Children with Attention Deficit Hyperactivity Disorder: Epidemiology, Comorbidity and Assessment

Alice Charach, Msc, MD

Hospital for Sick Children, Canada

March 2010

Epidemiology of ADHD

Children with Attention Deficit Hyperactivity Disorder (ADHD), characterized by developmentally excessive levels of inattention, over-activity and impulsiveness, are most frequently identified and treated in primary school. Studies worldwide identify a prevalence rate for ADHD equivalent to 5.29% (95% Confidence Interval: 5.01-5.56) of children and adolescents.[1] Rates are higher for boys than for girls, and for children under 12 years of age compared with adolescents.[1,2] Prevalence estimates vary based on method of ascertainment, diagnostic criteria used, and whether functional impairment criteria are included.[1] Overall, estimates are remarkably similar from country to country with the exception of African and Middle Eastern countries where rates are lower compared with North America and Europe.[1]

Symptoms generally interfere with academic and behaviour functioning at school, and often disrupt family and peer relationships.[3,4] Children with ADHD use more health services and sustain more injuries than those without.[5,6] While hyperactivity symptoms lessen in adolescence, the majority of children with ADHD continue to show some cognitive impairment, (eg. poor executive functioning, impaired working memory) relative to same-age peers through their teen years and into adulthood.[7,8] Outcome studies identify lower rates of high school completion, earlier onset of alcohol and illicit substance use, and increased rates of cigarette smoking and driving accidents among teens with ADHD.[9-14] Childhood hyperactivity is also associated with subsequent onset of other psychiatric disorders, including anxiety, conduct problems, mood disorders and suicidal behaviour and antisocial personality disorder.[13,15-18] Adults with childhood history of ADHD have higher than expected rates of injuries and accidents, marital and employment difficulties, teen pregnancy and children born out of wedlock.[15,17,19-21] ADHD is an important public health concern, not only for the long-term impairments facing individuals and families but also for the heavy burden on educational, health and criminal justice systems.[22-24]

Population studies identify that childhood inattention and hyperactivity are more common in single parent families, with low parent education attainment, parent unemployment, and low family income.[17,25,26] Evidence from family studies identify that symptoms of ADHD are highly heritable,[27] however, early environmental factors contribute as well. History of prenatal maternal smoking and drinking, low birth weight, and developmental problems are associated with high levels of inattention and hyperactivity.[26,28] More recently, examination of longitudinal data from the Canadian National Longitudinal Survey of Children and Youth identified that approximately 7% of children show persistent high levels of parent reported hyperactivity from 2 years until early primary school.[29] Prenatal maternal smoking, maternal depression, poor parenting practices and living in a disadvantaged neighborhood in the first year of life are all associated with later childhood behaviour problems, including inattention and hyperactivity four years later.[29-31]

Clinical identification and treatment of ADHD in North America can vary geographically, apparently reflecting differences in community practices or access to services.[32-34] Treatment with stimulant medications for inattentive and hyperactive symptoms increased in the early to mid 1990s, and likely reflects longer periods of use with treatment extended into adolescent years as well as an increased number of girls identified and treated.[35-38]

Concurrent (or Comorbid) Disorders

Half to two thirds of school children identified with ADHD also have concurrent psychiatric and developmental disorders, including oppositional and aggressive behaviours, anxiety, low self esteem, tic disorders, motor problems, and learning or language disabilities.[39-46] Sleep difficulties, including enuresis (bed-wetting), are common, with sleep-disordered breathing, a potentially correctable reason for increased inattention.[47,48] Global impairment in children with ADHD increases with increasing numbers of concurrent disorders.[13,49] The concurrent conditions alsoincrease the likelihood of additional difficulties developing as children become adolescents and young adults.[10,15,16,50-55]

Neurocognitive difficulties are an important source of impairment in children with ADHD. Areas of executive functioning and working memory as well as specific language and learning disorders are common in clinic groups.[56,57-64] Approximately a third of children referred for psychiatric, often behaviour problems, may have previously unrecognized language difficulties.[65] Whenever possible the potential for cognitive problems requires

evaluation so that appropriate academic interventions can be implemented.

