Mountain Plains (HHS Region 8)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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- Today's presentation will be recorded.

SAMHSA
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Not Otherwise Better Explained: Adequate Assessment of ADHD in a Culture of ACEs and Trauma

Melanie M. Wilcox, Ph.D., ABPP

May 20, 2024

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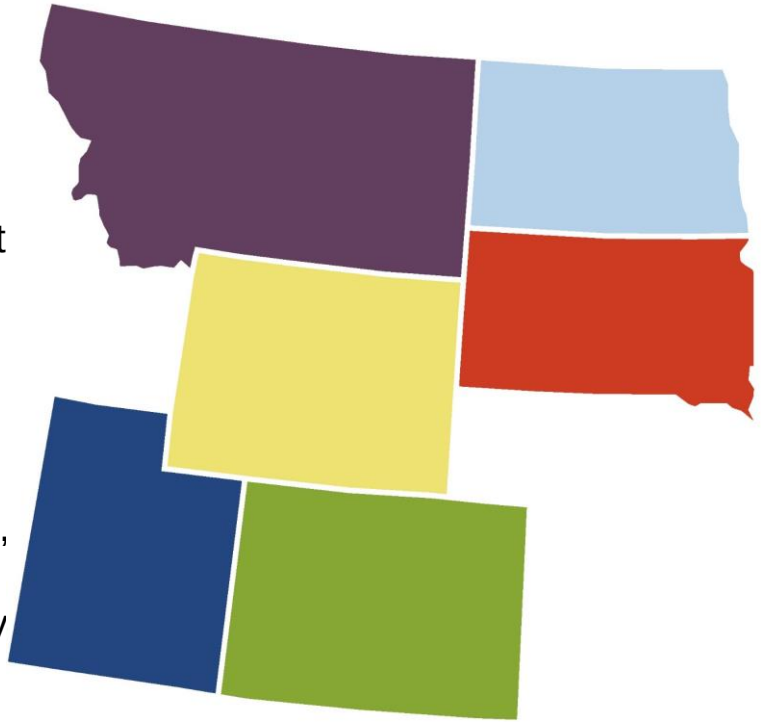
The work of the Mountain Plains MHTTC is supported by grant H79SM081792 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



Evaluation Information

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https://ttc-gpra.org/P?s=242053

Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

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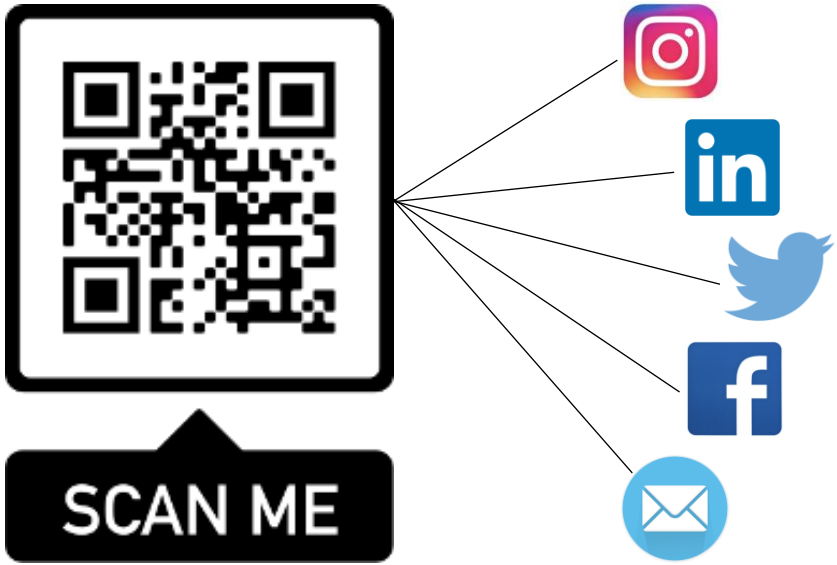


