

A Sociolinguistic Analysis of In-Office Dialogue Between Psychiatrists and Adult Patients with Depression and Possible Comorbid ADHD

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ABSTRACT

Objective: To study the tone, content, and structure of in-office discussions between psychiatrists and adults with depression and possible comorbid attention-deficit/hyperactivity disorder (ADHD).

Methods: Patients with a pre-existing diagnosis of depression, but not ADHD, and screening results indicating the possible presence of ADHD, were selected. Office visits were videotaped and analyzed for tone, content, and structure, using sociolinguistic techniques. Separate post-visit interviews were conducted with patients and psychiatrists.

Results: The study sample comprised 14 patients and eight psychiatrists, although data on the possibility of ADHD were available for only 13 patients. The possibility of an ADHD diagnosis was not discussed in any office visit. Psychiatrist- or patient-driven language suggesting possible ADHD symptoms occurred during five (36%) visits. In post-visit interviews of 13 patients, nine (69%) felt they had or might have ADHD. In contrast, psychiatrists felt that 12 patients (92%) did not have ADHD. Nine psychiatrist-patient pairs (69%) disagreed about the possibility of ADHD.

Conclusion: Psychiatrists and their patients diagnosed with depression showed low levels of agreement regarding the possibility of comorbid ADHD. Psychiatrists frequently missed or misinterpreted patient cues regarding potential ADHD symptoms, suggesting psychiatrists may need to be more vigilant in screening for ADHD in this at-risk population.

FOCUS POINTS

- Attention-deficit/hyperactivity disorder (ADHD) shares an overlapping symptom profile with depression, and the two disorders are frequently comorbid.
- The accurate diagnosis and treatment of both depression and ADHD depends on adequate communication between physicians and their patients.
- An observational study was conducted using accepted sociolinguistic methodologies to evaluate the tone, content, and structure of in-office discussions between psychiatrists and patients with depression and possible comorbid ADHD.
- Approximately 33% of the visits contained either psychiatrist- or patient-driven language suggesting possible ADHD symptoms, although none contained discussions about the possibility of an ADHD diagnosis.
- This analysis of psychiatrist-patient interactions suggests that opportunities exist to help psychiatrists recognize patient cues that may indicate possible comorbid ADHD symptoms.

INTRODUCTION

Attention-deficit/hyperactivity disorder (ADHD) is common in children and adolescents.¹ Although ADHD has been more extensively studied in children and adolescents than in adults, longitudinal studies indicate that symptoms persist into adulthood for 15% to 60% of all children with ADHD.² Recent estimates of the prevalence of ADHD in adults in the United States range from 4.4% to 5.2%,^{3,4} indicating that ~10 million American adults may have ADHD.⁵ Despite the prevalence of

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Disclosures: Dr. Dodson is consultant to, is on the speaker's bureaus of, and receives honoraria from Novartis and Shire; and is on the speaker's bureau of GlaxoSmithKline. Dr. Findling is a consultant to Abbott, Addrenex, AstraZeneca, Biovail, Bristol-Myers Squibb, Eli Lilly, Forest, GlaxoSmithKline, the Guilford Press, KemPharm, Lundbeck, the National Institutes of Health (NIH), Otsuka, Pfizer, sanofi-aventis, Sepracor, Shire, Supernus Pharmaceuticals, WebMD, and Wyeth; is on the speaker's bureaus of Bristol-Myers Squibb and Shire; receives grant support from Abbott, Addrenex, AstraZeneca, Bristol-Myers Squibb, Eli Lilly, Forest, GlaxoSmithKline, Johnson & Johnson, the NIH, Neuropharm, Otsuka, Pfizer, Shire, Supernus Pharmaceuticals, and Wyeth; receives honoraria from Abbott, Addrenex, AstraZeneca, Biovail, Bristol-Myers Squibb, Eli Lilly, Forest, GlaxoSmithKline, the Guilford Press, KemPharm, Lundbeck, the NIH, Otsuka, Pfizer, sanofi-aventis, Sepracor, Shire, Supernus Pharmaceuticals, WebMD, and Wyeth. Ms. Eagan and Ms. Onofrey report no affiliation with or financial interest in any organization that may pose a conflict of interest. Preparation of this manuscript was supported by Shire US Inc., Wayne, Pennsylvania.