ADHD in Preschoolers

Attention Deficit Hyperactivity Disorder, usually begins before children enter school. However in the preschool age group ADHD is characterized not only by impairment in attention span, excessive impulsivity and over-activity but also is frequently accompanied by severe temper tantrums, demanding, uncooperative behaviour and aggressiveness that can interfere with attendance at daycare or preschool, avoidance of family gatherings, and high family burden of care and distress.[66,67,68] These disruptive behaviours are often the target of parental concern, and many[66] receive a diagnosis of oppositional defiant disorder. Early identification can be helpful to address the range of developmental issues children with ADHD can have.

Assessment of ADHD in School-Age Children

Among primary school children, concerns about learning style and behaviour difficulties are often brought to the parents' attention by classroom teachers. Educators generally anticipate that by senior kindergarten and grade 1, children should be able to follow classroom routines, follow simple instructions, play cooperatively with peers, and remain focused for 15 to 20 minutes at a time on academic tasks. Concerns raised by teachers, especially experienced ones, provide important details about a child's academic and social functioning.

The formal diagnosis of ADHD reflects pervasive and detrimental levels of inattention, distractibility, overactivity and impulsiveness. The child's symptoms must be developmentally excessive and cause impaired functioning, most often in academic or social skills, peer or family relationships. Difficulties generally have been present since preschool, although is not always recognized. The troublesome behaviours are present in more than one context, at home, at school or in the community, for example on outings to the park or to a grocery store.

There are two sets of formal diagnostic rules used in Canada, DSM IV TR (Diagnostic and Statistical Manual, Fourth Edition, Text Revised) and ICD-10 (International Classification of Disorders, Tenth Edition). The DSM IV Diagnosis of Attention Deficit/Hyperactivity Disorder (ADHD) reflects consensus understanding of the diagnosis largely from the United States. There are three subtypes of ADHD, primarily inattentive type, where the child shows six of nine prescribed inattentive symptoms, primarily hyperactive-impulsive type, where the child shows six out of nine hyperactive-impulsive symptoms, and combined type, where the child shows high levels of both types of symptoms (see Chart 1 for diagnostic symptoms). The ICD-10 diagnosis of Hyperkinetic Disorder is used more often by physicians who do not practice in North America. There is a great deal of overlap in the underlying concept, with the ICD-10 Hyperkinetic Disorder identifying a smaller group of children who must meet criteria for both high levels of activity as well as inattention and distractibility. However, when aspects of overall clinical picture are taken into account, children with ADHD, especially those with combined type, show similar impairments in functioning and need for intervention as those with Hyperkinetic Disorder.[69]

The clinical assessment of a child with ADHD is best done by a health professional familiar with pediatric mental health and psychosocial assessments. Since young children frequently respond to stressful circumstances with increased levels of activity and distractibility as well as difficulties in learning and social relationships, assessments of developmental, family and social contexts are required to identify alternative explanations for the impairing symptoms where appropriate. Physical contributions such as poor sleep, or

chronic medical conditions should also be evaluated as explanations for or contributors to the child's difficulties. Ideally, the clinician can obtain information about the child social and academic functioning from more than one informant who knows the child in different situations, for example, the child's parent and a teacher. Self-report surveys for parents and teachers are widely used to elicit information about specific child's behaviours in the home or school settings, respectively.[4] In addition, a detailed clinical interview with the parents of younger children, and, for older children, with the child or youth him/herself, is essential. Reviewing school reports over several years is also helpful to provide a longitudinal perspective from several teachers. An important aspect of the assessment includes identification of concurrent disorders, including learning and language disorders, as reviewed in the section above. Psychosocial or developmental concerns should also be identified as they may complicate treatment of the ADHD and impact the long-term prognosis.

Chart 1: DSM IV TR[a] Criteria for Attention Deficit Hyperactivity Disorder

A. Either **(1)** or **(2)**:

(1) six or more of the following symptoms of *inattention* have persisted for at least 6 months to a degree that is maladaptive and is inconsistent with developmental level:

Inattention

- often fails to give close attention to details or makes careless mistakes
- often has difficulty sustaining attention in tasks or play activities
- often does not seem to listen when spoken to directly
- often does not follow through on instructions and fails to finish schoolwork, chores or duties (not due to oppositional behaviour or failure to understand instructions)
- often has difficulty organizing tasks and activities
- often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
- often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books or tools)
- is often easily distracted by extraneous stimuli
- is often forgetful in daily activities

(2) six or more of the following symptoms of *hyperactivity-impulsivity* have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

- often fidgets with hands or feet or squirms in seat
- often leaves seat in classroom or in other situations where remaining seated is expected
- often runs about or climbs excessively in situations in which it is inappropriate

- often has difficulty playing or engaging in leisure activities quietly
- is often “on the go’ or often acts as if “driven by a motor”
- often talks excessively

Impulsivity

- often blurts out answers before questions have been completed
- often has difficulty awaiting turn
- often interrupts or intrudes on others (eg. butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (eg. at school and home).