Not Otherwise Better Explained: Adequate Assessment of ADHD in a Culture of ACEs and Trauma

Melanie M. Wilcox, Ph.D., ABPP

About Me

Ph.D., Counseling Psychology, University at Albany (2015)

Assistant Professor of Psychology, Augusta University (Fall 2024: Associate Professor, University at Albany)

Research:

- Culturally and structurally responsive psychotherapy and training
- Racial and socioeconomic inequity in higher education
- Whiteness, antiracism, social justice

President Elect-Elect, APA Division 17 (Society of Counseling Psychology)

Licensed Psychologist and Board Certified in Counseling Psychology

- Part-time practice (100% telehealth) at the Aguirre Center for Inclusive Psychotherapy in Atlanta

Learning Objectives

Understand

The complexity of psychodiagnosis and differential diagnosis

01

Define

02

Attention Deficit/Hyperactivity Disorder—what it is and is not

Explain

03

The causes of executive function symptoms and why they occur

Describe

04

How to thoroughly assess for ADHD in a trauma-informed way

Why Is Psychological Diagnosis So Difficult?

Modern Nosology

Nosology: The branch of medical science dealing with the classification of diseases/disorders

In mental health treatment, the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5)* is our primary diagnostic classification system

The DSM-5 is *symptom-based,* and is merely an organization and re-organization of the *human symptom pool*

- Only so many ways that humans have to express distress
  - Each diagnosis is a different combination from the same pool of symptoms
- Thus, diagnostic overlap is the rule rather than the exception—especially for individuals in greater distress (or causing greater distress to others)

Modern Nosology

The DSM-5 is based on *committee consensus* rather than on empirical evidence

- Personality disorders a great example: Empirically supported diagnostic classification system of PDs abandoned
- Empirically well-established disorders (e.g., Complex PTSD [C-PTSD]) do not appear at all

It is incumbent upon us to think critically about our predominant nosological system.

Modern Nosology

Etiology: The (presumed) cause, set of causes, or manner of causation of a disease or disorder

Most diagnoses in the DSM-5 are *etiology-agnostic*: They describe *what*, but not *why.*

The neurodevelopmental disorders are inherently an exception: They are diagnoses of exclusion that are meant to be diagnosed only when more probable causes of the same symptoms are ruled-out and the only option that remains is an otherwise unconfirmable brain-based (i.e. *neurological*) disorder.

That the DSM-5 is not incredibly concrete about this, however, and that it is largely considered etiology-agnostic, causes confusion.

Modern Nosology

Crucially, our treatments are usually *not* etiology-agnostic:

ADHD medication (usually, stimulants) and other psychotropics prescribed to correct a presumed chemical imbalance

Learning disorder interventions based on assumption that the problem resides in the individual (e.g., brain-based weakness) rather than the situation (e.g., inadequate instruction)

Modern Nosology

We also struggle with both over – and under-pathologizing

- Overpathologizing normal responses to abnormal situations (e.g., distractibility under stress; inability of young children to sit still for many hours at a time)

- Underpathologizing societally acceptable unhealthy behavior, such as heavy drinking, lack of downtime/rest time, overworking

Differential Diagnosis

For all these reasons, *differential diagnosis* is absolutely critical in mental health care

Differential Diagnosis: Distinguishing between different disorders, diagnoses, and/or explanations for a presenting problem to identify the most likely explanation(s) and rule out other, similar potential explanations

- Requires working both within *and* outside of the DSM-5
- Requires that we *not* be etiology-agnostic

What Causes a Headache?

My Head Hurts!

Tylenol and Rest?

What if it's a brain tumor?

Chemo and Radiation?

What if it's a tension headache? A sinus infection? A migraine?

Etiology and Assessment Matter

Most Common Neurodevelopmental Referral Concerns

Attention Deficit Hyper-activity Disorder

Autism Spectrum Disorder

Specific Learning Disorder

[Intellectual Disability]

Shared Core Characteristics

Difficulty with Attention, Concentration, Focus

Difficulty with Memory

Difficulty with Sitting Still and/or Impulsivity

Poor/Inconsistent Academic Performance

Difficulty with Reading and/or Mathematics

Social and/or Communication Difficulties

What Else Causes These Symptoms?

