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developmental level.

2. Temper outbursts occur three or more times a week, on average.

3. Mood between temper outbursts is persistently negative: irritable, angry, sad, or any combination of these. The negative mood is observable by parents, teachers, peers, or others.

4. Criteria 1-3 have been present for at least 12 months; during that time, the person was not without criteria 1-3 for more than 3 months at a time.

5. Temper outbursts and negative mood occur in at least two settings, such as home, school, or with peers, and must be severe in at least one setting.

6. Chronological age is at least 6 years old, or an equivalent developmental level.

7. Onset occurs before age 10 years.

8. TDD should be excluded if in the past year there never was a distinct period, lasting more than 1 day, during which an abnormally elevated or expansive mood was present most of the day, and the abnormally elevated or excessive mood was accompanied by onset or worsening of three of the "B" criteria of mania, such as grandiosity or inflated self-esteem, decreased need for sleep, pressured speech, flight of ideas, distractibility, increase in goal-directed activity, or excessive involvement in activities with high potential for painful consequences. (Abnormally elevated mood is distinct from developmentally appropriate mood elevation, such as in the context of a highly positive life event or its anticipation.)

9. The behaviors do not occur exclusively during a psychotic or mood disorder (such as major depressive disorder, dysthymic disorder, or bipolar disorder), and are not better explained by another

mental disorder (such as pervasive developmental disorder, posttraumatic stress disorder, or separation anxiety). The diagnosis of TDD can coexist with oppositional defiant disorder, ADHD, conduct disorder, and substance use disorders. Symptoms do not directly result from the physiological effects of a drug of abuse, or are secondary to a medical or neurologic condition.

Non-suicidal Self-Injury

NSSI involves much less controversy. Currently, the DSM-IV connects self-mutilation to borderline personality disorder and links it with recurrent suicidal behavior, Dr. Shaffer said.

A new diagnostic entity makes sense because about half of these self-mutilation cases do not meet criteria for borderline personality disorder; the self-inflicted damage differs from suicide attempts; misperception of NSSI events as suicide attempts leads to inappropriate treatment; and correct categorization of these patients should aid research.

NSSI episodes and suicide attempts differ by the methods used, a higher repetition rate with NSSI, broader comorbidity with NSSI, a stronger link between NSSI and peer experience, and a difference in lethality (that is, death from NSSI cutting is very rare).

The following four criteria have been proposed for NSSI, according to Dr. Shaffer:

1. On 5 or more days in the past year, the person has engaged in intentional, self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain, using methods such as cutting, burning, stabbing, hitting, or excessive rubbing.

Unlike body piercing or tattooing, the

damage is done for purposes that are not socially sanctioned, and with an expectation that the injury will involve only mild or moderate physical harm. Either the patient reports no suicidal intent, or the lack of intent can be inferred by the patient's frequent use of a method known through experience to have no lethal potential. The behavior is not of a common or trivial nature, such as picking at a wound or nail biting.

2. The intentional injury associates with at least two of the following four characteristics:

► Negative feelings or thoughts – such as depression, anxiety, tension, anger, generalized distress, or self criticism –

Patients who meet the NSSI criteria and express an intent of achieving relief or positive feeling, but also intend to commit suicide, meet an 'intent uncertain' form of NSSI.

are present immediately prior to the self-injurious act.

► A period of preoccupation with the intended behavior is present prior to engagement in the act.

► There is a frequent urge to perform self-injury, even if the urge is not acted upon.

► The self-injury occurs with a purpose, such as relief from a negative feeling, cognitive state, or interpersonal difficulty or the induction of a positive feeling. The patient anticipates that the relief or positive feeling will occur either during or immediately after the self-injury.

3. The behavior and its consequences cause clinically significant distress or impairment in interpersonal, academic, or

other important areas of function. (This criterion is tentative.)

4. Self-injury does not exclusively occur during states of psychosis, delirium, or intoxication. In people with a developmental disorder, the behavior is not part of a pattern of repetitive stereotypies.

The behavior cannot be attributed to another mental or medical disorder, such as psychotic disorder, pervasive developmental disorder, mental retardation, or Lesch-Nyhan syndrome.

The proposed criteria also establish a subthreshold diagnosis, if all other criteria are met but self-injury occurred fewer than five times during the past 12 months, in people who frequently think about performing self-injury but infrequently do it.