D. There must be clear evidence of clinically significant impairment in social, academic or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (eg. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

References

1. Polanczyk G, de Lima MS, Horta BL, Biederman J, Rohde LA. The worldwide prevalence of ADHD: a systematic review and metaregression analysis. *American Journal of Psychiatry* 2007;164(6):942-948.
2. Waddell C, Offord DR, Shepherd CA, Hua JM, McEwan K. Child psychiatric epidemiology and Canadian public policy-making: the state of the science and the art of the possible. *Canadian Journal of Psychiatry* 2002;47(9):825-832.
3. American Academy of Pediatrics. Subcommittee on Attention-Deficit/ Hyperactivity Disorder and Committee on Quality Improvement. Clinical practice guideline: treatment of the school-aged child with attention-deficit/hyperactivity disorder. *Pediatrics* 2001;108(4):1033-1044.
4. Pliszka S, AACAP Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry* 2007;46(7):894-921.
5. Bruce B, Kirkland S, Waschbusch D. The relationship between childhood behaviour disorders and unintentional injury events. *Paediatrics & Child Health* 2007;12(9):749-754.
6. Leibson CL, Katusic SK, Barbaresi WJ, Ransom J, O'Brien PC. Use and costs of medical care for children and adolescents with and without attention-deficit/hyperactivity disorder. *JAMA-Journal of the American Medical Association* 2001;285(1):60-66.
7. Brassett-Harknett A, Butler N. Attention-deficit/hyperactivity disorder: an overview of the etiology and a review of the literature relating to the correlates and lifecourse outcomes for men and women. *Clinical Psychology Review* 2007;27(2):188-210.
8. Spencer TJ, Biederman J, Mick E. Attention-deficit/hyperactivity disorder: diagnosis, lifespan, comorbidities, and neurobiology. *Journal of Pediatric Psychology* 2007;32(6):631-642.
9. Barkley RA, Fischer M, Edelbrock C, Smallish L. The adolescent outcome of hyperactive children diagnosed by research criteria ? III. Mother-child interactions, family conflicts and maternal psychopathology. *Journal of Child Psychology and Psychiatry* 1991;32(2):233-255.
10. Barkley RA, Fischer M, Edelbrock CS, Smallish L. The adolescent outcome of hyperactive children diagnosed by research criteria: I. An 8-year prospective follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry* 1990;29(4):546-557.
11. Biederman J, Faraone S, Milberger S, Guite J, Mick E, Chen L, Mennin D, Marrs A, Ouellette C, Moore P, Spencer T, Norman D, Wilens T,

Kraus I, Perrin J. A prospective 4-year follow-up study of attention-deficit hyperactivity and related disorders. *Archives of General Psychiatry* 1996;53(5):437-446.