Psychological
(more common)

Anxiety
Depression
Adjustment
Trauma
Toxic Stress*
Substance use

"Normal" Functioning
(more common)

Perfectionism
Stress
External Pressure/Demands
Limits of being human!

Behavioral or Environmental
(more common)

Poor sleep
Poor nutrition
Poor study habits
Household dysfunction
Classroom management
School curriculum or resources

Neurodevelop-mental or Severe Psychological
(least common)

[Intellectual Disability]
Autism Spectrum Disorder
Communication Disorders
Personality Disorders
Serious Psychiatric Concerns

What Else Causes These Symptoms?

Medical Concerns! Including, but not limited to:

Endocrine (e.g., thyroid; diabetes)
Anemia
Ophthalmologic/Neuro-Ophthalmologic
Chronic fatigue
Pain
Cardiovascular (e.g., high blood pressure)

A Modern Challenge: People Want the Diagnosis they Want

- Less stigma
- Less perceived blame
- Sense of community
- Easier answers (e.g., pharmaceuticals)
- More “outside of my control”

All of this is why we do an assessment *battery*, inclusive of records review

What Truly Is ADHD?

ADHD Diagnosis

ADHD is a disorder of *executive functioning* that is a diagnosis of exclusion – ***the many other causes of executive function difficulties have been ruled out***.

There is no symptom of ADHD that is unique to ADHD!

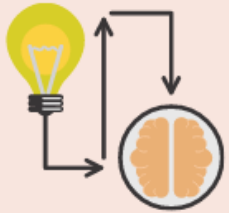
Diagnostic Criterion E (p. 60): *Symptoms are not better explained by another mental disorder*

This means you ***must*** **rule out other (much more likely) causes first.**

What Are Executive Functions?

