ADHD Practice Guidelines And Then Some: What's Missing?

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ADHD is Considered to be a Common Childhood Condition

- Extensively researched
- AMA Council on Scientific Affairs 1998 quote ”Overall ADHD is one of the best-researched disorders in medicine and the overall data on it’s validity are far more compelling than for many medical disorders.”
- Writers for American Academy of Child and Adolescent Psychiatry ADHD Practice Guidelines go one step further and assert “Although scientists and clinicians debate the best way to diagnose and treat ADHD, there is no debate among competent and well informed health care professionals that ADHD is a valid neurobiological condition..”

Epidemiology

- Multiple large studies, some of which had as many as 100,000 children, indicate a national lifetime prevalence of an ADHD diagnosis in 7.5% of children between the ages of 4 and 17 years.
- Although it is difficult to quantify the extent, there is significant evidence that symptoms of ADHD persist into adulthood.
- Upon general review of adult data the "rule of thirds" still seems to apply

Comorbidities

- 2/3 of children with ADHD will meet criteria for Oppositional Defiant Disorder and a significant number of these will go on to develop Conduct Disorder
- 1/6 of children with ADHD will go on to smoke or develop other substance use disorders
- 1/3 will have a coexisting learning or language problem
- 1/3 will have an anxiety disorder
- Research on the prevalence of mood disorders is more controversial ranging from 0 to 33%

Etiology: underlying brain function

- Neuropsychological testing research shows impairments in executive functioning areas of “response inhibition” e.g. impulse control, “vigilance” e.g. attention and concentration, “working memory” e.g. holding thoughts or information in the moment for immediate application, and “some measure of planning” e.g. organizational abilities.

Etiology: genetics and other causes

- Twin studies indicate a high correspondence of genetic factors. 3/4 of twins have corresponding ADHD symptoms compared to 1/8 of the general population.
- Genome and Chromosome studies are complex and varied with genetic marker correlations at chromosomes 4, 5, 6, 8, 11, 16, and 17
- Non-genetic cause correlates include perinatal stress and low birth weight, traumatic brain injury, maternal smoking during pregnancy, and severe early deprivation associated with institutional rearing and child maltreatment.

ADHD Evaluation and Diagnosis DSM V Diagnostic Criteria

- Clinical interview with child and parent plus parent and teacher rating scales (Connors is a common one but there are many others) and/or obtain information directly from the school
- Always ask/screen for other psychiatric disorders of childhood and adolescence: LD, ODD, CD, SA, Anxiety, Mood, Psychosis as they may mimic ADHD
- Extensive medical workup not indicted as so few conditions masquerade as ADHD
- Psychological testing not indicated for ADHD Diagnosis but to rule out LD or low cognitive functioning

DSM 5 Diagnostic Criteria

≥ 6 symptoms present for ≥ 6 months (adults and adolescents aged ≥ 17 years require ≥ 5 symptoms) that

- clearly interfere with function
- are inappropriate for developmental level

several symptoms must be present in ≥ 2 settings (home, school, work, with friends, etc.)

symptom threshold ≥ 6 (or ≥ 5 for patients ≥ age 17 years) must be met in either inattention or hyperactivity-impulsivity category to be diagnosed with that subtype; patient with symptom threshold must be met in both categories to qualify for diagnosis of combined subtype

Inattention Symptoms

- fail to pay close attention to details or makes careless mistakes in schoolwork, work, or other activities
- have difficulty holding attention on tasks or play activities
- seem not to listen when directly spoken to
- get easily side-tracked, often not following through on instructions and failing to finish schoolwork, chores, or other duties
- have trouble organizing tasks and activities
- avoid, dislike, or are reluctant to do tasks requiring mental effort over a long period of time
- lose things necessary for tasks or activities (school materials, pencils, books, wallets, tools, keys, eyeglasses etc.)
- are easily distracted
- are forgetful in daily activities

Hyperactive Impulsive Symptoms

- fidget with or tap hands and/or feet; or squirm in seat
- leave seat when remaining seated is expected
- run about or climb in inappropriate situations (for older children and adolescents this may be limited to feeling restless)
- unable to play or take part in leisure activities quietly
- are "on the go" acting like they are "driven by a motor"
- talk excessively
- blurt out answers before questions have been fully articulated
- have trouble waiting for their turn
- interrupt or intrude on others (in conversations or in games)

Other Criteria

- several inattentive or hyperactive-impulsive symptoms must be present before 12 years old
- symptoms are not better explained as part of alternative disorder or only present during course of schizophrenia or other psychotic disorder
- symptoms may change over time, altering child's ADHD presentation
- May be comorbid with Autism

Treatment

- Behavioral therapy
- Medications
  - Methylphenidate products
  - Methlyphenidate derivatives (Focalin)
  - Dextroamphetamine products
  - Dextroamphetamine derivatives (Vyvanse)
  - Strattera
  - Alpha 2-agonists
  - Others (TCA's, Wellbutrin, Buspar, Effexor, SSRI)

Beyond Medical Algorithms: Common Sense Psychiatry

- Over the past thirty years I have found that, in psychiatry, more often than not, things really *are* as they appear.
- If one is living under stressful circumstances eg., experiences trauma, and begins to exhibit behavioral problems, it is often, at least in part or in whole, a reaction to those circumstances.
- In some cases, if the circumstances can be corrected, ADHD symptoms will remit.
- As can be seen from the Practice Guidelines above standard psychiatry often bypasses common sense
- ADHD is seen as first and foremost as a genetic and neurochemical disease to be eradicated medically.

We Are More Than Molecules

- The most effective form of psychiatric medicine is when the practioner engages with the whole individual and their family *before* diagnosing
- Treatment is most effective when we truly come to know our clients as people first
- If we don't know our clients and we don't ask, we may miss what underlies or is causing the symptoms of ADHD

The Three Pillars of Common Sense For Psychiatry

- Pillar I) When something ‘perceived as’ devastating occurs, emotional and behavioral changes are the rule rather than the exception
- Pillar II) After an event, if an individual is unable to return to a functional baseline in a period of time reasonable to them, there are other underlying factors operating. I call these the “Developmental Trauma Risk Factors,” The consequences of which can mimic any mental disorder particularly ADHD
- Pillar III) Only *after* all other avenues have been explored and attempts at resolution failed [Identify Trauma/Explore on going causes and conditions/and resolve them] should the biomedical mental illness model based on DSM 5 diagnostic check list(s) take the front seat.

Context Is Everything

- The Three Pillar model places symptoms in context and goes beyond biology
- One goal is to communicate that the essence of the individual is “the main event,” not the diagnosis
- This empowers a shift in perspective. The symptoms of a mental condition become the side show while what the individual needs to be whole (safe) becomes the main event

Medication In Context

- By addressing causes and conditions treatment effectiveness soars
- Client families become open to the idea that medication alone is not the answer, not the magic bullet
- Client families are more likely to actively engage in treatment as they become educated to the fact that medication is merely the “oil” while they and their participation in creating a recovery environment is the “machinery” of healing

Why The Three Pillar Model?

- A common reason for treatment non-response or "resistance" is society's expectation and the psychiatric prescriber's hair trigger response of trying to medicate to the symptom check list without first discerning and resolving underlying causes and conditions.
- Medicating symptoms without addressing causes has limited effectiveness.
- Prescribing at symptoms misses the mark (sometimes for years): ends up 'looking like' treatment failure
- What often has occurred is ineffective medication treatments of conditions that mimic ADHD