Acknowledgments: Medical writing and editorial assistance were provided by Kira Belkin, William Perlman, and Rosa Real, Excerpta Medica, Bridgewater, New Jersey.

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ADHD in adults and the substantial impact that symptoms can have on daily functioning, most cases of adult ADHD remain untreated. Epidemiologic surveys have found that only 11% to 13% of adults with ADHD in the US received treatment for ADHD within the previous 12 months.^{3,4}

Diagnosing ADHD in adults can be complicated because many ADHD symptoms resemble those associated with other psychiatric disorders,⁶ and ADHD in adults frequently occurs comorbidly with other psychiatric disorders, including mood, anxiety, and substance abuse disorders.³ For example, there is a high degree of symptom overlap between ADHD and major depressive disorder (MDD). Distractibility, difficulty concentrating, an inability to sit still, and impaired social and occupational functioning are all included in the diagnostic criteria for both ADHD and MDD.⁷ Additionally, ADHD and MDD are frequently comorbid. In the National Comorbidity Survey Replication,³ the prevalence of MDD among adults with ADHD was 18.6%, compared with a prevalence of 7.8% for adults without ADHD. Similarly, 9.4% of patients with MDD have ADHD, compared with 3.7% of patients without MDD.³ Clinical studies further support these high rates of comorbidity for depression and ADHD. In a study of 116 adult patients with depression, 16% met the diagnostic criteria for full or subthreshold ADHD in childhood and, in 12%, symptoms persisted into adulthood.⁸ A study⁹ of 102 male offenders in the Utah State Prison found high prevalence rates for both MDD (25.5%) and ADHD (25.5%). Of the 26 men with high levels of depressive symptoms, 13 (50%) were reported to have had significant symptoms of ADHD in childhood, and 15 (58%) had the same as adults. The presence of symptoms characteristic of both ADHD and MDD in adults with ADHD can lead to misdiagnosis of ADHD as MDD, or, in patients with comorbid depression, physicians may diagnose the depression but not the ADHD. In patients with comorbid disorders, a diagnosis of ADHD may be overlooked if symptoms overlap with those of the comorbidity. The time course of symptoms can help distinguish between ADHD and other disorders.⁷

Accurate diagnosis and treatment of ADHD depends on a combination of physician training and adequate communication between the physician and patient. Despite the importance of communication in diagnosing and treating psychiatric disorders, no studies to date have analyzed actual in-office conversations concerning ADHD in adults with psychiatric conditions. This observational study used techniques from sociolinguistic research to evaluate the tone, content, and structure of in-office psychiatrist-patient discussions of possible ADHD in adult patients with depression.¹⁰⁻¹²

METHODS

Letters were mailed to 1,613 community-based psychiatrists who were high prescribers of antidepressants. Psychiatrists were invited to participate in a study centered

on patients initiating treatment for depression or currently being treated for depression. The stated research goal was to increase understanding of the patient/provider relationship through detailed, textual analysis of their interactions, in an effort to discover why and how improved communication can lead to better health care. Study protocols received approval from Independent Investigational Review Board, Inc. (IIRB) in July 2007. IIRB-approved, written consent was obtained from all psychiatrists and patients before the beginning of each recorded office visit. Psychiatrists were offered an incentive of \$1,500 for their participation.

Inclusion criteria for the psychiatrists were as follows: board certification; between 2 and 25 years in practice post-residency; at least 75% of time spent in direct patient care (ie, not administrative or research) in an outpatient setting; no current affiliation with any pharmaceutical or healthcare manufacturing company as a clinical investigator, consultant, or researcher; and a practice focused exclusively on adult patients. Any patient who described a prior diagnosis of ADHD and/or treatment with stimulant or non-stimulant medications approved for the treatment of ADHD during the office visit was ineligible for enrollment in the final study sample. Informed, written consent was obtained from both psychiatrists and patients using Health Insurance Portability and Accountability Act-compliant consent forms approved by IIRB.