12. Mannuzza S, Klein RG, Konig PH, Giampino TL. Hyperactive boys almost grown up. IV. Criminality and its relationship to psychiatric status. *Archives of General Psychiatry* 1989;46(12):1073-1079.
13. Fergusson DM, Horwood LJ. Early onset cannabis use and psychosocial adjustment in young adults. *Addiction* 1997;92(3):279-296.
14. Barkley RA, Guevremont DC, Anastopoulos AD, DuPaul GJ, Shelton TL. Driving-related risks and outcomes of attention deficit hyperactivity disorder in adolescents and young adults: a 3- to 5-year follow-up survey. *Pediatrics* 1993;92(2):212-218.
15. Fergusson DM, Horwood LJ, Ridder EM. Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. *Journal of Child Psychology and Psychiatry* 2005;46(8):837-849.
16. Copeland WE, Miller-Johnson S, Keeler G, Angold A, Costello EJ. Childhood psychiatric disorders and young adult crime: a prospective, population-based study. *American Journal of Psychiatry* 2007;164(11):1668-1675.
17. Fergusson DM, Boden JM, Horwood LJ. Exposure to single parenthood in childhood and later mental health, educational, economic, and criminal behavior outcomes. *Archives of General Psychiatry* 2007;64(9):1089-1095.
18. Woodward LJ, Fergusson DM, Horwood LJ. Driving outcomes of young people with attentional difficulties in adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry* 2000;39(5):627-634.
19. Mannuzza S, Klein RG, Bessler A, Malloy P, LaPadula M. Adult outcome of hyperactive boys. Educational achievement, occupational rank, and psychiatric status. *Archives of General Psychiatry* 1993;50(7):565-576.
20. Mannuzza S, Klein RG, Bessler A, Malloy P, LaPadula M. Adult psychiatric status of hyperactive boys grown up. *American Journal of Psychiatry* 1998;155(4):493-498.
21. Biederman J, Petty CR, Fried R, Kaiser R, Dolan CR, Schoenfeld S, Doyle AE, Seidman LJ, Faraone SV. Educational and occupational underattainment in adults with attention-deficit/hyperactivity disorder: a controlled study. *Journal of Clinical Psychiatry* 2008;69(8):1217-1222.
22. Birnbaum HG, Kessler RC, Lowe SW, Secnik K, Greenberg PE, Leong SA, Swensen AR. Costs of attention deficit-hyperactivity disorder (ADHD) in the US: excess costs of persons with ADHD and their family members in 2000. *Current Medical Research & Opinion* 2005;21(2):195-206.
23. Leibson CL, Long KH. Economic implications of attention-deficit hyperactivity disorder for healthcare systems. *Pharmacoeconomics* 2003;21(17):1239-1262.
24. Secnik K, Swensen A, Lage MJ. Comorbidities and costs of adult patients diagnosed with attention-deficit hyperactivity disorder. *Pharmacoeconomics* 2005;23(1):93-102.
25. St Sauver JL, Barbaresi WJ, Katusic SK, Colligan RC, Weaver AL, Jacobsen SJ. Early life risk factors for attention-deficit/hyperactivity disorder: a population-based cohort study. *Mayo Clinic Proceedings* 2004;79(9):1124-1131.
26. Szatmari P, Offord DR, Boyle MH. Correlates, associated impairments and patterns of service utilization of children with attention deficit disorder: findings from the Ontario Child Health Study. *Journal of Child Psychology and Psychiatry* 1989;30(2):205-217.
27. Faraone SV, Perlis RH, Doyle AE, Smoller JW, Goralnick JJ, Holmgren MA, Sklar P. Molecular genetics of attention-deficit/hyperactivity disorder. *Biological Psychiatry* 2005;57(11):1313-1323.
28. Fergusson DM, Woodward LJ, Horwood LJ. Maternal smoking during pregnancy and psychiatric adjustment in late adolescence. *Archives of General Psychiatry* 1998;55(8):721-727.
29. Romano E, Tremblay RE, Farhat A, Cote S. Development and prediction of hyperactive symptoms from 2 to 7 years in a population-based sample. *Pediatrics* 2006;117(6):2101-2110.
30. Elgar FJ, Curtis LJ, McGrath PJ, Waschbusch DA, Stewart SH. Antecedent-consequence conditions in maternal mood and child adjustment: a four-year cross-lagged study. *Journal of Clinical Child & Adolescent Psychology* 2003;32(3):362-374.
31. Kohen DE, Brooks-Gunn J, Leventhal T, Hertzman C. Neighborhood income and physical and social disorder in Canada: associations with young children's competencies. *Child Development* 2002;73(6):1844-1860.
32. Brownell MD, Yogendran MS. Attention-deficit hyperactivity disorder in Manitoba children: medical diagnosis and psychostimulant treatment rates. *Canadian Journal of Psychiatry* 2001;46(3):264-272.
33. Rappley MD, Gardiner JC, Jetton JR, Houang RT. The use of methylphenidate in Michigan. *Archives of Pediatrics & Adolescent Medicine* 1995;149(6):675-679.
34. Jensen PS, Kettle L, Roper MT, Sloan MT, Dulcan MK, Hoven C, Bird HR, Bauermeister JJ, Payne JD. Are stimulants overprescribed? Treatment of ADHD in four U.S. communities. *Journal of the American Academy of Child & Adolescent Psychiatry* 1999;38(7):797-804.
35. Charach A, Cao H, Schachar R, To T. Correlates of methylphenidate use in Canadian children: a cross-sectional study. *Canadian Journal of Psychiatry*

2006;51(1):17-26.