Attention

Concentration/ Focus



Working Memory

Mental Flexibility

Self-Regulation and Control

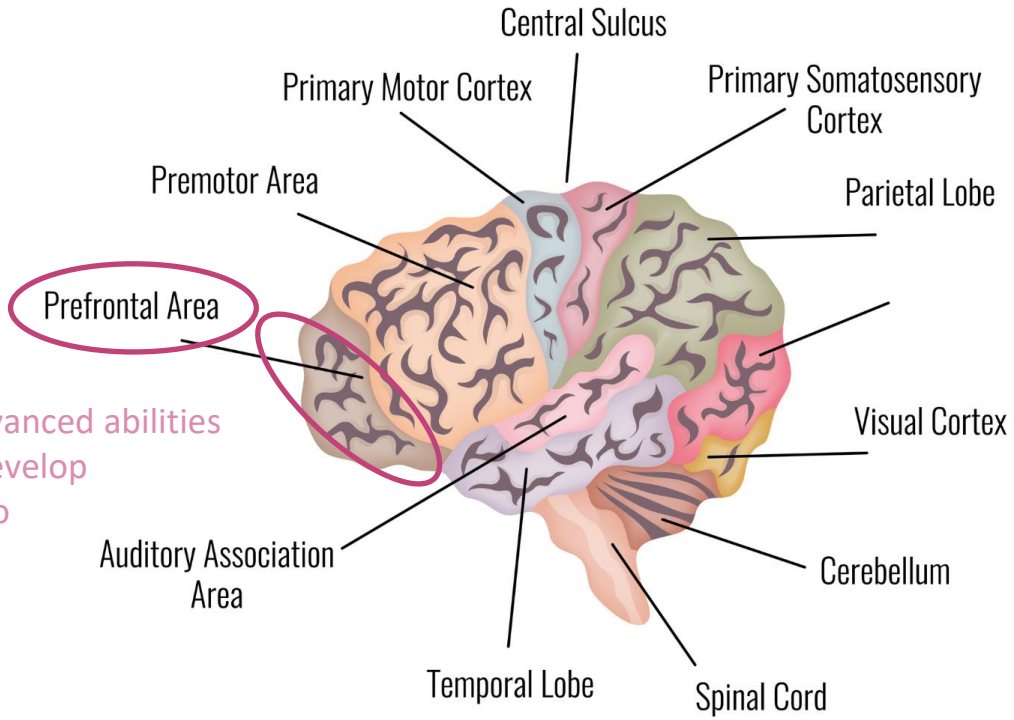
Planning

Organizing

Multitasking

Time Management

Executive Functions and the Brain



- Our most advanced abilities
- The last to develop
- The first to go

Think about the most anxious or panicked *you've* ever been.

How easy would these have been for you in that state?

What about at your most sleep-deprived?

In your worst grief?

Actual Base Rates vs. Diagnosis

< 1 - 5%

Estimated population base rates (adults and children, respectively)

> 50%

Rate of school-aged boys on prescription stimulants for ADHD in some counties/parishes (Schwarz, 2016)

ADHD Diagnosis

Criterion E **requires** that we rule out other (more likely) causes of *executive function difficulties.*

Lack of ADHD diagnosis does *not* mean that the person is not having executive function symptoms! It means we have identified a different *cause* (which begets a different *solution*)

What else is required?

- Onset of symptoms before age 12
- Present in two or more settings (not just home or school)
- Six or more symptoms of inattention or six or more symptoms of hyperactivity/impulsivity (many of which overlap substantially with anxiety/threat response)
- Clear evidence the symptoms detrimentally impact social, academic, or occupational functioning

Symptom Organization

Inattention

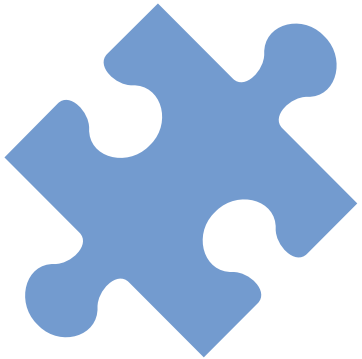
1. Inattention to detail
2. Difficulty sustaining attention/focus
3. Does not seem to listen when spoken to
4. Does not follow through on instructions or finish homework, chores, work
5. Difficulty organizing tasks/activities
6. Avoids, dislikes, reluctant to engage in tasks that require sustained mental effort
7. Loses important things often
8. Easily distracted by external stimuli
9. Forgetful in daily activities

- Learned skill deficit
- Age appropriateness
- Stress and/or anxiety
  - ACES
  - Dissociation
- Depression
- Self-Confidence
- Educational Mismatch (gifted/remedial)
- Autism Spectrum Disorder

- Anxiety/Stress (#1)
  - ACES
- Age Appropriateness
- Personality
- Home/Classroom Expectations
- Educational Mismatch (gifted/remedial)
- Autism Spectrum Disorder

Hyperactivity/ Impulsivity

1. Often fidgets, taps hands or feet, squirms in seat
2. Often leaves seat when expected to remain seated
3. Often runs about or climbs in inappropriate situations
4. Often unable to play or engage in leisure activities quietly
5. Is often “on the go,” acting as if “driven by a motor”
6. Often talks excessively
7. Often blurts out answer before a question has been completed
8. Often has difficulty waiting one’s turn
9. Often interrupts or intrudes on others



Neurodevelopmental disorders are, by definition, statistically rare

Old medical axiom: If you hear hoofbeats, assume horse, not zebra

Distract us

Fatigue us

Depression, Anxiety, Adjustment, Trauma, Stress....

