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ADHD, Attention Deficit-Hyperactivity Disorder, versus hyperactivity

When we look at the five problem areas (externalising conduct disorder and problem, internalising conduct disorder and problem and ADHD), we can say that the diagnostics for ADHD have been developed the most. At the same time the usual diagnostics are rather limited. Many diagnosticians restrict themselves more or less to the criteria stated in the *DSM-IV* (American Psychiatric Association 1994). On the basis of the characteristics of ADHD, also compared to other conduct difficulties, it is possible to refine the diagnostics and to obtain more certainty about the image.

Below I list questions to use in order to diagnoseADHD.

Questions in order to diagnose ADHD

1. Do the criteria of the *DSM-IV* apply?
2. Are there neurological indications for immaturity or hyperkinesis?
3. Are there other maturation disorders?
4. Are there learning disorders?
5. Did the problems start in early childhood: as a baby, as a pre-schooler or in the first year of primary school?
6. Are there family members who have ADHD?
7. Does the child adjust easily?
8. Does the child have a good me–other differentiation?
9. Is the child able to self-reflect?
10. Does the child have a need to play with other children?
11. Does the child remain active during a conversation? (This question is useful if the element of hyperactivity applies.)
12. Are there circumstances that explain the child's behaviour?

The *DSM-IV* has a symptom list for the three aspects that play a part with ADHD:

hyperactivity, impulsivity and attention deficit (Question 1). On the basis of this list of symptoms we can formulate a diagnosis, although it would be wiser to speak of a hypothesis which can be researched further. Because it concerns strongly subjective criteria here and experience with the problems plays a part, the following questions are intended to test the diagnosis more sharply and to support it. Neurological examination is also possible in order to underpin the diagnosis (Question 2). The most appropriate people to do this are the psychiatrist, paediatrician and neurologist. The degree of maturation of the motor apparatus can be measured neurologically and signs of *hypokinesis*, too little movement, or *hyperkinesis*, overactivity, can be diagnosed. Although it appears that the corpus callosum of children with ADHD is smaller than average and the prefrontal brain is underdeveloped,we do not yet have standardisation at our disposal, enabling us to find individual abnormalities, as is possible with, for example, IQ.

The diagnosis of ADHDwithout hyperactivity and impulsivity is often hard to make. We tend to imagine a chaotic child when we think of ADHD; this is, however, not the case with the form AD(H)D-attention deficit. A second difficulty is that the child with ADHD without inadequate attention function seems to functionwell in structured situations like a school. In that case the behaviour of the child is not recognised at school and people are quick to point, unjustly, at the childrearing by the parents as the cause of the behaviour.

To support the diagnosis of ADHD we can check whether there are other symptoms of a delayed maturation (Question 3). These symptoms do not necessarily have to be present but are an extra indication when they do occur. A number of areas that we can pay attention to can be distinguished. The first is the child's *temperament* as a baby.When the child cried a lot as a baby, this is possibly an indication for problems with the maturation of the brain. The second question is whether the child showed any *sleeping disorders*, because many maturation disorders occur during the night and maturation takes place for an important part during the night. The third area is the development of *toilet-training*. Late toilet-training can be a sign of late maturation. When the child is toilet-trained at night and not in the daytime, then it is not a maturation problem but more a behaviour problem. If it is a case of delayed maturation of the bladder muscles then this plays a role at least at night. Finally, there is the area of the learning disorders where indications for delayed maturation can be found: *dyslexia*, *mathematics disorder* and *writing disorder* or *dysgraphia* (Question 4).

The diagnostics of dyslexia has been well mapped, for example thanks to the work of people like Dumont (1990, 1994), and is still being researched. As far as the writing disorder is concerned, Hamstra-Bletz and de Bie (1985) mapped the specific way of writing of children with a writing disorder. Table 2.1 showing maturation disorders can be found in Chapter 2. Because children with ADHD are expected to be normally intelligent, an intelligence test will in principle not offer anything to hold on to for the diagnosis of ADHD.