Patients who meet the NSSI criteria and express an intent of achieving relief or positive feeling, but who also intend to commit suicide, meet criteria as an "intent uncertain" form of NSSI.

"The issue is failure to recognize NSSI as benign," Dr. Shaffer said in an interview. "I think [the new diagnosis] will safely avert hospital admissions. Although some of these youngsters will, at certain times, make suicide attempts, an episode of cutting doesn't mean that they need hospitalization, which can be a traumatizing and damaging process."

In addition, keeping patients with NSSI out of hospitals will prevent the contagion that often results. (Introduction of a child or adolescent who has self-mutilated in a hospital ward often leads to an outbreak of similar behavior among others in the ward.)

Dr. Leibenluft, Dr. Pine, and Dr. Shaffer had no relevant financial disclosures. ■

Prevalence of ADHD in U.S. Reached 9.5% in 2007-2008

BY MITCHEL L. ZOLER

FROM THE ANNUAL MEETING OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

NEW YORK – The U.S. prevalence of attention-deficit/hyperactivity disorder among children and adolescents rose to its highest level in 2007-2008, with 9.5% of children and adolescents ever diagnosed, according to a federally sponsored national telephone survey covering more than 70,000 American children and adolescents.

Although the reasons behind the increased prevalence of attention-deficit/hyperactivity disorder (ADHD) remain unclear, the increase over the 7.8% rate of ever-diagnosed ADHD in 2003-2004 reached statistical significance and appears real.

"We think something is going on," Melissa L. Danielson said while presenting a poster at the annual meeting of the American Academy of Child and Adolescent Psychiatry.

Explanations might include increased awareness of the diagnosis, and more children and adolescents undergoing formal evaluation, she said. Backing up the national finding are data on ADHD prevalence in each individual state. Prevalence rates rose in almost every state, and in 13 states recent increases reached statistical significance, she said in an interview.

The National Survey of Children's Health, run by the Centers for Disease Control and Prevention, receives its

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Major Finding: During 2007-2008, U.S. children and adolescents aged 4-17 years had a 9.5% prevalence rate of ever having attention-deficit/hyperactivity disorder, a significant increase from the 7.8% rate in 2003-2004.

Data Source: The National Survey of Children's Health, a random-sample telephone survey of parents with data on more than 70,000 U.S. children and adolescents aged 4-17 years run by the Centers for Disease Control and Prevention.

Disclosures: Ms. Danielson said that she had no disclosures.

primary funding from the Department of Health and Human Services. In 2007 and 2008, a randomly selected sample of U.S. parents answered a telephone survey about their children's health. Parents answered four questions about ADHD: Did they have a child aged 4-17 years who ever received a diagnosis of disorder? Did their child have a current diagnosis? Is the ADHD mild, moderate, or severe? Does the child receive medication?

Extrapolated survey results showed that in 2007-2008, 4.1 million children and adolescents had a current diagnosis, 7.2% of the 4- to 17-year-old population (less than the 9.5% ever diagnosed with ADHD). Of these, two-thirds – 2.7 million – received medical treatment for their ADHD, and parents said that 570,000 (14%) of

their kids had severe ADHD. About half had mild ADHD, with the remaining patients having what their parents described as moderate disorder. Subgroups with significantly less-severe ADHD included girls and adolescents aged 15-17.

Boys, adolescents aged 15-17 years, and multiracial and non-Hispanic children all had significantly higher prevalence rates of current ADHD relative to their respective comparator subgroups. Gender, race, and ethnicity had no linkage with medication use, but medication treatment occurred less often in the 15- to 17-year-olds, said Ms. Danielson, a statistician on the Child Development Studies team of the CDC in Atlanta. Children aged 11-14 years had the widest medication use, 73%, while adolescents aged 15-17 had the lowest rate of medication, 56%, a statistically significant difference.

Children aged 11-14 years with severe disease had a roughly 90% rate of medical treatment; teens aged 15-17 years with mild ADHD had the lowest medication rate, about 50%.

Children and teens with a concurrent diagnosis of disruptive behavior disorder had a statistically significant, 50% adjusted, relative increased rate of receiving medical treatment for their ADHD and also had a significantly higher prevalence of current, severe ADHD. More than 30% of children with the combination of current ADHD and disruptive behavior disorder had severe ADHD. ■