Socially impair us

Accumulate consequences over time

Symptoms of Depression

- Diminished interest in, pleasure from things (may require higher-reward activity to capture attention!)
- Insomnia or hypersomnia – both begetting exhaustion (hard to pay attention, learn when tired)
- Psychomotor agitation
- Fatigue, loss of energy
- Diminished ability to think, concentrate; indecisiveness

Symptoms of Anxiety

- Restlessness, keyed up, on edge
  - Common symptom on ADHD screeners: “Do you feel like you are being driven by a motor?”
- Easily fatigued
- Difficulty concentrating or mind going blank (i.e. attention!)
- Irritability
- Sleep disturbance (again, exhaustion)

Relatedly, OCD and OCPD: Hard to concentrate on task at hand owing to internal distractions

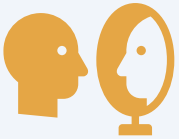
Adverse Childhood Experiences

61%
of adults

Have an ACE score of at least 1

15-20%
of adults

Have an ACE score of **four or more** – substantially increasing poor outcomes



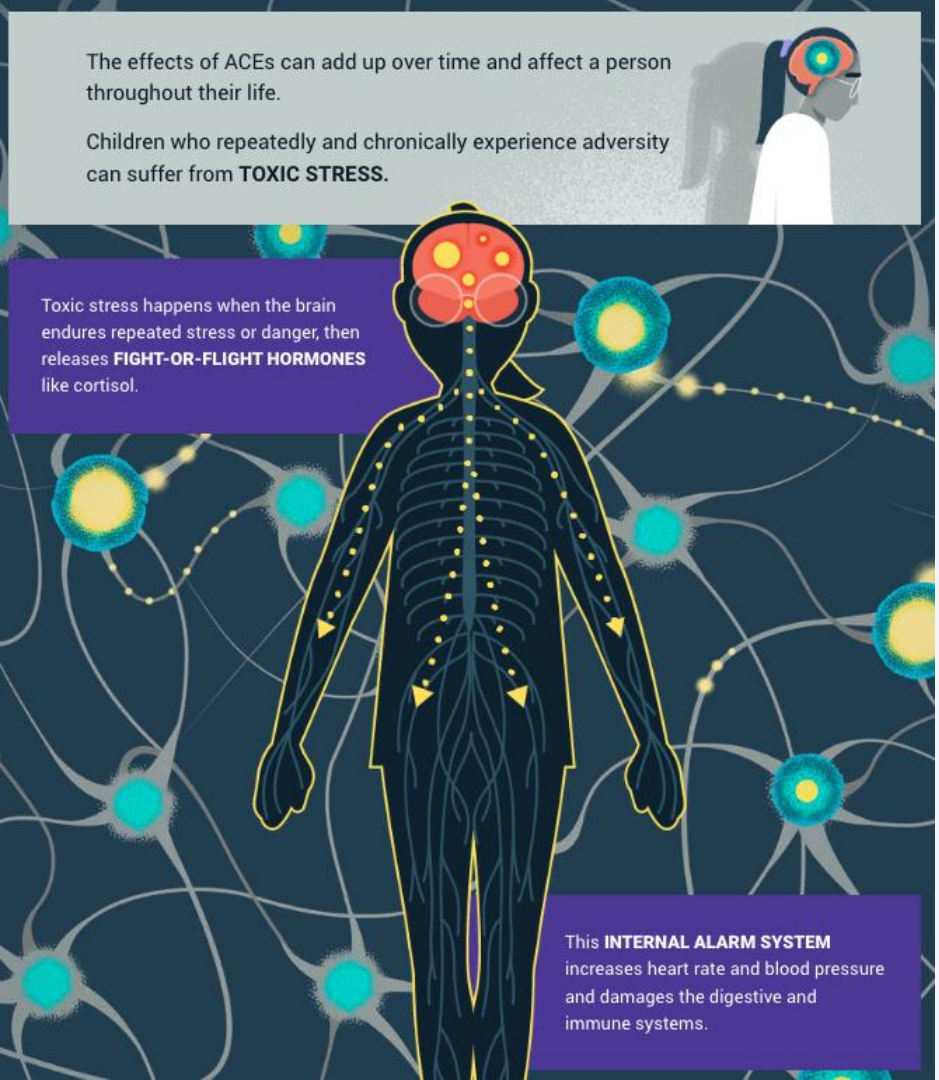
Up to
21 million

Cases of depression result from ACES

Toxic stressors occurring during childhood that include, but are not limited to, violence, abuse, growing up in a family with mental health or substance abuse problems, household dysfunction, parental loss, verbal abuse, neglect, and economic insecurity

