The Crisis of Overdiagnosed ADHD in Children

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This commentary arises from my concern about the superficiality that characterizes the process of diagnosing attention-deficit/hyperactivity disorder (ADHD) in children—usually followed by the prescription of one of the most powerful drugs on earth, methylphenidate. The years pass and I see an even more frightening picture—one in which disorders in children are often given inaccurate and punitive psychiatric diagnoses and treated with inappropriate medication. And yet, the 2 organizations that represent the majority of American psychiatrists, the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) show no sign of worry, despite the terrible consequences that often follow when a disorder is incorrectly diagnosed and treated in emotionally disturbed young people.

Consider the case of María (not her real name), a Hispanic teenager I have been treating for several years. In 2003, María and her mother came to me because the girl had been experiencing hallucinations, racing thoughts, insomnia, elevated mood, and grandiose ideation. She had been taking mixed amphetamine salts prescribed by another psychiatrist who had diagnosed ADHD. No doubt, the psychiatrist had based this diagnosis on features such as increased energy and arousal as well as disruptive behavior and distractibility in the classroom. But the patient's symptoms and family history made me suspicious of a psychotic or affective disorder, especially in light of what María's mother told me: "María is acting exactly like her father, and you know that I have a bad temper and my mother is schizophrenic."

I decided to discontinue the mixed amphetamine salts and started giving María quetiapine. Unfortunately, the psychotic process that had been under way for some time could not simply be stopped in its tracks. A week later, the girl's mother called me in desperation because María had just run into oncoming traffic, apparently in response to the ongoing command auditory hallucinations she was experiencing. I advised her mother to take her to the hospital immediately and talked with the doctor on call to discuss my impression that María's symptoms were a common side effect of amphetamines when they are prescribed to individuals with bipolar spectrum disorders. Despite the obvious red flags for a serious mental illness, María was hospitalized with a primary diagnosis of oppositional defiant disorder (ODD) and ADHD as a secondary diagnosis. In her mental status examination report, the admitting psychiatrist quoted the girl as saying that she was "hearing voices." Yet this doctor wrote, "I am not clear if the patient is really psychotic, or [whether] she is just trying to get what she wants and using the symptoms to her advantage."

In a discharge summary, the physician noted ADHD as the final diagnosis but sent the girl home on a regimen of 200 mg of quetiapine at bedtime. I suspect this doctor was deferring to my judgment while maintaining his belief that ADHD was the correct diagnosis.

Factors contributing to misdiagnosis

This sort of disposition is all too familiar to me in my practice, which raises the following question: how can competent and caring psychiatrists miss the diagnostic target when assessing patients like María? There may be a few important contributing factors:

- **Failure to obtain a complete family history.** Family history was reported as "negative" by both the inpatient psychiatrist and the outpatient psychiatrist who had preceded me. In reality, the family history was strongly positive, based on my evaluation and treatment of several of the patient's relatives. Specifically, bipolar disorder had been diagnosed in the patient's parents, sister, and maternal cousin; her maternal grandmother had schizophrenia; the
paternal grandfather had a history of extreme violence; and her maternal uncle had a history of depression.

- **Cultural and linguistic barriers.** The other doctors involved in María’s care did not speak Spanish, and the patient’s mother does not speak English. This sort of communication barrier is known to create diagnostic confusion and may interfere with culturally competent treatment.5,6

- **Failure to communicate with clinicians who know the patient well.** Neither the clinician who performed the initial intake nor the evaluating psychiatrist on call that weekend called to speak with me.

- **Misconstruing behaviors as causative explanations.** "Hyperactivity," "oppositional behavior," and "defiance" may be seen in a variety of neuropsychiatric disorders. This does not mean that we should ignore better-defined disorders such as bipolar disorder and reflexively diagnose ADHD or ODD.

María's case illustrates not only the trend toward overdiagnosing ADHD but also the dangers inherent in DSM-IV-TR diagnoses of conduct disorder and ODD.7 Both diagnoses may open the door to blaming the victim for behavior that he or she cannot control and denying medical services to patients in desperate need of psychiatric services.

To dissipate any doubt as to how much confusion the ODD diagnosis has brought to the mental health community, suffice it to say that in a note written by the social worker who held a family session with María and her mother, this professional implied that there was a secondary gain in the girl's auditory hallucinations and display of anger, that is, to manipulate her mother. The social worker also noted that the treating psychiatrist labeled María's symptoms as "behavioral" and, therefore, not suitable for inpatient treatment.

Obviously, 2 experienced professionals forgot that behavior is determined by the patient's psychological functioning (mood, needs, and dynamics).8 The patient's supposed manipulation of her mother, in my judgment, was an expression of her anger and represented a sign of mental illness—not a conscious decision to be bad just for the fun of it. Indeed, the whole concept of the manipulative patient has been carefully deconstructed by Bowers.9

Like the social worker and the psychiatrist in this case, thousands of experienced professionals and psychiatric residents at training centers follow the guidelines set forth in DSM-IV-TR. This is why I postulate that a real change in the current child-blaming stance has to start from the top: the APA and the AACAP need to make the first move if we are to influence the writers of the guiding principles in DSM-V.

I think that our profession has been in the grips of a kind of post-Freudian denial when it comes to recognizing psychiatric disorders in children. I believe this denial has indirectly contributed to high rates of school dropouts and unnecessary commitments to juvenile detention centers. For example, by the time of her hospitalization, María had already been sent by the school district to a school for the behaviorally disturbed because of her aggression toward teachers and peers as well as her defiance of adult authorities.

In the past 10 years, I have been the medical director at a juvenile detention center and several residential treatment centers. I have reviewed hundreds of cases that started with placement of a youngster in foster care, owing to parental abuse and neglect; and ended up with the child being transferred to a detention facility because of aggressive behavior or sexual acting out, often exacerbated by the ADHD medications wrongly prescribed on the basis of an incorrect diagnosis. Need for a more logical approach

Having seen all too many cases like that of María, I have joined the voices of a few colleagues, such as Charles Huffine9,10 and Andres Pumariega,11 who have called for a more logical approach to diagnosing mental illnesses in children. The current DSM classification of childhood diseases resembles a collection of recipes in which several "dishes" look very similar, even though they originate from exceedingly different ingredients. That is, DSM-IV classification fails to distinguish among conditions presenting with similar symptoms (including, hyperactivity, agitation, increased energy) but arising from vastly different disorders. This problem is exacerbated by diagnostic conclusions based on the clinician's best recollection of DSM-IV wording and arrived at after 10-to-15-minute evaluations.

For the sake of children like María, I believe it is time for a change in perspective.4,12 We need to open our ears when a mother says, "Doctor, I am bipolar, and I think that my son has what I have."
References

7. Mota-Castillo M. Eliminate conduct disorders and ODD . . . this is the right time! *J Hisp Am Psychiatry.* 2004;4:3-5.


Links:

[1] [http://www.psychiatrictimes.com/adhd](http://www.psychiatrictimes.com/adhd)
[3] [http://www.psychiatrictimes.com/schizophrenia](http://www.psychiatrictimes.com/schizophrenia)
[9] [http://www.psychiatrictimes.com/authors/manuel-mota-castillo-md](http://www.psychiatrictimes.com/authors/manuel-mota-castillo-md)