at 1-3%, while the prevalence rates for ADHD (DSM-V) are estimated at 3-5% of schoolchildren (6 to 14 years). The predominantly inattentive type accounts for 35-50% of cases. Boys are affected two to four times more often than girls. The prevalence in adult population samples is estimated at 1.3-4.7%. Girls with ADHD have less pronounced symptoms of hyperactivity, inattention, impulsiveness and externalizing problems, but they are more likely to have intellectual impairments and internalizing problems (e.g. depressive mood) [8] [9].

The diagnostic procedure, the recording of possible comorbidities and their prevalence rates, and the differential diagnosis are divided into several steps. Firstly, the exploration of the symptoms starts. In addition to the occurrence of main symptoms, exploration describes the frequency, intensity and situational variability of the symptoms. Another aspect in diagnostics should be the exploration of the disorder-specific development history, as well as the recording of the psychiatric comorbidity and the accompanying disorders (disruption of social behaviour, school performance deficits, reduced intelligence, depressive disorders, tic disorders and anxiety disorders). The next step in diagnostics includes general conditions relevant to the disorder, for example, inconsistent parenting behaviour, a lack of warmth in the family relationship, failure concepts of parents and teachers, and their therapy expectations and their willingness to actively participate as well as the cooperation with family and paediatricians, neurological examination and the performance of hearing and vision tests.

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Psychological diagnostics must follow this for schoolchildren, in which the psychological test examination of intelligence and partial school performance is necessary if there are indications of performance problems or insufficient or excessive demands on the school. Besides, questionnaire procedures can be used (for example, Conners questionnaire, external and self-assessment questionnaire for hyperkinetic disorders [FBB-HKS, SBB-HKS], Child Behavior Checklist [CBCL], Teacher Rating Form [TRF], Strengths and Difficulties Questionnaire [SDQ]).

Behavioural observation is important during diagnostics. It can be supplemented by equipment diagnostics, for example, to objectify attention disorders using the Continuous Performance Test (CPT).

The information obtained through the diagnosis should flow into a multiaxial evaluation. This requires a summary of the diagnostic results and verification of the presence of the main symptoms of attention deficit disorder, hyperactivity and impulsivity.

If the criteria for social behaviour disorders are also met, then a hyperkinetic disorder of social behaviour (F90.1) is diagnosed. Disruptions in social performance are characterized by a repetitive and persistent pattern of dissocial, aggressive or defiant behaviour. It must also be determined whether there are circumscribed developmental disorders, a reduction in intelligence, organic diseases and current abnormal psychosocial conditions. Furthermore, a global assessment of psychosocial adjustment must be performed.

The course and prognosis of the HKS and AHDS are very individual. Three probable forms, of course, are described for the HKS [10]. The symptoms can recede from adolescence or persists into adulthood, which affects 50% of patients. A third possibility is transitioning the hyperkinetic syndrome into another disorder (for example, addictions, disorders social behaviour, anxiety and mood disorders). The early detection of symptoms and the start of treatment should be done before the disorders appear in early adolescence. It has been reported that prognosis ranges from early school leaving (32 to 40%) to antisocial activities (40 to 50%) and poor performance in the workplace (70 to 80%) [6].

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