Managing Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

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KEYWORDS

• Attention-deficit/hyperactivity disorder • DSM-V • Pharmacologic approaches
• Nonpharmacologic approaches • Shared decision making • Stimulant medication
• Nonstimulant medication • Adolescents

KEY POINTS

- 6.4 million children aged 4–17 are diagnosed with ADHD, but only 3.5 million reported taking medication for ADHD.
- Updates in the DSM-V diagnostic criteria for ADHD including age ranges and environment sare discussed.
- Pharmacologic therapy serves as front line treatment for ADHD including both stimulant and non-stimulant therapy.
- Medical management of side effects is a key factor in adherence to treatment.
- Non-pharmacologic approaches such as behavioral and cognitive therapies can provide an effective alternative for treatment of ADHD Adolescent views of ADHD differ from adults and share decision making and self management strategies can improv adherence to treatment.
- Teens with ADHD may be at a increased risks of substance abuse, but several intervention strategies have demonstrated effectiveness for early intervention. Educational resources to support ADHD are available through the Individuals with Disabilities Act and Americans with Disabilities Act Section 504.

BACKGROUND

Attention-deficit/hyperactivity disorder (ADHD) is the most frequently diagnosed neurodevelopmental disorder.[1,2] The percentage of children between 4 and 17 years of age diagnosed with ADHD has consistently increased in less than a decade from

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Prim Care Clin Office Pract 42 (2015) 99–112
http://dx.doi.org/10.1016/j.pop.2014.09.014 primarycare.theclinics.com
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7.8% in 2003 to 9.5% in 2007.[1] As of 2011, 11.0% (6.4 million) have been diagnosed with ADHD.[1] Sex differences have also been identified, with boys (13.2%) more likely to obtain a diagnosis when compared with girls (5.6%).[1] When comparing 2003 to 2011, these data indicate that the proportion of children having a history of ADHD has increased by 42% in less than a decade. This finding translates to an estimated increase of 2 million additional children/adolescents aged 4 to 17 years diagnosed with ADHD in 2011 in the United States alone. Adolescents with ADHD are much less willing to pursue or adhere to medication or psychosocial therapy often because their perceptions of side effects or perceived value of treatment. Adolescents with ADHD, therefore, experience an increased risk for challenges because of performance issues at school, work, and home environments These adolescents often demonstrated an inability to meet common expectations for increased independence in organization, time management, and schoolwork without continued formal ADHD treatment. According to a parent report, more than 3.5 million children in the United States, or 6% of 4 to 17 year olds, were reported by their parents to be taking medication for ADHD, marking a 28% increase from 2007–2008 to 2011–2012.[1] According to data reports there is variation on adherence to ADHD prescribed treatments including medication and mental health therapy. Reports show that approximately 7 out of 10 children or (69%) of children with current ADHD diagnosis report current medication therapy.[1] Whereas only 5 out of 10 children or (51%) report ongoing treatment or counseling from a mental health professional.[1] Finally when all data is combined, 8 out of 10 children or 82.5% of children diagnosed with ADHD currently receive either medication or ongoing mental health treatment for their ADHD diagnosis.[1]

DEFINITION

ADHD is characterized by a pattern of behavior that must be present in multiple settings, such as work, school, or home. This pattern of behavior can negatively impact performance across multiple environments, including social, education, or work. Symptoms are divided into 3 categories: (1) inattention, (2) hyperactivity and impulsivity, and (3) combined (if criteria for both inattention and hyperactivity and impulsivity are met). The standard accepted diagnostic criteria for ADHD diagnosis is provided through the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.[3] The fifth edition (*DSM-V*) was released in May 2013 replacing the fourth edition. The Centers for Disease Control and Prevention has focused on the use of a common standard of diagnosis across communities in an effort to improve accuracy in determining the number of children diagnosed with ADHD and the public health impact this condition has across communities.

CHANGES FROM THE *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (FOURTH EDITION) TO THE *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (FIFTH EDITION) CRITERIA

The following specific changes were made in the *DSM-5* for the diagnosis of ADHD[3] (see http://www.cdc.gov/ncbddd/adhd/diagnosis.html):

- Symptoms can occur by 12 years of age rather than by 6 years of age.
- Several symptoms are required to be present in multiple settings rather than just some impairment in more than one setting.
- Descriptions of symptoms now include examples for older ages (17 years of age to adult).
- Older adolescents and adults must exhibit 5 instead of 6 of the criteria.

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