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Brief report

Dysthymic disorder contributes to oppositional defiant behaviour in children with Attention Deficit Hyperactivity Disorder, combined type (ADHD-CT)

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Abstract

Background: The specific relationships between oppositional defiant disorder (ODD), ADHD-CT, dysthymic disorder (DD) and anxiety disorders symptoms have not been studied in children with ADHD-CT. The relationship to DD is important because DD is common, has an earlier age of onset, is associated with significant morbidity and with increased rates of treatment non-responsiveness when comorbid with major depressive disorder and/or ADHD-CT.

Methods: 200 clinically referred children with ADHD-CT, without comorbid major depressive disorder, were identified. 'ODD', 'ADHD-CT', 'DD' and 'anxiety disorders' symptoms were defined by composite measures of (1) semi-structured clinical interview and (2) parent and/or child standardized questionnaires. Standard multiple regression was used to examine how well 'ADHD-CT', 'DD' and 'anxiety disorders' symptoms predict 'ODD' symptoms.

Results: Only 'ADHD-CT' (15% of the variance) and 'DD' (8% of the variance) symptoms made independent significant contributions to the prediction of 'ODD' symptoms.

Limitations: The study's sample size did not allow 'ODD' and 'conduct disorder' symptoms to be analysed separately.

Conclusions: The association of DD with ODD may reflect a unique contribution of DD to ODD in children, whether ADHD-CT is present or not, or only when ADHD-CT is present.
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Keywords: ADHD; Combined type; Dysthymic disorder; Oppositional defiant disorder

1. Introduction

The greater than chance association of oppositional defiant disorder (ODD) with Attention Deficit Hyperactivity Disorder, combined type (ADHD-CT), depressive disorders and anxiety disorders is a

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replicated finding in epidemiological studies (Angold et al., 1999; Maughan et al., 2004). Further, independent relationships exist between ODD, ADHD-CT and depressive disorders, but not ODD and anxiety disorders in the absence of ADHD-CT and depressive disorders (Angold et al., 1999). In contrast, ADHD-CT is independently associated with ODD, depressive disorders and anxiety disorders (Angold et al., 1999).

To date, the specific relationships between ODD, ADHD-CT, dysthymic disorder (DD) and anxiety disorders symptoms have not been studied in primary school age children with ADHD-CT. In this study, how well ADHD-CT, DD and anxiety disorders symptoms predict ODD symptoms will be examined in a clinical sample of primary school age children with ADHD-CT. We hypothesise that ADHD-CT and DD symptom dimensions will predict ODD symptoms, while anxiety disorders will not.

2. Methods

2.1. Subjects

200 children aged from 6 to 12 years were identified with ADHD-CT, defined through a semi-structured clinical interview (Silverman and Albano, 1996) with the child's parent(s) and by the parent and/or teacher report of the subscale scores of the core symptom domains of ADHD-CT (Conners, 1985) being greater than 1.5 standard deviations above the mean for a given child's age and gender. None of these children had a current diagnosis of a major depressive disorder, while 64 (32%) had DD, defined by a semi-structured clinical interview (Silverman and Albano, 1996) with the child's parent(s) and/or the child and by the parent and/or child report of total depression scores (Achenbach and Edelbrock, 1983; Lang and Tisher, 1983) being greater than 1.5 standard deviations above the mean for a given child's age and gender. 86(43%) had ODD and 64(32%) had conduct disorder, both diagnoses defined categorically and dimensionally. 86(43%) had generalized anxiety disorder; 66(33%)—specific phobia; 50(25%)—separation anxiety disorder; 48(24%)—social phobia; 48(24%)—obsessive compulsive disorder; 14(7%)—panic disorder; 6(3%)—agoraphobia and 14(7%)—post traumatic stress disorder, again defined categorically and dimensionally. The children were all medication naïve, consecutively referred for assessment because they were not responding to usual clinical psychological management approaches, met the inclusion criteria of living in a family home, attending normal primary schools, had IQs above 70 (Wechsler, 1991) and none had overt neurological disease or psychotic symptoms. [Subject characteristics: Age (months)—106.16 (28.34) (range 72–151 months); Gender (M, F)—170,30; ACRS (parent)—22.20 (5.24); CBCL anxiety/depression subscale (parent T score)—71.34 (10.10)-DD group; 68.21 (11.31)—Anxiety disorders group; CDS total depression subscale (decile)—8.19 (1.83)-DD group; RCMAS total anxiety subscale (T score)—53.98 (11.88)-Anxiety disorders group; Verbal IQ—95.46 (14.44), Performance IQ—99.88 (13.67), Fullscale IQ—97.19 (13.29); Social adversity scale—7.71 (1.82) (range 4–13)].

2.2. Measures

The Anxiety Disorders Interview Schedule for Children (A-DISC) (Silverman and Albano, 1996), the Abbreviated Conners' Rating Scale (ACRS) (Conners, 1985), the Child Behaviour Checklist (CBCL) (Achenbach and Edelbrock, 1983), the Revised Children's Manifest Anxiety Scale (R-CMAS) (Reynolds and Richmond, 1985), the Children's Depression Scale (CDS) (Lang and Tisher, 1983), the Parental Account of Childhood Symptoms (PACS) (Taylor et al., 1986) and the third edition of the Wechsler Intelligence Scale for Children (WISC-3) (Wechsler, 1991) were used. All these measures have published, adequate psychometric properties, particularly inter-rater reliability.

2.3. Procedure

The ACRS and CBCL parent and teacher forms were completed before the child's assessment. A registered psychologist interviewed the child and administered the WISC-3, while a trainee child psychiatrist concurrently administered the A-DISC parent form and the PACS. At a separate session, the child completed the CDS and the R-CMAS and then a trainee child psychiatrist administered the A-DISC child form.

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