**Questions and Answers**

**Hyperactivity or Emotional Abuse?**

Two or three recent ADHD assessments have drawn attention to the fact that distinguishing ADHD from the symptoms of an emotional disorder is not always a straightforward matter. In two cases, one of which is presented briefly here, the children could fairly be described as emotionally abused.

**Case history**

Mrs L and her 6-year-old son M were referred for intensive help with parenting problems. L was extremely critical and rejecting of her son, and his behaviour towards her was difficult and demanding. Mrs L had heard about hyperactivity, and was convinced that her son had ADHD.

M lived in a small, crowded council flat with his older brother and two younger half-siblings, his mother, and his stepfather. His mother had had a very troubled childhood herself, and felt unsupported by her current husband and her extended family. M was not in contact with his father.

He was the product of a normal birth but his mother was depressed in the 2 years that followed. She remembers little of her relationship with him as a baby. By 2 years of age he was described as an irritable child who screamed. As a toddler, he was restless, fidgety, and accident prone. Difficulties emerged as soon as he began primary school, with disruptive, aggressive behaviour. He was described as impulsive and a loner, with poor peer relationships. His mother had to put locks on cupboards to control his binge eating.

At interview, M was a pale child of average height and weight, with immature speech and a rather vacant, listless look. He craved adult attention and responded well to it, becoming more animated. He could sustain concentration well when building Lego models, an activity that he particularly enjoyed. He was difficult to engage in conversation, tending to drift off into his own world or go off at a tangent. By the end of the interview he was restless, although not dramatically so. Observation of mother/son interaction in a play session showed mother to be initially disengaged, then increasingly irritated and relentlessly critical as M attempted to attract her attention. Eventually, he gave up and lapsed into a withdrawn state.

We remained open-minded about the possibility that M had ADHD. Teacher’s Connors score was 30 and it was of note that 24 of 28 items were in the ‘very high’ category. Mother’s Connors score was 29, with 31 of 48 items in the ‘extreme’ category. The school visit revealed a classic picture of ADHD, with fidgety, restless behaviour, poor concentration, and impulsive calling out in a group situation. We were told that M did well in a one-to-one situation, when he received support for his mild learning difficulties. He was, at this stage, 2 to 3 years behind academically, which was thought to be partly due to his difficulty in concentration.

M was started on a low dose of Methylphenidate, 5mg bds. He was quite subdued on this dose, and we noted that he was spending a long time doing uncharacteristically detailed drawings. No dramatic improvement was reported at his school, where our attempts to do a follow-up were foiled by M’s expulsion and subsequent move to a school for behaviourally disturbed children. In a smaller unit, with more individual attention, he blossomed. Mother also felt supported by the school, and was happier with M during this period. When we reassessed him we discovered that she had discontinued the Methylphenidate, and he was doing better than he had done in a long time. The new school did not report restlessness or poor concentration.

It was difficult to engage Mrs L in productive parenting work. Two years later, however, she returned, her husband having left, saying that M was worse than ever. He was at that stage on 50mg daily of Methylphenidate, prescribed by his GP. Her older son had developed similar problems, and she wondered whether he might have ADHD.

**Question**

I remain uncertain as to whether this child has ADHD. The symptoms of this condition appear, at times, to be very similar to those attributed to an emotionally disturbed, deprived child who craves adult attention.

I would appreciate clarification of the diagnostic issues, and any advice that can be offered regarding management.

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**Hyperactivity or Emotional Abuse? A Response**

There are various questions arising from Dr DeJong’s interesting case description. The first is in the title: Can one distinguish between the hyperkinetic syndrome and emotional abuse? The answer here is straightforward. Hyperkinetic disorder is a psychiatric syndrome, and emotional abuse is either a description of a childhood experience or of a characteristic type of negative behaviour shown by an adult towards a child. It is quite possible for a child both to show the syndrome and to suffer abuse. The case description strongly suggests M had the features of the syndrome. The emotional abuse is far less clear cut but, for the sake of argument, let us assume that Mrs L was not just critical of M because of his inattentiveness etc., but constantly belittled him, treated him in a developmentally inappropriate way, and was cold and emotionally unavailable to him. In these circumstances both problems were present, and indeed, there is some suggestion from the case report that M might have met criteria for conduct disorder as well.

The second question is this: Is it possible for emotional abuse to cause hyperactivity in the absence of biological vulnerability? Some suggestion that this might be the case is provided by clinical studies such as that reported by Haddad and Garralda (1992), who described five 8–10-year-olds who had had extremely disruptive early experiences and then a prolonged period living in stable families. Despite a lack of biological risk factors, these children showed classical features of the hyperkinetic syndrome. This suggests that adverse family experiences alone can cause some cases of the hyperkinetic syndrome and that, if only we had more effective ways of improving poor parent-child interaction, some children with hyperactivity might be helped in this way without medication. Personally, I would be cautious about accepting the suggestion that no biological vulnerability factors were present in these children. How could one be sure of this? But it seems...
quite likely that severe stress could elicit the hyperkinetic syndrome in children whose biological vulnerability is low.

The third question is this: Is it possible to distinguish two syndromes—one a form of hyperkinetic syndrome caused by biological factors and the other closely similar but caused by environmental adversity? Perhaps the latter might be characterised by more anxiety, attention-seeking, and signs of attachment disturbance. Attractive as this idea is, I do not think at this stage it is possible to make such a distinction reliably. Further, the notion that one could make the distinction carries certain dangers. In particular, it might lead one to deny medication to a child who would benefit just because there was an adverse background. We know (Barkley, 1989) that parents of hyperactive children who are successfully treated with Methylphenidate interact more and give more praise than parents of those who have been treated with placebo.

The fourth question is: How should one proceed with a hyperkinetic child who is the target of severe parental criticism, perhaps with parents lacking insight into the way their behaviour is adversely affecting their child? Conventional advice is that, after assessment, before even considering medication, one should embark on parent management training (PMT) to see what difference this might make. This is good advice and it will sometimes result in an improvement in a child’s behaviour that will mean medication is unnecessary. However, it is not uncommon for PMT to be unacceptable to parents who have heard of medication and want it for their child.

A fifth question is, therefore: Should one prescribe medication in this situation? In these circumstances, providing the diagnosis of hyperkinetic disorder has been unequivocally made, I would not withhold medication, though others might. Let me add two points. If I prescribed medication, I would want to do this as a co-operative venture with the parents, and I would wish to explain that the medication would be likely to work better if it were possible for them to change the child’s life in other ways: boosting self-esteem by praising the child when good behaviour did occur, being pleased with small changes, and avoiding over-stimulation (only one friend home at a time and only one toy out at a time). Keeping in close touch with the school and calling on the Social Services department to provide additional family support, especially if the emotional abuse became more worrying, would also be in my mind.

Having said all that, I doubt if M would have done any better in my care than he did with Dr DeJong looking after him!

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References