Lost in the SHUFFLE

The Inattentive Child without Hyperactivity

BY MARY ROBERTSON, R.N.

AD/HD-C (combined type) and AD/HD-I (predominantly inattentive type) differ dramatically, yet within the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*), they are subtypes of the same disorder: attention-deficit/hyperactivity disorder (AD/HD). As the parent of two children, one diagnosed with AD/HD-C and one with AD/HD-I, I learned the hard way how this excessively broad diagnostic category creates confusion and misinformation and—most troubling—can result in delayed diagnosis and less effective treatment for children who are inattentive but not hyperactive.

From the day Samantha was born, she was undeniably different from her brother. She rarely cried and seemed perfectly content to have simply joined the world, cooing her afternoons away. Her brother Anthony, on the other hand, cried throughout infancy, was hard to console and did not stay satisfied for long. With the passing of each year, their differences intensified.

Once Anthony learned to crawl, he moved quickly to jumping, climbing and running. A

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very alert child, he soaked up everything in his environment. Novelty thrilled him. While his eyes sparkled with excitement, I could barely keep mine open; he exhausted me. In fact, I decided to go back to work as an oncology nurse, just for the break. For a short while, he enjoyed preschool, but the feeling wasn't mutual. His growing frustration with following rules in a structured setting combined with his excessive energy led to aggressive behavior.

After he ripped the mini-blinds off the window and pushed everything on the director's desk to the floor, his teachers decided they'd had enough, and he was kicked out of the program. As I tearfully got his Ninja Turtle lunch box from his cubby, the director suggested that I have him evaluated for "hyperactivity." I didn't need a doctor to tell me that he was hyperactive. It had never occurred to me that there might be a medical reason for his out-of-control behavior. After visiting his pediatrician, a neurologist, an allergist and finally a psychiatrist, Anthony was diagnosed with AD/HD-C.

In stark contrast, Samantha's preschool years were idyllic. She was cooperative, loving and friendly. In fact, one day she came to me and asked why I never gave her "time outs" when Anthony received them all the time.

I must admit that I often glowed with maternal pride while watching Samantha play so nicely, especially after years of parenting a child who was hyperactive. However, at times I wondered if she was too quiet and too complacent. She did not even try to walk until she was 17 months old. Although at some level I was concerned during her infancy and preschool years, I relished the calmer behavior. I dismissed my concerns because, after all, I was comparing her to her on-the-go brother.

Difficulties in school

Not until after Samantha started elementary school did her undetected AD/HD-I symptoms create problems. Her behaviors weren't glaringly inappropriate; instead they were insidious. At first, her teachers noticed that she seemed to miss directions and other important information. She then began to submit incomplete work and misplace supplies and homework. Gradually, poor time management and difficulties in recognizing cues affected her learning and confidence. Her worries about the daily challenge to keep up in school grew, and by the time Samantha was in the second grade, she dreaded going to school and often refused to leave my side. Once again, we turned to a psychiatrist for help.

She had developed an anxiety disorder, according to the psychiatrist, but surprisingly to me, he also gave her the same general diagnosis as her wildcat brother: AD/HD. Unlike Anthony, however, Samantha's symptoms fell into the category AD/HD-I (predominately inattentive type).

Other than their apparent mutual inability to sustain attention, Anthony and Samantha are polar opposites. Anthony seems driven by an industrial-sized motor, with many interests and hobbies, but Samantha's motor often rests in neutral, making it hard for her to sustain interest in activities, often leaving her bored and dissatisfied. Overall, Anthony tends to be a leader, frequently speaks too loudly, is persistent when making a point and is a bit egocentric. Samantha, on the other hand, tends to follow others and is quieter, humorous, articulate and resilient. Interestingly, Anthony has always thrived on organization, unlike many with AD/HD. As a toddler, he organized my Tupperware. More predictably, Samantha's room contains piles of clothing, CDs out of their cases, scattered magazines, beauty supplies here and there, etc.

Academic differences

Their academic differences are striking. To Samantha, reading came easily and remains one of her strengths, but Anthony was diag-

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nosed with a reading disability in first grade. Anthony excelled in math and now is a college junior in mechanical engineering. Samantha breaks out in a cold sweat at the mention of math, and as a high school junior is considering a career in broadcasting.

Could these two children be more different? How can they possibly have the same DSM-IV diagnosis? I'm not alone in my confusion with this diagnostic label. The media often use the acronyms ADD (attention deficit disorder) and AD/HD to describe two different forms of attentional problems or use ADD to include all types of attention deficits, as in "attention deficit disorders." It's safe to say that most people perceive AD/HD as a label for hyperactivity, impulsivity and inattentiveness. Thus, children with AD/HD-I are out of the public picture altogether.

