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Complexity of ADHD with Comorbid Disorders

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Thomas E. Brown, PhD, is the developer of the Brown Attention-Deficit Disorder Scales assessment tool, BrownADDScales®. As such, he has both a financial and an intellectual interest in the tool. The purpose of this presentation is to provide a balanced view on the complexity of ADHD with comorbid disorders.

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- A recording of this presentation will be emailed to everyone in 2 weeks' time.
- The recording will include the presentation slides.

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- You are on mute. Communicate using the **Q&A box** in the webinar screen. Submit your questions for our speakers using the Q&A box.
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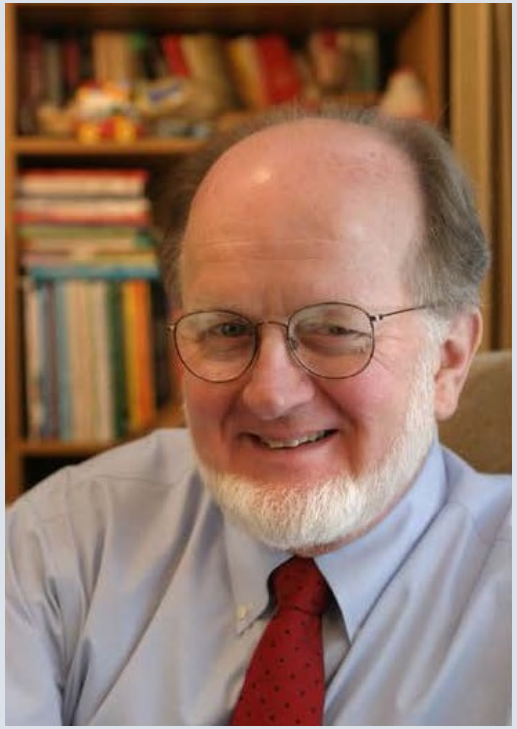

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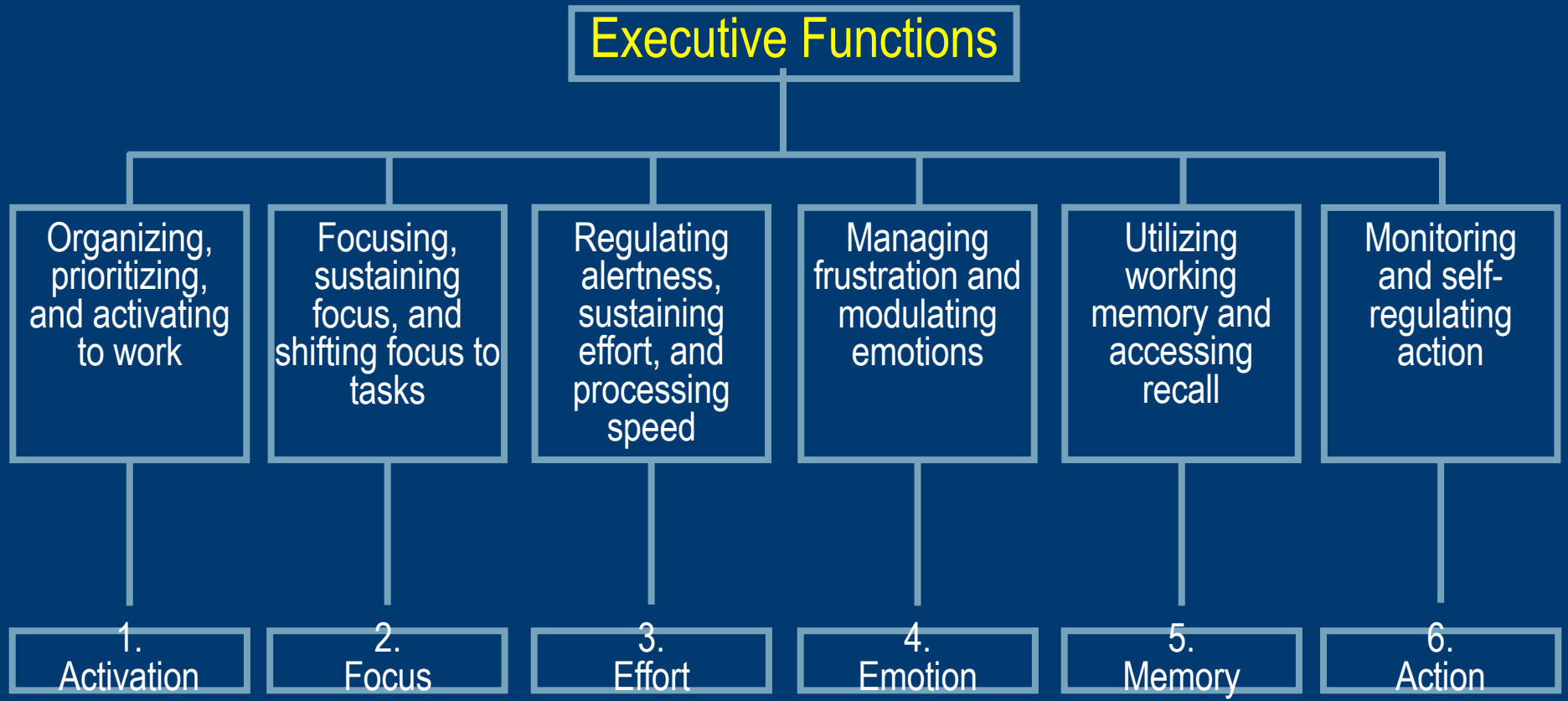
Thomas E. Brown earned his Ph.D. in Clinical Psychology at Yale University and then served on the clinical faculty of the Department of Psychiatry at Yale School of Medicine for 20 years while operating a clinic in Connecticut for children and adults with ADHD and related problems. In May 2017, he relocated to California where he opened the Brown Clinic for Attention and Related Disorders in Manhattan Beach. He has taught continuing medical education courses on ADHD for the American Psychiatric Association for the past 18 years and has given lectures and workshops in hospitals, medical schools, universities and for professional and advocacy groups throughout the United States and in more than 40 other countries. Dr. Brown is a Clinical Professor of Psychiatry and Neuroscience at the University of California Riverside School of Medicine and is an elected Fellow of the American Psychological Association, The APA Division of Psychopharmacology and Substance Abuse, and the Society of Clinical Child and Adolescent Psychology. He has published 30 articles in professional journals and 7 books on ADHD with translations of 12 foreign languages. His most recent books are Smart, but Stuck: Emotions in Teens and Adults with ADHD; Outside the Box: Rethinking ADD/ADHD in Children and Adults-A Practical Guide, and ADHD and Asperger Syndrome in Smart Kids and Adults: Twelve Stories of Struggle, Support and Treatment. His 28-minute video on YouTube “What Is Attention Deficit Hyperactivity Disorder?” has received more than 8 million views. For more information, please visit his website at www.BrownADHDclinic.com.