ADHD, as a disorder of the maturation of the central nervous system, is already present from earliest childhood, but is not always clearly noticeable. I have already stated that there are three phases when the disorder becomes apparent, depending on the requirements set by the development tasks to the child: as a baby, as a pre-schooler and in the first year of primary school (Question 5). When it is not possible to point at one of these moments based on the *anamnesis*, case history, then the diagnosis ADHD is not plausible. The behaviour of the child with ADHD is structural, systematic. If the child is hyperactive, then this will show in all 'free' situations. If the child has attention deficit this will become noticeable in all tasks that require concentration. If the child is impulsive, then it will always want to give into its wishes and new stimuli that occur. When the child only shows certain behaviours in specific situations, then it might be a conduct problem instead of ADHD. A child with ADHD-hyperactivity-impulsivity, without attention deficit, will generally function well at school. The structured situation ensures that the child does not attract attention by chaotic and active behaviour, except in free situations like the schoolyard and at home. Because there are strong indications thatADHDis hereditary (Question 6) and seems to be easy to inherit, it is probable that there are family members who also have or had ADHD. It mainly occurs with boys. It is therefore useful when diagnosing to find out whether it occurs within the family. When it occurs with a family member, for example the father, the extent that he has controlled it is a possible indication for the pace of maturation of the son. The chances are that the child will show the same pace of maturation. This is an indication for the prognosis. Because of their disturbing behaviour children with ADHD are easily confused with children with externalising conduct problems.When describing the various problems I stated similarities and differences (see Table 6.1 in Chapter 6). With the diagnostic outline, however, we start from a child who only has the disorder ADHD, although in many cases it goes together with one of the forms of conduct difficulties. Although he keeps on starting a new activity because of his impulsivity-hyperactivity, the child with ADHD has difficulty in adjusting to situations (Question 7) and is more likely to make his own plan than do what someone else asks.

The child with ADHD does not, in principle, have a strongly underdeveloped me–other differentiation (Question 8), unless there is co-morbidity with a disorder where that is the case. They will also not come across as unscrupulous. As a result of a reasonably developed me–other differentiation, the child will be able to self-reflect (Question 9) and he will understand his part in an event pretty well. This also means that he suffers because of the fact that his insights and possibilities to direct his behaviour are not synchronised. Children with ADHD do generally show anxiety and are weighed down with

conflicts with the environment. Despite the many conflicts that the child experiences and the rejection by peers, the child withADHDwill need to play with others (Question 10). Not thinking egocentrically and having a reasonable empathic capacity ensures that the child needs to be with other people. Other children, however, often see the impulsive, hyperactive peer as someone who disturbs their play.When the child is hyperactive, it will be even more troubled by it when a situation is exciting or when he is required to sit still for a long period of time, for example during a conversation (Question 11). Finally, when the diagnosis ADHD does not apply, there must be factors in the child's environment that lead to the problem behaviour (Question 12). When the questions stated above do not lead to ADHD, but there is hyperactivity, then this is an indication for hyperactivity as a way of expressing underlying problems.

Co-morbidity

Although the various conduct problems and ADHD are described separately, there is the possibility of co-morbidity, the occurrence at the same time of various disorders or problems. When discussing ADHD I stated that, as a result of the frustrationswhich the child meets with his environment, conduct problems can arise. This co-morbidity often occurs in the group of children with ADHD, and applies both to internalising and to externalising *problems*. Because the child with ADHD shows difficult behaviour for the environment, he will often get into conflict with the environment and on those grounds develop behaviour problems. This means that children who have ADHD almost always exhibit problematic behaviour that is not directly caused by their predisposition in addition to the behaviour that is. Moreover, ADHD and the externalising conduct disorder do not exclude each other. With these two disorders some areas of the central nervous system are involved which are partly different and partly the same, but are not working in opposite directions. This means that co-morbidity of ADHD and the externalizing conduct disorder is possible. This will, however, occur less frequently. The same goes for ADHD and the internalising conduct disorder. The latter will seldom occur and if it does then it will do so more with girls than with boys. The characteristics of conduct *disorders* in internalising and externalising forms exclude each other. They cannot therefore occur at the same time. If there is a combination of externalising and internalising characteristics in the behavior then we are dealing with *conduct problems*.

In order to make the right diagnosis it is important to diagnose all problems separately. In this way everything can be mapped correctly. When a child with ADHD has indications for an inadequate me–other differentiation, then it is necessary to examine the diagnostic criteria of the externalising conduct disorder alongside the finding of ADHD. Because the child with ADHD has, in principle, a normal me–other differentiation, an inadequate me–other differentiation is an indication of different problems or co-morbidity with a different disorder. These could be the conduct disorder or a contact disorder like *PDD-NOS (Pervasive Developmental Disorder – Not Otherwise Specified).*