They are often passed down intergenerationally

(Centers for Disease Control)



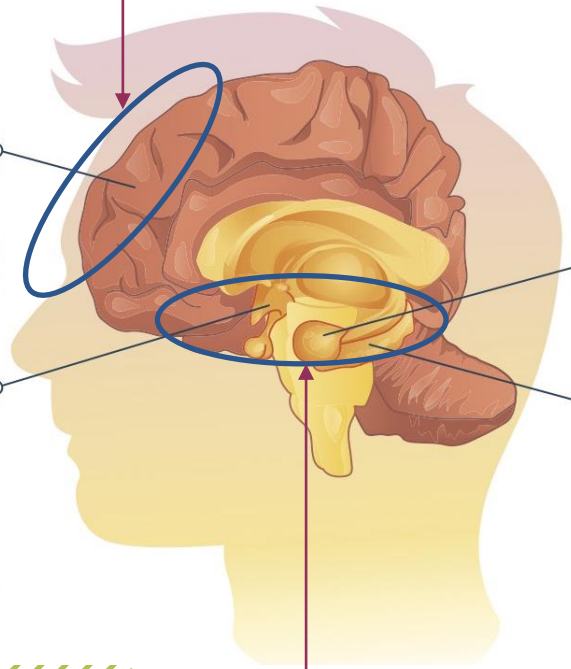
HPA Axis

- The Hypothalamic-Pituitary-Adrenal (HPA) Axis is very important to understanding stress
- This is our body's internal alarm system
- Although this is how the process works in everyone, each individual has their own idiosyncratic nervous system functioning, endocrine system functioning, and common responses to stress—informed in large part by our experiences, including ACES

Centers for Disease Control
https://vetoviolence.cdc.gov/apps/aces-infographic/home

Executive Functions and the Brain

This goes offline (bye bye, executive functioning!)



PREFRONTAL CORTEX

Normal
Complex Thinking, Decision Making and Appropriate Behavior

PTSD
Dysfunctional Thought Processes and Decision Making. Inappropriate responses to Situations

AMYGDALA

Normal
Sets off Fight or Flight in Response to Danger

PTSD
Sets off Fight or Flight in Response to Memories or Thoughts about Danger

HYPOTHALAMUS (HPA) AXIS

Normal
Releases Hormones like Cortisol to help Manage and Direct Efforts to Stressor

PTSD
Overactive, which leads to Imbalances in Hormone Levels and Increases Stress and Anxiety