Regularly scheduled visits, not pre-recruited or scheduled specifically for the study, between psychiatrists and their patients were audio- and videotaped. Following these visits, patients and psychiatrists were interviewed separately. Follow-up interviews were conducted by one of six freelance researchers with training in semi-structured interviewing techniques and focus-group moderating. Interviews were conducted face to face. Patients were interviewed immediately following their encounter with the psychiatrist; psychiatrists were interviewed at the end of the clinical day to avoid exposing them to the questions and changing their behavior with subsequent patients. Post-visit interview questions were designed to reveal the relative match or mismatch of participants' perceptions regarding issues discussed. These issues included psychiatrist and patient perceptions of how well the depression was being managed, psychiatrist and patient perceptions of depression symptom severity, psychiatrist perceptions of any symptoms of ADHD in patients, and patient perceptions of any symptoms of ADHD in themselves. Medical records were available to the psychiatrist at the post-visit interview to assist with recall. Psychiatrists and patients were not made aware of the contents of each other's post-visit interviews, and all parties were assured of confidentiality.

At post-visit interviews, patients were provided a written questionnaire to collect demographic information. The questionnaire also asked them to report on what comorbidities they believed they had, as well as what medications

they were taking for the condition(s). Patients were asked to complete the form without the assistance of their physician. Additionally, patients were asked to complete Part A of the Adult ADHD Self-Report Scale (ASRS v1.1) Symptom Checklist, a six-item screening version of the 18-item ASRS v1.1 Symptom Checklist.¹³ Part A contains four items regarding frequency of recent *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition,¹⁴ symptoms of inattention and two items regarding frequency of recent *DSM-IV* symptoms of hyperactivity-impulsivity. A screen is considered positive if four out of six symptoms are rated as occurring “sometimes, often, or very often.”

The final study sample comprised 14 patients who had a positive post-visit screen for possible ADHD based on the ASRS v1.1 Screener but no pre-existing diagnosis of ADHD. Videos of the 14 visits and 14 post-visit interviews were transcribed using audio recordings, with videotapes providing a means for both quality controls and nonverbal cues (eg, nodding, shrugging shoulders), and these transcripts were analyzed by at least two individuals trained in the field of interactional sociolinguistics, the study of how individuals use shared language to facilitate social interaction.¹⁰⁻¹² All analyses were descriptive and qualitative. Conversations were evaluated on a variety of levels, including word-level (ie, what vocabulary was used) and turn-level (ie, which participants were speaking and when). The conversational roles of each speaker (psychiatrist, parent, patient, and visit companions, if any) were examined in detail. The approaches used were influenced by the work of social psychology, particularly the participation framework elaborated on by Schiffrin.¹⁵ Specific linguistic analyses of the visits included, but were not limited to quantification of topics discussed and the time spent on each topic; quantification and qualification of questions asked and answered; and linguistic markers (eg, words, phrases, or tones) demonstrating social relationships.

Post-visit interview responses were examined to determine psychiatrist-patient agreement regarding severity of depression and whether or not the patient exhibited possible symptoms of ADHD. Agreement regarding severity of depression was analyzed for all 14 psychiatrist-patient pairings, and agreement regarding the presence/absence of ADHD symptoms was analyzed for only 13 psychiatrist-patient pairs, as data for one subject was excluded due to a protocol violation.

RESULTS

Patient and Psychiatrist Demographics

Forty-one psychiatrists responded with interest in the study (response rate, 2.5%); of these, 15 met the inclusion criteria and were available to participate. A total of 52 patients

with depression were enrolled in the study, but one subject was excluded because the treating physician attributed the depression symptoms to a diagnosis of schizophrenia. Thirty-four patients were excluded from enrollment in the study sample because they did not screen positive for potential ADHD post-visit (per ASRS v1.1). Three additional patients were excluded because they discussed a previous diagnosis of ADHD and/or medication for ADHD during the office visit. Demographics for the 14 patients that screened positive for possible ADHD are presented in Table 1. All but one of the patients were female. The mean age was 49 years, and the mean time since the diagnosis of depression was made was 7.3 years, although 64% of patients were seeing their current psychiatrist for <1 year. Patients were taking an average of 2.1 (range, 1–5) psychiatric medications concurrently prior to the recorded visit. Patients reported an average of 5.7 (range, 2–11) medical and psychiatric comorbidities.

