ATTENTION DEFICIT/HYPERACTIVITY DISORDER: UNDERWRITING IMPLICATIONS

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Abstract

Attention deficit/hyperactivity disorder (AD/HD) encompasses a wide clinical spectrum which can have major significance in the underwriting process of insurance. Recent studies suggest that there is evidence of familial incidence for AD/HD as well as association with affective disorders. The combination of depression and AD/HD is associated with a higher incidence of completed suicide than with depression alone.

ATTENTION deficit disorder, with and without hyperactivity, is a heterogenous disorder of unknown etiology characterized by inattentiveness, excessive motor activity, impulsivity, and distractibility. It is a major clinical and public health problem estimated to affect 6% to 9% of school age children. It is one of the most common causes of referrals in family practice, pediatric, neurology, and child psychiatry clinics. Treatment, which can vary significantly from doctor to doctor and from region to region, can include medical as well as psychotherapy or a combination of both.

As such, this disorder has particular significance in the underwriting of life and health insurance policies. In this article we hope to raise consciousness regarding the breadth of symptomatology and severity of attention deficit/hyperactivity disorder (AD/HD), as well as explore underwriting implications.

Clinical Perspective

As with most psychiatric conditions, AD/HD is a clinical spectrum. This can range from the minimally affected first grader who has reading difficulties to the destructive uncontrollable teen. It is clear that there are certain affective disorders that when present in combination with AD/HD can signal concern for more serious underlying psychiatric needs and concerns.

Recent studies have shown that there appears to be a significant correlation between AD/HD and affective disorders. Anderson et al² found that 15% of children with attention deficit also had a major depressive disorder. Similar findings were reported by Bird et al.³ In clinical samples, Staton and Brumback reported that 75% of hyperactive children met criteria for depression.⁴

In addition to affective disorders, AD/HD can be associated with conduct disorders. Conduct disorder is defined by DSM III as a persistent pattern of conduct in which the basic rights of others and major appropriate societal norms or rules are violated. Kutcher⁵ reported that within an adolescent group diagnosed with conduct disorder, the incidence of substance abuse and AD/HD was higher than in the normal population.

Familial Incidence

Studies of AD/HD patient family members show that relatives suffer from a statistically greater incidence of psychiatric disorders. Biederman⁶ reports that the risk for AD/HD, antisocial behaviors, and mood disorders among relatives of AD/HD patients were significantly higher than those observed among relatives of both psychiatric and normal controls. In these findings, 64.8% of the AD/HD group had at least one relative with AD/HD compared with only 24.0% of the psychiatric controls and 15.4% of the normal controls. The morbidity risks for adult or child anxiety disorders and drug dependence were significantly higher in relatives of AD/HD patients compared with relatives of normals.

Biederman⁶ also reports that the overall risk for affective disorders among relatives of AD/HD patients was higher than normal controls. He also addresses the possibility that these results could be more reflective of the stresses of living with a child with AD/HD by noting that in his data the finding that the onset of parental depression preceded the onset of AD/HD symptoms in the child. Interestingly, he also shows that this increased risk among relatives was independent of social class of intactness of the family.

It therefore appears that there is strong indication of some form of familial association between AD/HD as well as other affective disorders.
Morbidity and Mortality Risk Classification

The mixture of impulsiveness, excessive energy, and lack of concentration is a potent combination which frequently is channeled in hazardous behaviors. The impulsivity can manifest itself by increased trauma, risky sexual practices, and substance abuse, for example. However, with the addition of affective disorders especially depression, which we have seen is not an infrequent accompaniment, the energy expenditure often is turned inward and sometimes can be lethal.

The high rate of AD/HD among depressed adolescents who committed suicide, along with an increased rate of suicide attempts found among hyperactive children, suggests that children with AD/HD plus depression are at risk for greater psychiatric morbidity, disability, and perhaps suicide than other children with AD/HD by itself. These findings are again echoed in a study by Brent who found although adolescents who committed suicide and those who attempted suicide did not differ in overall rates for affective disorders, those who also had a diagnosis of hyperactivity in addition to the affective disorder had a higher rate of successful attempts. Indeed the combination of depression and impulsivity seem to be a deadly combination.

Despite the thought that hyperactivity is a disorder which a child "grows out of," AD/HD seems for some to persist into adulthood. One study reported that the full AD/HD syndrome persisted in 31% of male patients. Conduct and substance abuse disorders aggregated to AD/HD patients in which the condition persisted into adulthood. In fact persistence of AD/HD symptoms was the greatest risk factor for the development of antisocial personality disorder and substance abuse disorders.

Underwriting for Insurance

The syndrome of hyperactivity/attention deficit covers a wide spectrum. As mentioned earlier in this article, it can range from the minimally affected to the severe. In order to classify the risk for any one particular individual it is necessary to look for clues as to the severity and extent of the disorder as well as concomitant psychiatric disorders.

As a rule of thumb, I would like to propose the use of the mnemonic: DEFICIT.

In the underwriting of AD/HD look for the following clues to stratify the extent and complexity of the disorder:

D- Depression, as we have seen, the combination of hyperactivity and depression can be a lethal duo. Previous suicide attempts should be heeded as a very serious warning given the higher than average rate of completed suicide in this combination group.

E- ETOH or drug abuse, the diagnosis of AD/HD should alert the cautious underwriter to search for soft signs of substance abuse.

F- Family history, since there is at least some loose association between family members, any family history of hyperactivity or excessive impulsive behavior as well as affective disorders should be evaluated.

I- Impulsive Behavior, look for high risk activities, often AD/HD patients are described as thrill seekers or "all boy." There may be a history of excessive injuries, fractures or frequent trips to the Emergency room. In the adolescent watch for speeding tickets or motor vehicle accident history.

C- Conduct disorder, has the patient had run-ins with the police? Any vandalism, theft, assault, etc. Has the patient ever been referred by the school for behavior problems?

I- Inattentiveness, how has the patient been performing in school or work? Are the symptoms still adversely affecting performance? Any improvement with treatment?

T- Time, how long has it been since the last treatment? The majority of children afflicted with this disorder do improve with age. However, those who continue to show symptoms into adulthood are likely to be ones who continue to have problems.

Summary

Attention deficit/hyperactivity disorder is a wide reaching syndrome with a wide spectrum of clinical involvement. In its most benign form it is little more than an annoyance which the child eventually outgrows. However, in its most severe form, particularly in association with affective disorders it can manifest many severe symptoms which can be quite lethal and continue into adulthood.

References


