Does your patient have a residual neurodevelopmental disorder?

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Symptoms of neurodevelopmental disorders are difficult to recognize because patients often 'age out' of obvious manifestations

Neurodevelopmental disorders are "life span" clinical syndromes[1] that may contribute to development of axis I and axis II disorders and are associated with high rates of psychiatric comorbidity. Behaviors and symptoms of neurodevelopmental disorders are enduring and difficult to recognize—particularly in their milder and attenuated forms—because patients often "age out" of obvious manifestations. High rates of comorbidity with other DSM-IV-TR disorders also can contribute to substantial underdiagnosis and underrecognition. Failure to accurately identify a residual neurodevelopmental disorder can cause problems establishing and maintaining a working alliance and may lead to poor treatment outcomes.

Clues to help identify patients with residual neurodevelopmental symptoms include:

- repeating grade levels, requiring special education services, and/or failing to graduate high school
- academic and/or career underachievement
- developing uneven sensory, motor, cognitive, and/or academic skills
- chronically distressed "high achiever"
- long-term social ostracism and/or peculiarity.

Classification and typology

Patients within the dyslexic spectrum typically have a history of difficulty reading, spelling, and writing. These problems cannot be explained adequately by sociocultural factors and/or general limitations in cognition.

Nonverbal learning disability patients have selective deficits in math reasoning and visuospatial processing, motor planning problems, and, at times, weak social interaction skills.

Signs of suspected residual attention-deficit/hyperactivity disorder include a history—usually dating back to elementary school—of poor concentration and weak retention abilities. These patients also have difficulty organizing, planning, and completing activities, particularly those requiring multiple steps and/or sustained mental effort.

Socially ostracized patients with social peculiarity, especially if coupled with ≥1 specific information processing and learning problems, frequently have mild residual difficulties that fall within the pervasive developmental disorder (autistic) spectrum.

Patients with histories of "across-the-board" problems acquiring academic skills and a lack of compensatory success in at least some non-academic pursuits may have generalized intellectual disability. This may be so-called "borderline" intellectual functioning or, in a much smaller number of cases, mild mental retardation/mild intellectual disability.

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Making an accurate diagnosis

To more easily identify patients with a residual developmental disorder, take a more detailed academic/educational history that includes Scholastic Aptitude Test scores, previous "coding" for ≥1 special needs psychoeducational conditions, and/or a childhood/adolescent history of psychometric testing. Also, obtain your patient's educational/psychoeducational records.

Complete a detailed developmental history that includes exploring subtle anomalies in acquiring language pragmatics, motor coordination/planning, and social interaction skills.

Interview parents, spouses, and friends who are familiar with your patient's longitudinal neurodevelopmental functioning.

Review recent texts on residual neurodevelopmental disorders.[2] Consider referring your patient for psychometric testing to firm up diagnostic impressions and assist in treatment planning.

References

1. Stimmel GL. Addressing the chronicity of ADHD across the life span: implications for long-term adherence. Psychiatric Times Reporter. 2009;(suppl):1-7.
2. Pennington BF. Diagnosing learning disorders: a neuropsychological framework. 2nd ed. New York, NY: Guilford Press; 2008.