Eight psychiatrists participated in the study. The psychiatrists were predominantly male (88%) with a mean duration of post-residency practice of 15.4 years. On average, they spend 87% of their time in direct patient care. They treat patients with a variety of psychiatric disorders, including depression (48% of patients), anxiety (39%), bipolar disorder (28%), and ADHD (14%).

TABLE 1
PATIENT DEMOGRAPHICS (N=14)

Age	
Mean	49 years
Range	33–77 years
Gender	
	93% female
Time since depression was first diagnosed	
Mean	7.3 years
Range	4 months–25 years
Medical and psychiatric comorbidities	
Mean	5.7
Range	2–11
Non-psychiatric medications (mean)	
Mean	4.5
Range	0–14
Pre-visit psychiatric medications	
Mean number per patient	2.1
Range	1–5
Atypical antipsychotic (n)	2
Benzodiazepine (n)	7
Mood stabilizer (n)	1
Serotonin/norepinephrine reuptake inhibitor (n)	8
Selective serotonin reuptake inhibitor (n)	7
Other antidepressants (n)	4

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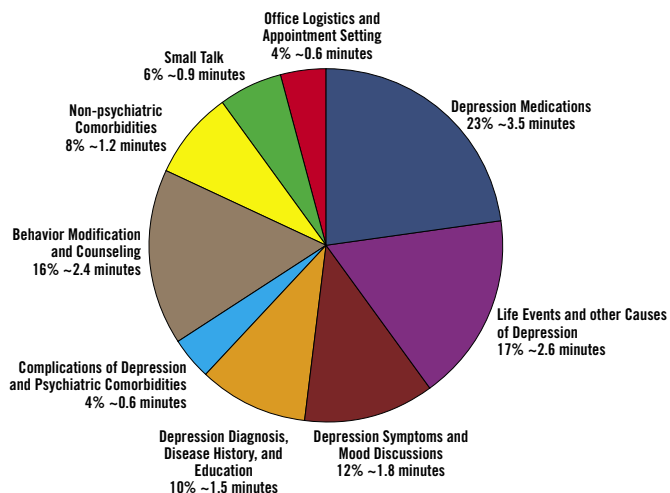
Office Visits

In-office visits lasted an average of 15 minutes. Medication for depression was the topic that occupied the largest proportion of time, approximately 25% of each visit or nearly 4 minutes (Figure). Eleven patients (79%) changed their medication regimen in some way, augmenting, discontinuing, switching, or changing the dose of at least one of their medications. Patients' emotions were also a frequent topic, discussed in 12 of the visits (86%). Sadness was the most commonly discussed emotion, followed by guilt/regret, anger/irritability, and happiness. Nine of the patients (64%) discussed the negative impact of depression on family life and social activities.

In general, the discussions were complex and emotionally charged. In six visits (43%), patients explicitly or implicitly asked for help, with statements such as "You know, I need help" or "I cannot handle this." In some cases (58%), psychiatrists clearly engaged, rather than avoided, patients' emotions. For example, psychiatrists asked probing questions such as "How do you get angry?" or offered commentary following patients' disclosures, eg, "I am sorry you are feeling badly... obviously it is very painful."

ADHD was not discussed in any of the visits. Five of the visits (36%) contained either psychiatrist- or patient-driven language suggesting possible ADHD symptoms. Psychiatrists asked questions about patients' memory, focus, and concentration, but did not follow up on patients' answers or unsolicited comments describing their inability to focus or poor concentration. These included comments such as, "My mind just gets busy and I cannot focus nor concentrate, and the thoughts race," and "I cannot settle my brain down."

