To the Editor:

I have a comment regarding three articles in *CNS News*, February 2007, which seem to be closely intertwined: "'NOS' Too Often a Catch-All Diagnosis in Child Psychiatry" (p. 1), "High Switch Rate From ADHD Found in Children, Adolescents" (p. 13) and "Bipolar Disorder Seen in Preschoolers" (p. 13).

Not otherwise specified (NOS) is a well-justified diagnosis in child psychiatry, as we still do not have a child-oriented classification of mental problems, and are desperately trying to fit child pathology into an adult-oriented mold. Strangely enough, we do not buy clothes or furniture for our children in adult stores, we do not entertain them with movies geared toward adults, but we feel quite at ease using an adult measuring tape for children in psychiatry. The sad truth is that our child psychiatry is, so to speak, developmentally delayed and at this point we are probably at prekindergarten levels in terms of our knowledge.

This brings me to the article regarding preschoolers with bipolar disorder. For quite a few years now, I have been seeing four- and five-year-olds with symptoms of overt mania and psychosis. I respectfully disagree with the concept of "conversion" of attention-deficit/hyperactivity disorder (ADHD) into bipolar or any other mental disease.

I recently evaluated a 7-year-old boy with severe manic agitation, grandiose delusions, hypersexuality and a dangerous level of aggression and self-destruction due to his sense of invincibility. He was put on [guanfacine] during his recent inpatient admission, which was also prescribed by his outpatient psychiatrist, who insisted that the child had oppositional behavior, attention problems and past sexual abuse (without any data substantiating those allegations). The team working with this psychiatrist was quite upset with the parents, who insisted that the child could not have had just behavioral problems, given his level of inexhaustible energy and inability to sleep for more than four hours a day. Eventually, the psychiatrist and the team directly asked the family not to interfere with the work of "professionals" and to stop making their own diagnosis. After my evaluation, we sent the child directly into another inpatient unit, where he was treated with appropriate medications.

Similar cases of misdiagnoses are unfortunately more of a rule than an exception. Almost on a weekly basis, I see one or more intakes of children or adolescents misdiagnosed with ADHD, oppositional defiance disorder (ODD) or depression, with signs of mixed emotional phases or psychosis completely overlooked and accordingly mistreated by previous providers.

It appears that we have three big areas of concern in child psychiatry with regard to diagnostic approach. First, we do not have a child-oriented diagnostic manual. The second problem is that few child psychiatrists are prepared or trained to interview children in a professionally appropriate manner, keeping in mind the possibility of mood disorders, psychosis, formal thought disorders, etc. I guess we pay a high price for years of denying the possibility of medical psychiatric problems in children, writing them off to the family malfunctioning or "behavioral" problems.

The third and most complicated issue is that the symptomatology we see in children is not evidence of an ultimate diagnosis. In my work with an adult psychiatric population, I always take time to review early development and ask specific questions regarding behavior and mood, as far back as my patients can remember. The vast majority can remember emotional and behavioral problems (diagnosed as ADHD, ODD, conduct disorder, etc.) preceding the development of schizophrenia, schizoaffective disorder, severe bipolar disorder, etc. In light of this, the use of the term,NOS, is legitimate. The fact that the child shows mania does not mean that the diagnosis is going to be "bipolar;" it could become something else in the years to come. By virtue of anatomical and developmental immaturity, children present with mercurial changes of symptomatology in any given age group. That's why it looks more appropriate just to outline the nosological area of concern, paying close attention to presenting phenomenology, which would ultimately define the treatment intervention. In this case, we hopefully can avoid using guanfacine in an acutely psychotic child.

It appears that by now we have almost a dichotomy: to diagnose with either bipolar disorder or ADHD. Why not consider the coexistence of psychosis/mood disorders along with frontal lobe deficiency? It is not uncommon for children and adults with a long-standing major psychiatric pathology display symptom presence with a lack of attention, concentration, set shifting, planning, etc. There are studies showing that the frontal lobe changes in adult patients with long-standing psychotic disorders with clinically corresponding deficits in executive functioning. So, we can deal with the possibility of two independent phenomena of concomitant ADHD and psychotic disorder, as well as secondary frontal lobe deficiency, as a complication of a psychotic process.

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Hopefully, as we accumulate more clinical data, we will come to a better understanding of those very complicated issues.

Sincerely,

Irene Abramovich, MD, PhD
Children's Treatment Center
West Hartford, Conn.