36. Miller AR, Lalonde CE, McGrail KM, Armstrong RW. Prescription of methylphenidate to children and youth, 1990-1996. *CMAJ ? Canadian Medical Association Journal* 2001;165(11):1489-1494.
37. Robison LM, Sclar DA, Skaer TL, Galin RS. National trends in the prevalence of attention-deficit/hyperactivity disorder and the prescribing of methylphenidate among school-age children: 1990-1995. *Clinical Pediatrics* 1999;38(4):209-217.
38. Safer DJ, Zito JM, Fine EM. Increased methylphenidate usage for attention deficit disorder in the 1990s. *Pediatrics* 1996;98(6 Pt 1):1084-1088.
39. Fliers E, Vermeulen S, Rijsdijk F, Altink M, Buschgens C, Rommelse N, Faraone S, Sergeant J, Buitelaar J, Franke B. ADHD and Poor Motor Performance From a Family Genetic Perspective. *Journal of the American Academy of Child & Adolescent Psychiatry* 2009;48(1):25-34.
40. Drabick D, Gadow K, Sprafkin J. Co-occurrence of conduct disorder and depression in a clinic-based sample of boys with ADHD. *Journal of Child Psychology and Psychiatry* 2006;47(8):766-774.
41. Baeyens D, Roeyers H, Van Erdeghem S, Hoebeke P, Vande Walle J. The prevalence of attention deficit-hyperactivity disorder in children with nonmonosymptomatic nocturnal enuresis: a 4-year followup study. *Journal of Urology* 2007;178(6):2616-2620.
42. Angold A, Costello EJ, Erkanli A. Comorbidity. *Journal of Child Psychology and Psychiatry* 1999;40(1):57-87.
43. Corkum P, Moldofsky H, Hogg-Johnson S, Humphries T, Tannock R. Sleep problems in children with attention-deficit/hyperactivity disorder: impact of subtype, comorbidity, and stimulant medication. *Journal of the American Academy of Child & Adolescent Psychiatry* 1999;38(10):1285-1293.
44. Kadesjo B, Gillberg C. The comorbidity of ADHD in the general population of Swedish school-age children. *Journal of Child Psychology and Psychiatry* 2001;42(4):487-492.
45. Shreeram S, He JP, Kalaydjian A, Brothers S, Merikangas KR. Prevalence of enuresis and its association with attention-deficit/hyperactivity disorder among U.S. children: results from a nationally representative study. *Journal of the American Academy of Child & Adolescent Psychiatry* 2009;48(1):35-41.
46. Biederman J, Newcorn J, Sprich S. Comorbidity of attention deficit hyperactivity disorder with conduct, depressive, anxiety, and other disorders. *American Journal of Psychiatry* 1991;148(5):564-77.
47. Corkum P, Tannock R, Moldofsky H. Sleep disturbances in children with attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry* 1998;37(6):637-646.
48. Owens JA, Maxim R, Nobile C, McGuinn M, Msall M. Parental and self-report of sleep in children with attention-deficit/hyperactivity disorder. *Archives of Pediatrics & Adolescent Medicine* 2000;154(6):549-555.
49. Biederman J, Milberger S, Faraone SV, Kiely K, Guite J, Mick E, Ablon JS, Warburton R, Reed E, Davis SG. Impact of adversity on functioning and comorbidity in children with attention-deficit hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry* 1995;34(11):1495-1503.
50. Fischer M, Barkley RA, Edelbrock CS, Smallish L. The adolescent outcome of hyperactive children diagnosed by research criteria: II. Academic, attentional, and neuropsychological status. *Journal of Consulting & Clinical Psychology* 1990;58(5):580-588.
51. Fischer M, Barkley RA, Fletcher KE, Smallish L. The adolescent outcome of hyperactive children: predictors of psychiatric, academic, social, and emotional adjustment. *Journal of the American Academy of Child & Adolescent Psychiatry* 1993;32(2):324-332.
52. Fergusson DM, Horwood LJ. Early conduct problems and later life opportunities. *Journal of Child Psychology and Psychiatry* 1998;39(8):1097-1108.
53. Fergusson DM, Horwood LJ, Lynskey MT. The effects of unemployment on psychiatric illness during young adulthood. *Psychological Medicine* 1997;27(2):371-381.
54. Biederman J, Monuteaux MC, Mick E, Spencer T, Wilens TE, Klein KL, Price JE, Faraone SV. Psychopathology in females with attention-deficit/hyperactivity disorder: a controlled, five-year prospective study. *Biological Psychiatry* 2006;60(10):1098-1105.
55. Costello EJ, Erkanli A, Federman E, Angold A. Development of psychiatric comorbidity with substance abuse in adolescents: effects of timing and sex. *Journal of Clinical Child Psychology* 1999;28(3):298-311.
56. Solanto MV, Gilbert SN, Raj A, Zhu J, Pope-Boyd S, Stepak B, Vail L, Newcorn JH. Neurocognitive functioning in AD/HD, predominantly inattentive and combined subtypes. *Journal of Abnormal Child Psychology* 2007;35(5):729-744.
57. Hinshaw SP, Carte ET, Fan C, Jassy JS, Owens EB. Neuropsychological functioning of girls with attention-deficit/hyperactivity disorder followed prospectively into adolescence: evidence for continuing deficits? *Neuropsychology* 2007;21(2):263-273.
58. Thorell LB, Wahlstedt C. Executive functioning deficits in relation to symptoms of ADHD and/or ODD in preschool children. *Infant and Child Development* 2006;15(5):503-518.