HIPPOCAMPUS

Normal
Transfers and Stores Information into Memories

PTSD
Stores Memories Incorrectly and Affects Memory Retrieval

So this can come online

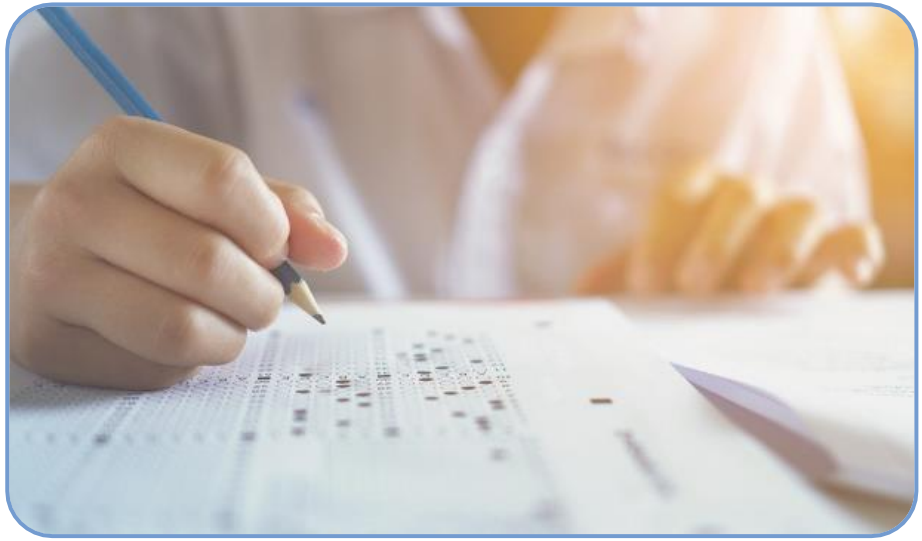
Arousal and Dissociative Symptoms

- Arousal symptoms, suggestive of sympathetic nervous system activation, include excessive alertness (hypervigilance), extreme startle response, or sleep disturbances
  - *Alertness* actually *inhibits* executive functioning

- Dissociative symptoms are essentially *reduced responsiveness*. May occur as:
  - Feeling detached from other people
  - Feeling dazed
  - *Difficulty remembering*
  - *Loss of interest in things*
  - ***Depersonalization*** or ***Derealization***
    - **Depersonalization**: Feeling as though one's conscious state or body are unreal
    - **Derealization**: Feeling as though the environment is unreal or strange; for example, some say it is as though color is more dull or as though the world is now seen through a sepia filter
  - Can't remember something you weren't mentally present for!


Toxic Stress MUST BE RULED OUT – and too often, *it will not be.*

Proper Diagnosis Requires Thorough Assessment.

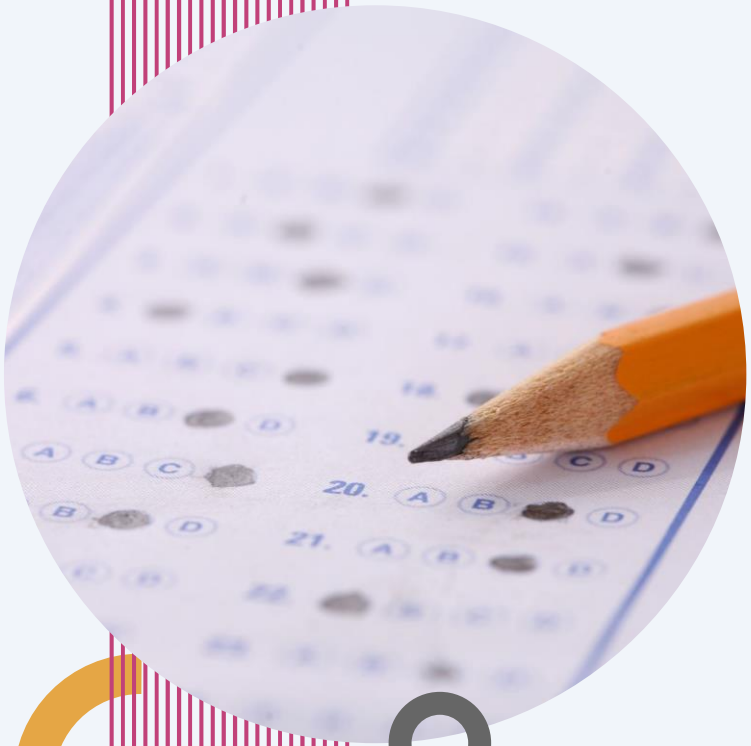


Be Curious

- Clients/patients are communicating with the best language they have available to them
    - “I think I have ADHD” does not mean we need to merely answer “ADHD: yes/no?”
    - *“I’m struggling with executive functioning.”* Many potential causes
- Social acceptability, psychological mindedness, knowledge will influence what they can and will report
- It is *our job* to get to the bottom of what *all* they are really struggling with.

