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past history of ADHD symptoms

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This letter reports on a female adolescent (GF) who participated in our study on adolescent gender differences in ADHD. GF was first seen in our research unit in August 1997 (age 11), as a normal control with no reported ADHD symptoms (0 inattentive symptoms (I), 1 hyperactive/impulsive symptom (H/I)) according to semi-structured clinical interviews conducted with parent and teacher. No other psychiatric diagnoses were made. IQ was within the High Average range.

In April 1999, GF (age 13) was invited to participate in the adolescent study. Based on information from the K-SADS-PL conducted with GF and her mother independently in addition to ratings on the Conners' Teacher Rating Scale, GF met criteria for 8/9 I and 5/9 H/I. Her grades had decreased since the previous assessment and she was frequently missing classes. The symptoms reportedly began within the last year and were present across all situations with significant impairment. Although retrospective parental report confirmed the previous assessment from August 1997 (1 I, 0 H/I), GF endorsed 3/9 I and 3/9 H/I for past behavior. No other psychiatric symptoms, drug or alcohol use, or immediate stressor was reported that could better account for the symptoms. Given that GF did not show clear evidence of a past history of symptoms, no diagnosis of ADHD was made. Further, the case was an atypical presentation as GF endorsed more symptoms than her mother, an unusual presentation in our adolescent ADHD population. The family was encouraged to visit with GF's pediatrician to verify whether any medical conditions could explain the presenting symptoms and was invited back for a six-month follow-up assessment.

In October 1999 (age 13), GF was reassessed with the K-SADS-PL - mother and daughter both endorsed 6/9 I and 6/9 H/I with continued impairment in school. GF did not endorse other psychiatric symptoms, including those of mood, anxiety and psychotic disorders. As GF continued to exhibit ADHD symptoms with marked impairment, it was suggested that the family discuss pharmacotherapy with GF's pediatrician. The family followed this recommendation and kept in contact with us during a placebo-controlled trial with methylphenidate conducted by the pediatrician.

In March 2000 (age 14), GF's mother reported that GF's behaviors had worsened; she was skipping more classes and had had an incident of stealing money from the bank machine (pretending to deposit money and then immediately withdrawing it). GF returned for further assessment and admitted that over the last two years, she had been experiencing obsessions and compulsions. She described that she would get a feeling that "something bad was going to happen" and in order to prevent a "bad thing" occurring, she would neutralize the feeling with rituals that included the number four: writing words in her homework in fours, touching things four times, or washing her hair four times. She explained that she skipped classes to avoid ritualizing in front of her classmates, in fear that they would think "she was crazy." With this additional information, it became clear that the initial presentation of inattentive symptoms likely stemmed from her worries and obsessions. The hyperactive/impulsive symptoms likely reflected from GF's coping strategy (albeit maladaptive) to leave the classroom in fear of ritualizing in front of peers. The symptoms were now more consistent with a diagnosis of OCD. GF struggled to explain the incident at the bank, other than she was compelled to do it in fear of "something bad happening." She admitted that she had withheld this information during

the previous two interviews in fear of being found “crazy” and “locked up.” Onset of symptoms continues to be unclear, although GF’s mother disclosed that when she was 13, she had been a “checker,” suggesting a possible genetic link. There was no recent history of streptococcal infection to indicate a pediatric autoimmune neuropsychiatric disorder (PANDAS). GF is currently receiving cognitive behaviour treatment for OCD.

This case illustrates several important clinical issues: 1) evidence of a childhood history of ADHD symptoms is essential in order to diagnosis ADHD, despite presentation of full clinical syndrome in adolescence, 2) fear of psychiatry and mental illness is strong as well as the shame attached to certain symptoms and may lead to underreporting and misreporting of symptoms, 3) the need to follow children with atypical presentations in order to confirm or rule-out various diagnoses, 4) the need for long-term follow-up studies to better document the course of ADHD symptomatology, and 5) that the use of a stimulant may have exacerbated the obsessions and allowed GF to reveal the full nature of her struggles.

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