J. Indian Assoc. Child Adolesc. Ment. Health 2007; 3(3): 80-82

Commentary

Some Observations on Nosology of Externalizing Disorders

(Commentary on the article "Classification of Externalizing Disorders: A Review" by Somnath Sengupta and Rupali Shivalkar)

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The main purpose of psychiatric classifications should ultimately be of help in management of patients. Classifications do this indirectly. They help a clinician to think about a child's mental and behavioral problems, and accurately diagnose, and classify them. This in turn helps the clinician to communicate with other professionals, and devise a management plan for the child. Also, classifications help the clinician to think about other psychiatric disorders and research them in relation to the child's problems and also, in general. All classifications are tentative. With advances in knowledge about etiology, clinical picture, treatment, course and outcome, the classifications undergo modifications and evolve. Another criterion for evolution of classification is their applicability and usefulness in clinical contexts for which they are devised.

The above review by Sengupta and Shivalkar critically analyses the existing knowledge about externalizing disorders: attention deficit/hyperactivity disorder/hyperkinetic disorder (ADHD/HD), oppositional defiant disorder (ODD) and conduct disorder (CD) with the specific aim to suggest changes in ICD-10 for the next revision.[1] This commentary looks at the suggested changes and their usefulness with regard to management of ED and makes some observations as regards their nosology.

ADHD/HD

1. The authors suggest that instead of a single diagnostic category of HD, there should be separate diagnostic categories for inattentive, hyperactive-impulsive, and combined types. I would suggest that a remission category, and a subsyndromal or atypical but impairing NOS category should also be there in ICD as in DSM-IV-TR. I support the sub-categorization of ADHD/HD because if we use ICD-10 Diagnostic Criteria for Research we will be able to diagnose fewer children with impairing inattention and hyperactivity-impulsivity than if we used DSM-IV-TR.[2] Thus, some children with impairing ADHD/HD symptoms will not be diagnosed and left without specific and effective treatment.
2. Another suggestion by the authors is that in ICD-10 comorbidity with other psychiatric disorders should be allowed. In my view this can yet be done in ICD-10 provided it can be shown that ADHD/HD diagnostic criteria are fulfilled outside the time boundaries of the comorbid disorder. In other words, ADHD/HD and the comorbid disorder must be shown to be independent of each other. Of course, the comorbid disorder will be diagnosed not within ADHD/HD category but in its own place. Another related problem is of pervasive developmental disorders like autism that have significant problems of inattention and hyperactivity-impulsivity. Because autism is likely to manifest since

earliest childhood and antedate ADHD/HD symptoms, it may not be possible to diagnose ADHD/HD comorbid with autism and prescribe specific, effective medication. This problem should be resolved because stimulants, the most effective ADHD/HD medication, are scheduled drugs and can not be prescribed unless a definite indication is present. More research is needed in such comorbid cases to find out their course and outcome, and similarities and dissimilarities between ADHD/HD, autism and the comorbid cases in order to decide the position and status of the comorbid disorder.

3. The authors suggest that hyperkinetic conduct disorder (HCD) should be a distinct category outside the domain of ADHD in ICD. In my view, there are advantages of keeping it with ADHD/HD because ADHD/HD symptoms arise earlier than ODD/CD symptoms and also because medication may be prescribed to children with HCD if they are classified within ADHD/HD than with ODD/CD or separately.
4. Another suggestion of the authors is that there should be an emphasis on inattentive subtype for girls of all ages. I would disagree with this. It is generally understood that there are cultural and gender differences in the ways in which the parents and the society view inattention and hyperactivity. Elicitation of psychiatric symptoms and impairment due to them is, at present, a matter of clinical judgment. Unless we have evolved a valid and objective way of quantifying mental and behavioral symptoms and the associated impairment, and also have established the age and gender specific norms and cut-off limits for ADHD/HD, it may not be possible to reliably identify gender specific ADHD/HD symptoms. Till such a time this happens, the girls should be diagnosed the same way as the boys. Also, boys with predominantly inattentive type of ADHD/HD are not uncommon in clinical practice, and boys with pure inattention without any hyperactivity are also seen, though rarely.
5. The current diagnostic criteria of ADHD/HD are written from the perspective of school-age children. However, in clinical practice ADHD/HD is diagnosed in both preschool children and adolescents. It may be difficult to clinically gauge inattention in preschool children and decide when normal motor activity and exuberance is becoming hyperactivity. Similarly, in adolescents, hyperactivity declines while inattention and impulsivity persist. Overt hyperactivity may be replaced by "inner restlessness." Although both DSM-IV-TR and ICD-10 mention development changes in ADHD/HD children as they grow up and become adults, there are no specific guidelines as to how ADHD/HD should be diagnosed in adolescents and adults. More research is needed in this regard. There is almost no research on adult ADHD in India except an exploratory clinical study of adult ADHD by Sitholey et al.[3] We used DSM-IV-TR criteria and Wender Utah Criteria for the diagnosis and found that Wender Utah Criteria are more descriptive of clinical picture of adult ADHD. Possibly, DSM-IV-TR and Wender Utah Criteria could be blended together for diagnosis of adult ADHD but it would require more research before modified diagnostic criteria can be clinically applied.
6. Out of 9 symptoms each for inattention, and hyperactivity and impulsivity, 6 or more are required for diagnosing inattention, and hyperactivity-impulsivity. In ICD-10 Diagnostic Criteria for Research, 4 symptoms of inattention, 3 of hyperactivity and 1 of impulsively are needed for a diagnosis of HD. Presence of symptoms is required in more than one setting in ICD-10. Also impairing symptoms are necessary in ICD-10. Impairment due to symptoms should be present in two or more settings in DSM-IV-TR. Research is needed to resolve these similar but also differing criteria. This can be done if DSM-IV-TR categories of ADHD and ADHD NOS are compared with HD for clinical characteristics such as severity, onset, and duration of symptoms, family history, response to treatment,

course and outcome and comorbidities. This would enable children with less, more, maximum possible and different combinations of symptoms to be compared. It should then be possible to separate mild from severe cases and cases from non-cases. To my knowledge, this has not been done so for.

ODD and CD

1. The authors suggest that in ICD, ODD should be placed apart from CD. This is as is done in DSM-IV-TR. In my view it does not matter because in ICD-10 ODD is a diagnostic subcategory of CD. Since their management is more or less the same, it does not matter whether ODD is diagnosed within or without CD. For academic research, however, if ODD is not distinctly categorized and globally labeled as CD, then this category will be masked and it will not be possible to research or follow it up. One disadvantage of labeling ODD globally as CD is prognostication of a poor outcome.
2. The authors' other recommendations is that CD should be subtyped on the basis of age of onset as well as the setting or the context in which it occurs. This is again like DSM-IV-TR. ICD-10 already suggests subtyping on the basis of severity, socialization, and context, but not age of onset. The unsocialized type of conduct disorder, in a way, represents greater deviance from normal. Severe and early onset CD predicts poorer outcome than do mild and adolescence onset CD. I would agree with suggestions of the authors.
3. The authors further recommend that CD should not be diagnosed if it is due to a time limited, stressful situation. In this context an adjustment disorder with disturbance of conduct should be diagnosed. I agree with the recommendation because such negative reactions are short lasting with good outcome whereas CD and ODD predict a continuation of problems and poor outcome. But this is already incorporated in ICD-10.

Overall, this review of externalizing disorder suggests that the future revision of ICD should bring it closer to DSM-IV-TR. Greater change is required in HD than in ODD and CD. The changes suggested by the authors with regard to ED, if incorporated in the next revision of ICD 10, are expected to make it more useful.

References:

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