Clinical Assessment

- There is no substitute for an incredibly thorough background history
- ACE screener (or recent expanded ACES questionnaire)
- Intervene on obvious concerns—thorough psychological assessment may not be worth the resources yet if toxic stress is clearly at play
    - Parent/Child, family interventions
    - School interventions
    - Psychotherapy
    - Referrals as needed



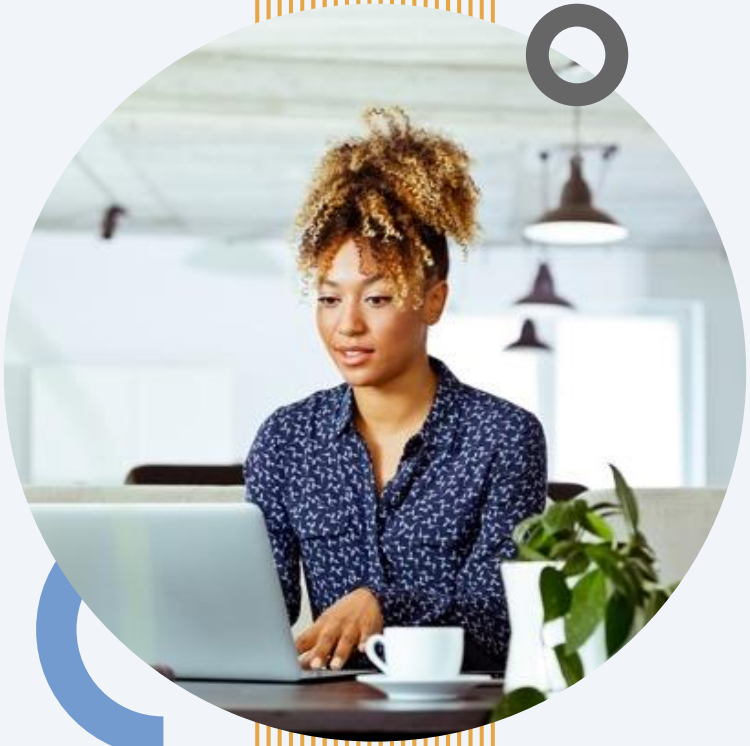
Psychological Assessment

- True ADHD assessment is time- and resource-intensive; but, anything less does not adequately diagnose ADHD
  - Screeners based on the symptoms that overlap with everything else!

- Battery will include
  - Cognitive (IQ) testing (inclusive of working memory; processing speed)
  - Executive function testing, ideally via multiple modalities
  - Personality testing (if pre-adolescent or older)
  - Mood/symptom testing
  - Trauma testing (e.g., TSI-2)
  - Adaptive behavior testing (if child or suspected ID)
  - Achievement testing
  - Autism testing (if ASD suspected or part of referral question)
    - MIGDAS-2 (structured interview) increasingly becoming the preferred method of assessment, especially for teens and adults

Analyze Environments

- Ask – multiple times, in multiple ways
- Curiosity will come in handy here
- Do different teachers have a different experience with the child? Why?
- Does the person struggle at college, but not at home, or vice versa?
- Inquire about stressors, supports
- Observe when possible



Diagnose Cautiously

- Have you truly narrowed down between the neurodevelopmental disorders?
- Have you truly, thoroughly ruled out the more common causes of similar symptoms, including (but not limited to) anxiety, depression, toxic stress, trauma, normal stressors, sleep issues?
- If not, what do you need in order to be able to do so?
- Remember, just because executive function, social, or learning symptoms (and demonstrated deficits) exist, does not mean it is neurodevelopmental!

In Sum

Differential diagnosis in mental health is difficult, but crucial—it's the difference between effective and ineffective (or even harmful) misdiagnosis and treatment.

Through curiosity and assessment or referral, do your due diligence.

And consider more training on ACES (https://vetoviolence.cdc.gov/apps/aces-training/#/)

Thank you!

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