FIGURE
TOPICS DISCUSSED AS PERCENT OF PSYCHIATRIC OFFICE VISIT (N=14)



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Post-Visit Interviews

In post-visit interviews, patients were asked to self-report any prior diagnoses of ADHD, anxiety, bipolar disorder, or another condition other than depression. Anxiety was the most frequently reported comorbidity (14 patients; 100%). Other *DSM-IV* diagnoses mentioned included bipolar disorder (two patients; 14%), insomnia (two patients; 14%), panic disorder (one patient; 7%), obsessive-compulsive disorder (one patient; 7%), and memory loss (one patient; 7%). Two patients reported having been diagnosed with ADHD; however, had their medical records indicated a previous diagnosis of ADHD or a history of stimulant or non-stimulant medication approved for the treatment of ADHD, they would have been excluded from the study. Because their medical records did not indicate prior ADHD diagnosis or treatment, they were maintained in the study. Given that these are patient self-reported data, it is possible that these patients did not, in fact, have confirmed diagnoses of all of the above reported *DSM-IV* disorders.

The treating psychiatrists were also asked in post-visit interviews which, if any, of several comorbidities (ADHD, anxiety, bipolar disorder, other) they suspected in their patients. Psychiatrists reported that anxiety was the most frequently suspected patient comorbidity (12 patients; 86%). Bipolar disorder was suspected in four patients (29%), and an additional patient had received a prior diagnosis of bipolar disorder from a psychiatrist, but the treating psychiatrist in this study was unsure of the accuracy of that diagnosis. Substance abuse was suspected in three patients (21%), and agoraphobia was suspected in one patient (7%). None of the psychiatrists reported ADHD as a suspected comorbidity.

Post-visit interviews indicated poor alignment in the psychiatrists' and patients' perceptions of possible ADHD symptoms. Nine psychiatrists and their patients out of the 13 psychiatrist-patient pairs (69%) did not agree when asked separately whether the patient exhibited possible symptoms of ADHD. Patients were much more likely than psychiatrists to suspect ADHD (Table 2). In 12 post-visit interviews (92%), psychiatrists felt that their patients did not have ADHD, mainly because of an absence of exhibited symptoms and/or an absence of a history of ADHD (Table 3). In contrast, nine patients (69%) believed that it was possible or probable that they had ADHD, based mainly on their lack of focus and/or concentration (Table 4). No patient specifically referred to ADHD symptoms as "lifelong"; however, eight of nine patients who believed that they may suffer from ADHD used language that indicated the presence of symptoms over some undefined period of time (eg, "I have a habit of not finishing what I start," or "I have always been real overactive.").

Psychiatrists and patients were also poorly aligned in their assessment of the severity of the patient's depressive symptoms. Only four out of 14 psychiatrist-patient pairs (28%) agreed on the severity of the patient's depression (mild, moderate, or severe; Table 5).

DISCUSSION

This study provided an opportunity to analyze the interaction between psychiatrists and their patients with depression who subsequently screened positive for possible ADHD. In 36% of the visits, psychiatrists asked questions that pertained to symptoms which can manifest in either depression or ADHD, and patients provided both solicited or unsolicited comments consistent with possible ADHD symptoms. Yet, ADHD was not considered by these psychiatrists as a possible comorbid condition (Table 2) even when it was presented to the psychiatrists in post-visit interviews. This is not necessarily an unexpected finding, as psychiatrists would rely on their knowledge of diagnostic criteria and patients would likely express symptom impact in terms of impact on their daily lives. However, as demonstrated in Table 1, these were not newly diagnosed patients with depression. The average number of psychiatric medications was 2.1 (range, 1–5), indicating that standard monotherapy medication intervention had not been adequate to produce remission. Ideally,

a lack of response to a polypharmacy regimen might have triggered an exploration of whether the initial diagnosis was correct or whether there were other coexisting conditions that had gone unrecognized. This analysis of psychiatrist-patient interactions suggests that opportunities exist to help psychiatrists recognize patient cues suggestive of comorbid ADHD in patients with depression.

