# Psychopharmacology for the Clinician
# Psychopharmacologie pratique

*The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided.*

**Sitting on the edge: when to treat symptoms of inattention without the full DSM-IV criteria of ADHD**

Diagnoses in psychiatry are made on the basis of explicit criteria according to which a subject is declared "disordered" if he or she fulfills several behavioural manifestations or symptoms selected from a list specific to each disorder. In addition to symptoms, which may vary from one disorder to another, the criterion of functional deterioration has to be present in all disorders. Fulfillment of these criteria, leading to the official diagnosis, opens the doors for treatment and services. Although rare, subjects fulfilling symptomatic criteria but not suffering from significant dysfunction are not problematic for therapists and often do not come to our attention. Abstaining from prescribing is the logical and natural attitude in these cases. After all, signs and symptoms, particularly in the field of psychiatry, are constructs with a debatable validity and do not require treatment if they do not cause dysfunction. The reverse situation, however, is much more prevalent and may pose important challenges to the therapist. Indeed, when a significant alteration in functioning is present in the absence of the required number of symptoms, the patient and his or her family may be denied treatment and, more often, services because the "official" diagnosis cannot be made. In child psychiatry, the typical example of these patients "on the edge of diagnostic boundaries" could be a subject whose IQ is T+1, where T is the threshold of eligibility for services to the mentally handicapped. The following example of a child with attention deficit illustrates very well the dilemma that may be faced by parents and therapist.

G.R. is an 8-year-old child who was referred by his school for difficulties of attention and learning. According to the Diagnostic Interview Schedule for Children, a standardized interview for diagnosing behavioural disorders in children, he was not diagnosed with any disorder. He missed the diagnosis of attention-deficit hyperactivity disorder, inattentive subtype (ADHD-I) because he was short by 1 item from the 6 required. Further investigations showed that his achievements on the Continuous Performance Task were in the clinical range. Neuropsychological testing also showed a poor attention index (third percentile). We conducted a prospective, double-blind, placebo-controlled crossover trial with methylphenidate at a dosage of 0.5 mg/kg daily. During the week of treatment with placebo, teachers and parents observed only mild improvement. In the laboratory, he showed a very significant improvement in task orientation as measured by the restricted academic situation scale. When treated with placebo, he was more disengaged from the task assigned to him after, compared with before, its administration (66% and 40% of the time, respectively). In contrast, methylphenidate treatment significantly improved his task orientation (from 20% to 80% of the time). On the Clinical Global Impression scale, no change was identified during the placebo week, whereas he was rated "much improved" during the week of treatment with methylphenidate.

It is clearly stated in the DSM-IV-TR that exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls short of the full criteria for diagnosis as long as the symptoms that are present are persistent and severe (p. xxxii).

Thus the case presented here can be diagnosed as attention deficit disorder because a clear impairment in functioning exists, although the patient presents with only 5 symptoms. Even though favourable therapeutic response was based on a short trial (1 wk), we believe that the treatment is very likely to benefit him in the long run. Although small in magnitude, daily benefits may translate into better long-tem outcome if integrated over a long period of time, as the recent literature tends to show. This observation illustrates the need for more sensible clinical judgment for patients who are on the "edge of the diagnostic boundary" when therapeutic decisions are to be made.

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*Psychopharmacology for the Clinician columns are usually based on a case report that illustrates a point of interest in clinical psychopharmacology. They are about 500–650 words long and do not include references. Columns can include a bibliography which will be available only at the journal Web site and can be accessed through a link at the bottom of the column.*

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