59. Loo SK, Humphrey LA, Tapio T, Moilanen IK, McGough JJ, McCracken JT, Yang MH, Dang J, Taanila A, Ebeling H, Jarvelin MR, Smalley SL.. Executive functioning among Finnish adolescents with attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry* 2007;46(12):1594-1604.

60. Barkley RA, Edwards G, Laneri M, Fletcher K, Metevia L. Executive functioning, temporal discounting, and sense of time in adolescents with attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD). *Journal of Abnormal Child Psychology* 2001;29(6):541-556.

61. Beitchman JH, Brownlie EB, Inglis A, Wild J, Ferguson B, Schachter D, Lancee W, Wilson B, Mathews R.. Seven-year follow-up of speech/language impaired and control children: psychiatric outcome. *Journal of Child Psychology and Psychiatry* 1996;37(8):961-970.

62. Clark C, Prior M, Kinsella G. The relationship between executive function abilities, adaptive behaviour, and academic achievement in children with externalising behaviour problems. *Journal of Child Psychology and Psychiatry* 2002;43(6):785-796.

63. Calhoun SL, Dickerson Mayes S. Processing speed in children with clinical disorders. *Psychology in the Schools* 2005; 42(4):333-343 .

64. Rabiner D, Coie JD, Conduct Problems Prevention Research Group. Early attention problems and children's reading achievement: a longitudinal investigation. *Journal of the American Academy of Child & Adolescent Psychiatry* 2000;39(7):859-867.

65. Cohen NJ, Davine M, Horodezky N, Lipsett L, Isaacson L. Unsuspected language impairment in psychiatrically disturbed children: prevalence and language and behavioral characteristics. *Journal of the American Academy of Child & Adolescent Psychiatry* 1993;32(3):595-603.

66. Cunningham CE, Boyle MH. Preschoolers at risk for attention-deficit hyperactivity disorder and oppositional defiant disorder: family, parenting, and behavioral correlates. *Journal of Abnormal Child Psychology* 2002;30(6):555-569.

67. Keown LJ, Woodward LJ. Early parent-child relations and family functioning of preschool boys with pervasive hyperactivity. *Journal of Abnormal Child Psychology* 2002;30(6):541-553.

68. Greenhill LL, Posner K, Vaughan BS, Kratochvil CJ. Attention deficit hyperactivity disorder in preschool children. *Child & Adolescent Psychiatric Clinics of North America* 2008;17(2):347-366.

69. Lee SI, Schachar RJ, Chen SX, Ornstein TJ, Charach A, Barr C, Ickowicz A. Predictive validity of DSM-IV and ICD-10 criteria for ADHD and hyperkinetic disorder. *Journal of Child Psychology and Psychiatry* 2008;49(1):70-78.

Note:

[a] American Psychiatric Association. *Diagnostic and statistical manual of mental disorders Text Revision (DSM-IV-TR)* . 4th Ed. Washington, DC: American Psychiatric Publishing, Inc., 2000.