Our observation that psychiatrists might often fail to consider the possibility of comorbid ADHD in patients with depression is consistent with previously reported observations. In one study¹⁶ of adults with ADHD, 44% had received a diagnosis for another psychiatric condition prior to diagnosis of ADHD, indicating that the opportunity to diagnose ADHD existed but was missed. A majority (56%) of the patients with previously unreported ADHD had seen a healthcare professional in the past regarding ADHD symptoms but had not been diagnosed with the disorder. According to the patients' medical records, 24% of these health professionals were psychiatrists. These results indicate frequent missed opportunities for diagnosing adult ADHD in clinical prac-

TABLE 2
AGREEMENT BETWEEN PSYCHIATRIST AND PATIENT REGARDING SUSPECTED ADHD (N=13)*

<i>Comorbid ADHD</i> ^{†‡}	<i>Patient (number of visits, % of visits)</i> [†]	<i>Psychiatrist (number of visits, % of visits)</i> [‡]
Yes	5 (38)	0 (0)
Sometimes/possible	4 (31)	1 (8)
No	4 (31)	12 (92)

* Data unavailable for one patient.

† Patient response to post-visit interview question, "Have you ever thought you might have ADHD?"

‡ Psychiatrist response to post-visit interview question, "Do you suspect ADHD?"

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TABLE 3
REASONS GIVEN BY PSYCHIATRISTS WHO DID NOT SUSPECT ADHD (N=12)*

<i>Reason</i> ^{†‡}	<i>Number of Psychiatrists (%)</i>
No symptoms exhibited or described by patient	6 (50)
No history described by patient	6 (50)
Patient can perform daily functions	2 (17)

* Data unavailable for one patient.

† More than one reason possible per patient.

‡ Psychiatrist response to post-visit interview question, "Why have you ruled ADHD out?"

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TABLE 4
REASONS GIVEN BY PATIENTS WHO SUSPECT ADHD (N=9)*

<i>Reason</i> [†]	<i>Number of Psychiatrists (%)</i>
Lack of focus/concentration	5 (56)
Racing thoughts	2 (22)
Bad memory/forgetful	2 (22)
Not finishing tasks	2 (22)
Overactive	1 (11)
Jumping around in conversations	1 (11)
Too much focus	1 (11)

* Data unavailable for one patient.

† ≥1 reason possible per patient.

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TABLE 5
AGREEMENT BETWEEN PSYCHIATRIST AND PATIENT REGARDING DEPRESSION SEVERITY (N=14)

<i>Depression Severity</i> [*]	<i>Number of Psychiatrist-Patient Pairs (%)</i>
Aligned	4 (28)
Misaligned	10 (72)
Psychiatrists rate more severe	5 (36)
Patients rate more severe	5 (36)

* Responses to post-visit interview question, "How would you describe the severity of your/patient's depression: mild, moderate, or severe?"

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tice and highlight the importance of considering adult ADHD as a diagnostic option, especially when a patient presents with depression or another affective disorder that may be frequently comorbid with ADHD. In some cases, careful questioning can distinguish between two similar symptoms such as anhedonia associated with depression and boredom common to ADHD, both of which might be described by the patient as a lack of interest.

While ADHD does have symptom overlap with other disorders, the time course of symptoms can help distinguish between ADHD and other disorders.⁷ Adult ADHD persists from childhood and is continually present; in contrast, most other disorders appear later and are intermittent. In the study conducted by the authors of this article, eight of nine patients used language implying indeterminate duration of symptoms of inattention or hyperactivity-impulsivity such as, "I have a habit of not finishing what I start," or "I have always been real overactive." An exploration of the chronicity of these symptoms may have provided clues to the presence of ADHD.

In this study, agreement between the psychiatrist's and patient's assessment of depression severity was poor, with only 28% of psychiatrist-patient pairs providing a similar assessment of disease severity. The lack of agreement may result from the different perspective of the psychiatrists, rating severity in comparison to the range of depressed patients seen in their practice, and the subjects, rating severity in terms of impact on their day-to-day activities. Likewise, there was poor agreement in the psychiatrist's and patient's assessment of the likelihood of ADHD. The frequent discordance between psychiatrists and their patients merits further exploration.