Compared to others who have AD/HD-I, Samantha was diagnosed early. Many people are in high school or beyond before their struggles are recognized as symptoms of a treatable health disorder. Although initial symptoms may appear harmless, as academic and social demands increase, those same symptoms may begin to have a negative impact on school and social performances. Undiagnosed, blame is often placed on the predominantly inattentive child for behaviors such as poor organization skills or inability to maintain self-motivation. Others may begin to find blame with the parents for an apparent lack of skill. Unfortunately, trying to place blame delays the evaluation process and, thus, delays access to appropriate interventions and accommodations.

In the future, researchers may learn that AD/HD-C and AD/HD-I are indeed two entirely different disorders. For now, wouldn't it be clearer if these subtypes were listed separately with their own sets of criteria and treatment recommendations?

For a list of references for this article, please visit www.chadd.org/references.

Understanding the Differences Between AD/HD-C and AD/HD-I

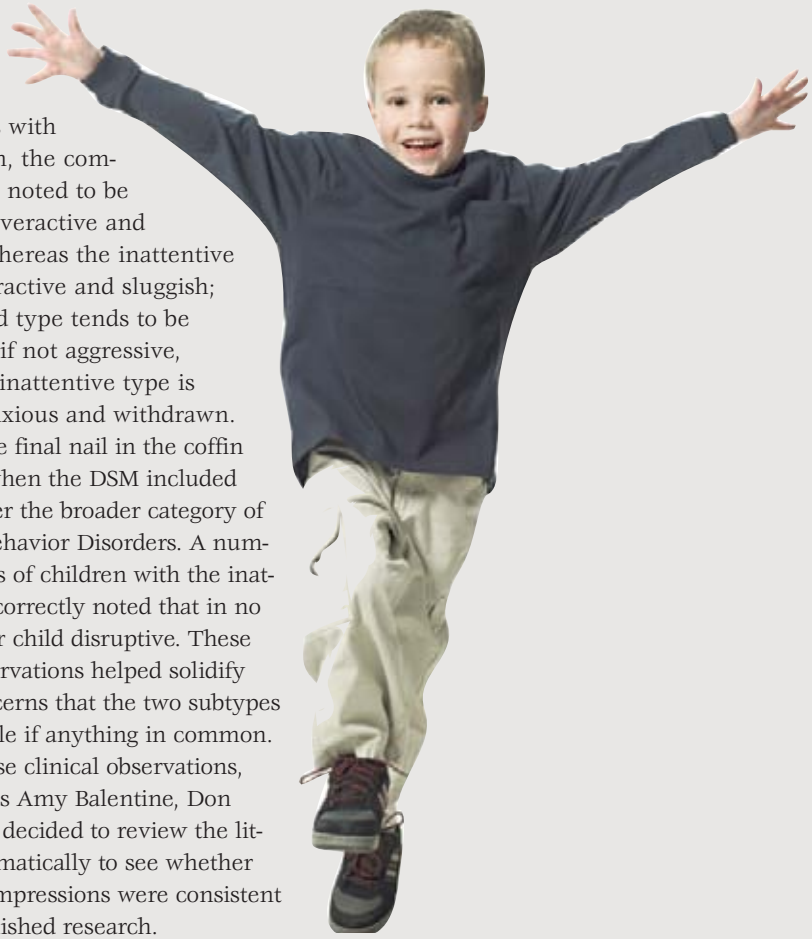
An Interview with Richard Milich, Ph.D.

BY MARY ROBERTSON, R.N.

Richard Milich, Ph.D., a professor of psychology at the University of Kentucky, has argued that AD/HD-C and AD/HD-I are distinct and unrelated disorders. Mary Robertson discussed concerns about the inclusion of the predominantly inattentive type under the title of AD/HD.

Q: You've written recently that the inattentive and combined subtypes of attention deficit/hyperactivity disorder (AD/HD) are distinct and unrelated disorders and that the inattentive subtype does not belong in the AD/HD category. What led you to these conclusions?

A: My concerns in this area started with clinical observations similar to the ones you identified for your two children, that the symptom picture for these two disorders was radically different. In fact, except for the common name and the possibility of common attention problems, I was hard pressed to find any behavioral similarities between the two disorders. In fact, I am not convinced that these two groups of children even have the same types of attention problems. As with your children, the combined type is noted to be excessively overactive and impulsive, whereas the inattentive type is underactive and sluggish; the combined type tends to be oppositional if not aggressive, whereas the inattentive type is often shy, anxious and withdrawn.



Perhaps the final nail in the coffin for me was when the DSM included AD/HD under the broader category of Disruptive Behavior Disorders. A number of parents of children with the inattentive type correctly noted that in no way was their child disruptive. These parental observations helped solidify my own concerns that the two subtypes may have little if anything in common. Based on these clinical observations, my colleagues Amy Balentine, Don Lynam and I decided to review the literature systematically to see whether our clinical impressions were consistent with the published research.

Q: What did you find from this review?

A: Unfortunately, perhaps the most startling aspects of the available research were the gaps and inconsistencies in the literature. What jumped out at us is that many of the most basic questions about the nature of the inattentive subtype had not been addressed. For example, we found no follow-up studies indicating what happens to these children as they get older. Similarly, there were only a handful of studies looking at the response of these children to treatment with stimulant medication. This is in contrast to the hundreds of studies examining this issue among the combined group.

