

The Evolution of the ADHD Diagnosis and its Implications for DSM-5

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The diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) has changed greatly through the years. A century ago, it didn't even exist. One of the first references to children who were unable to concentrate, hyperactive and displayed problems with learning was in 1902 [1]. DSM-I made no reference to the diagnosis. The closest diagnosis clinicians could cite was Minimal Brain Dysfunction [2], which was used to describe children who had hyperactive and impulsive behavior. The syndrome was thought to be of organic etiology.

It wasn't until 1968 that DSM-II [3] first acknowledged the syndrome and called it Hyperkinetic Syndrome of Childhood. In 1980, DSM-III [4] renamed the syndrome Attention Deficit Hyperactivity Disorder - with or without hyperactivity (ADHD and ADD). Then, DSM-III-R [5] classified the disorder in 1987 under the new category heading of Disruptive Behavior Disorder and changed the name to Attention Deficit Hyperactivity Disorder (ADHD), omitting the ADD category.

DSM-IV [6] kept the diagnosis largely the same but broke it into three subtypes: Attention Deficit Hyperactivity Disorder Combined Type, predominately Inattentive Type and predominately Hyperactive/Impulsive Type. Clinicians followed these guidelines until 2000.

At that time, DSM-IV TR [7] changed things a bit more. It still required the presence of 6 out of 18 behaviors, which was established during DSM-IV, but instead of three subtypes, it added a fourth category of Attention Deficit Hyperactivity Disorder, not otherwise specified.

That all laid the groundwork for the most recent DSM, DSM-5 [8] published in 2013, which no longer refers to the diagnosis as a type but instead a presentation. It codes it as Attention Deficit Hyperactivity Disorder, combined presentation, predominately Inattentive presentation and predominately Hyperactive/Impulsive presentation. Additional specifications include "in partial remission." In addition, DSM-5 no

longer considers ADHD as a Disruptive Behavior Disorder and instead lists it as a neurodevelopmental disorder.

Although the 9 possible Inattentive and 9 possible Hyperactive/Impulsive symptoms stayed basically the same, there were some notable differences between the latest DSM-5 and DSM-IV TR.

1. DSM-5 required only the presence of 5 (not 6) symptoms for the diagnosis of patients ages 17 and older.
2. DSM-IV TR required the presence of some hyperactive/impulsive or inattentive symptoms that caused impairment to be present before the age of 7. On the other hand, DSM-5 requires the presence of some of these symptoms prior to the age of 12.
3. The "in partial remission" category was used in DSM-IV TR for individuals (especially adolescents and adults). However, DSM-5 made this category applicable for all ages.
4. DSM-5 added specification for current severity: mild, moderate and severe. This was a new way to clarify the severity of ADHD symptoms, which had been absent to this point.
5. DSM-5 emphasized the importance of obtaining ancillary information when diagnosing ADHD in adults, since adults' recall of childhood symptoms tends to be unreliable. This seems to be an improvement over DSM-IV TR.
6. DSM-5 clarified that it is possible for symptoms to vary depending on the context within a given setting. This additional observation was absent in DSM-IV TR.

Although DSM-5 adds valuable information to the classification and definition of the various ADHD diagnostic categories, it also relaxes the qualifications needed to make the diagnosis. As noted, it reduces the number of required symptoms and widens the age range during which those symptoms could be present.

The effects can be far-reaching. The United States already diagnoses more children, adolescents and adults with ADHD than almost any other country. DSM-5 notes that the prevalence of ADHD in children is 5 percent and 2.5 percent in adults [8]. ADHD diagnoses are already climbing, with 11

percent of children between 4 and 17 diagnosed with the disorder as of 2011, according to the U.S. Centers for Disease Control and Prevention. The research also shows that adolescent abuse of ADHD medication as well as the number of doctors prescribing it is on the rise [9].

A more lenient model could open the doors to an even greater rate of diagnoses. This could lead to increased use of the high-risk medications that carry black box warnings, and with it, a potential rise in substance abuse given the propensity for adolescents and adults to misuse such stimulant drugs. For example, in one study, stimulant misuse in children prescribed ADHD medication reached almost 10 percent in elementary and high school and neared 35 percent for college students [10]. In addition, a longitudinal study of children and adolescents with ADHD found that 11 percent sold their medications while 22 percent either took more than they were prescribed or misused it [11].

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