The use of Part A of the ASRS v1.1 Symptom Checklist to screen for ADHD in this study presents another potential limitation. This screener has high predictive validity for ADHD in the general population. Sensitivity was 68.7%, indicating that >66% of patients with ADHD will screen positive. Specificity was 99.5%, indicating that only 0.5% of individuals without ADHD would screen positive.¹³ However, the validity of this screening tool in a population with depression has not been studied. It is possible that patients with depression may be more likely to score positively due to their symptoms of depression and not due to symptoms of ADHD.

Another potential limitation of this study stems from uncertainty regarding the diagnosis of depression, which was not independently corroborated through the use of validated assessment methodologies. Furthermore, in post-visit interviews, two patients self-reported a prior diagnosis of bipolar disorder and psychiatrists identified four patients with suspected bipolar disorder. Although these results are potentially confounding, they are not unexpected. Diagnoses of unipolar depression and bipolar disorder are mutually exclusive; however, bipolar disorder is frequently misdiagnosed in general, is most often misdiagnosed as unipolar depression, and can take as long as 10 years to accurately diagnose.¹⁷⁻¹⁹

The nature and implementation of the post-interview questions may be another potentially limiting factor. In one case regarding agreement between psychiatrist-patient pairs on the presence/absence of ADHD symptoms, the patient was not asked, "Have you ever thought you might have ADHD?" and that patient's psychiatrist was not asked, "Do you suspect ADHD?" as part of the post-visit interview process. This was an error on the part of the field researcher. In addition, the question "Have you ever thought you might have ADHD?" may have been too broad and not representative of whether the patient actually felt he or she had ADHD. The intent of this question may have skewed results. The authors' data on agreement may also suffer from a limitation stemming from the slightly different questions posed to the psychiatrists and the patients; the patients were asked about a lifetime history of suspicion, while the psychiatrists were asked about a current suspicion. Therefore, the patients' affirmative responses may have been inflated. It would be interesting to know whether, once the possibility of ADHD in these patients was investigated, psychiatrists' and patients' assessments would show greater convergence.

Lastly, the non-random sampling of psychiatrists and their patients being treated for depression, low psychiatrist response rate and potential effect of financial incentive on psychiatrist involvement, small sample size, and participant awareness of recording can all be seen as potential limitations. Several of these same limitations were described in a recent study²⁰ using similar methodology. Results showed that the psychiatrist response rate was commensurate with similar studies; although the sample size was smaller than what is often seen in clinical trials, it is comparable to the sample sizes used in other peer-reviewed work in the area of physician-patient communication in which sample sizes range from 16 to 70²¹⁻²³; and a number of studies conclude that recording has little to no effect on study subject behavior.²⁰

CONCLUSION

Both patients and therapists rely on multiple methods of communication to convey information and express understanding. Some of this communication is verbal, but much of it is not. As yet, there are few laboratory tests that can be used to diagnose *DSM-IV* conditions, and thus the diagnostic process necessarily relies almost entirely on the interchange of information between the patient and clinician. This study represents a preliminary attempt at discerning verbal and non-verbal components of the patient-clinician interaction that may trigger awareness of the possibility of ADHD and subsequent diagnostic exploration. The possibility of ADHD came to the awareness of the clinicians at low rates. Based on these limited data, it is not possible to ascertain why ADHD was not often considered. The data suggest, however, that the

mood sequelae of ADHD (chronic disaffection, frustration, demoralization) are often understood only in terms of depression, and the possibility of ADHD infrequently comes to the awareness of either the clinician or the patient. The overlap of symptoms and the high degree of comorbidity between mood disorders and ADHD may merit further exploration of the possibility of ADHD as either the sole diagnosis or a coexisting diagnosis as a routine part of the evaluation of depressive symptoms. This may be especially informative in patients with treatment failure or partial remission of depressive symptoms. The data collected by the authors of this article have implications for the training of mental health professionals, as the majority of psychiatric patients are not treated by psychiatrists, and therapists are often the initiators of referral to psychiatrists for medication treatment. Finally, on a larger scale, these data underscore the need for a nosological system in adults that distinguishes between the symptoms of these two common disorders. **PP**

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