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There were a number of intriguing findings suggesting that the two subtypes may represent completely different disorders.

A second problem we identified is that there were inconsistencies in how the children in the inattentive group were diagnosed for inclusion in the studies. These diagnostic inconsistencies may contribute to the inconsistent patterns of results we were finding in our review of the literature.

Q: What do you mean that there were inconsistencies in the diagnosis of the inattentive subtype?

A: We noticed that in a sense the literature was talking about two different types of inattentive disorders. First, we identified what can be considered the "classic" inattentive child, similar to your daughter Samantha. This is a child who clearly demonstrates problems in attention but has very few if any of the hyperactive/impulsive symptoms. When this "classic" group is studied, they tend to exhibit a pattern of behaviors that Keith McBurnett, Caryn Carlson and other investigators have identified as a "sluggish cognitive tempo" (SCT). These children tend to be underactive, sluggish, inattentive and "lost in space," and this is the group that clearly appears to be distinct from the AD/HD-combined type.

The second type of inattentive group we identified is what we called the subthreshold AD/HD-combined. This diagnosis actually reflects a problem with the *Diagnostic and Statistical Manual of Mental Disorders* diagnostic criteria for the inattentive subtype and also contributes to the inconsistencies in the literature. What we mean by the term subthreshold AD/HD-combined type is that these children clearly demonstrate problems in attention but they just miss meeting the criteria for the hyperactive/impulsive symptoms. They may have four or five symptoms of hyperactivity/

Editor's Note:
CHADD continuously works to provide its members and Attention!® readers with science-based information. The diagnostic and classification issues raised in this article, as well as the adult diagnostic criteria presented by Russell Barkley, Ph.D. and cited in the December issue of the magazine, are important but still emerging issues subject to discussion and debate by researchers and professionals. These ideas may or may not be addressed or incorporated in the next revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the official publication of the American Psychiatric Association used by clinicians and insurance companies to diagnose and classify mental disorders.

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impulsivity, but not the six symptoms required by the DSM to be formally diagnosed with AD/HD-combined type. Technically, then, according to the DSM criteria, the children are given a diagnosis of AD/HD-inattentive type. We argue in our paper that this does not make sense, because they exhibit a relatively large number of hyperactive/impulsive symptoms, just not a sufficient number to meet the arbitrary cutoff imposed by the DSM. Then, when research is undertaken comparing the inattentive and combined groups, if there are a large number of these subthreshold combined types in the inattentive group, this makes it much more difficult to find differences between the two groups.

Q: Given these problems in the research literature, it sounds as if it would be difficult, if not impossible, to draw any conclusions about whether the inattentive and combined types represent distinct or related disorders.

A: Difficult, but not impossible. We went into the review process with the preexisting bias that the two subtypes may well be distinct and unrelated disorders, and as I noted before, the research literature has too many gaps and problems from which to draw any firm conclusions. Nevertheless, there were a number of intriguing findings suggesting that the two subtypes may represent completely different disorders. The two disorders seemed to differ on many, if not most, of the defining features that go into identifying a disorder. These include the actual symptom picture, age of onset, boy-to-girl ratio, family history, comorbidity with other disorders and possibly other important areas that have not been addressed adequately.

I must admit that one of our goals in writing our paper was to raise these questions and to encourage researchers, as well as future DSM planners, to examine carefully whether the inattentive subtype is actually a subtype of AD/HD.

Q: What do your findings mean for parents with an inattentive child and

for the clinicians who may be treating this child?

A: Ideally, this diagnostic hairsplitting should not make any difference in the treatment of a child. As Bill Pelham argues, a careful assessment of a child should identify the specific areas of impairment, and the treatment recommendations should be targeted at these areas of impairment, regardless of the formal diagnosis. However, as you found out, the reality operates somewhat differently. Once a diagnosis is made, certain avenues of treatment come forward, such as stimulant medication, and other avenues of intervention may be overlooked, for example treatment of the anxiety symptoms. Because of the gaps in the literature we noted earlier, we don't even know what the optimal treatments for children with the inattentive subtype are. We believe that our understanding of the inattentive subtype has been seriously delayed because it is not identified as a separate disorder with unique problems, histories and treatments. In addition, we may be slow in identifying children with this subtype because they are not exhibiting the classic disruptive symptoms associated with AD/HD. In closing, the best advice I can give parents and the treating clinicians is to keep an open mind that the inattentive subtype of AD/HD may have little in common with the combined subtype. Therefore, don't assume that what we know about the combined subtype should be true for the inattentive subtype. Focus on the specific symptoms and behavioral impairments that the child presents. ■

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Richard Milich, Ph.D., is a professor of psychology and associate chair at the University of Kentucky and administrative director of the Center for Drug Abuse Research Translation.

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