ADHD Is a Complex Disorder Often Complicated by Comorbidity

- In 50-70% of cases, ADHD is further complicated by one or more additional psychiatric or learning disorders
- Not only is it possible to have another disorder with ADHD, **it is 6 times more likely** in lifetime than for those without ADHD

Brown's Model of Executive Functions Impaired in ADHD

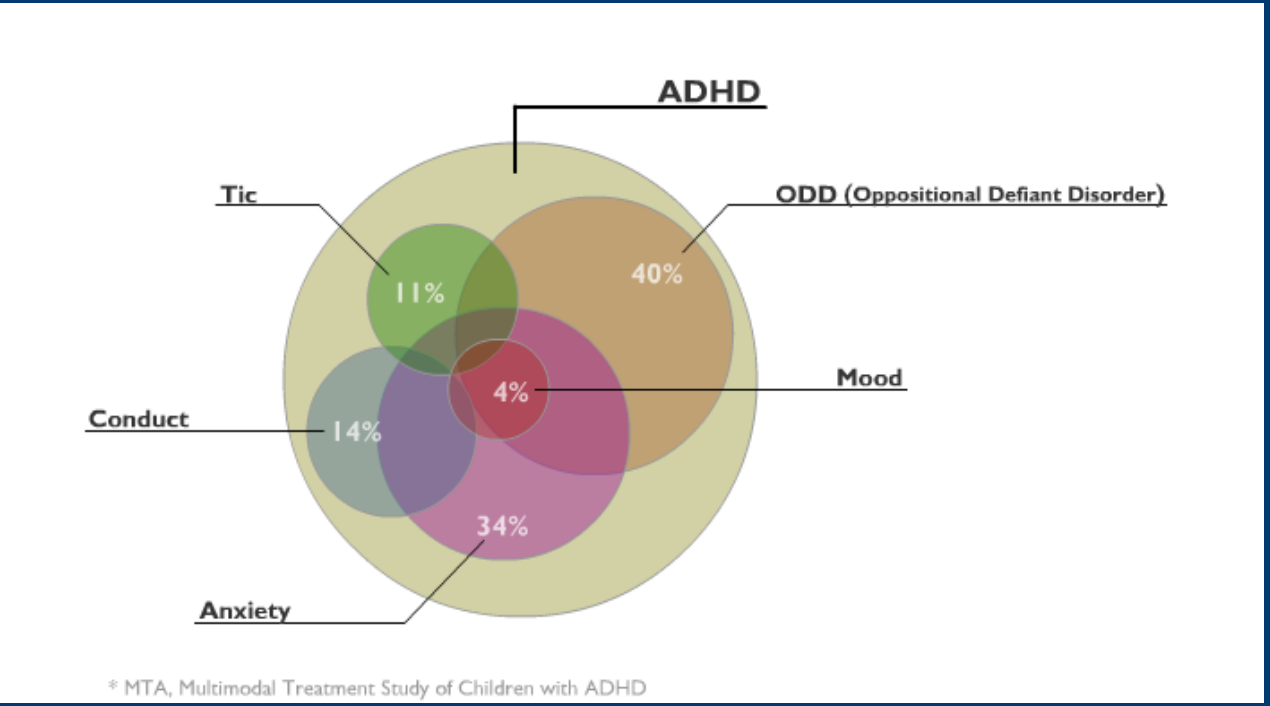


(Brown, *Outside the Box: Rethinking ADD/ADHD*. 2017, Attention Deficit Disorders, 2005)

Types of Comorbidity

1. Cross-sectional (within past 6-12 mos)
2. Lifetime (ever within entire life)
3. Dynamic (waxing and waning)
4. Subthreshold (impairing w/o full criteria)

Other Psychiatric Disorders Often Accompany ADHD



70% of children with ADHD had at least one psychiatric disorder in addition to ADHD.

(MTA, 1999)

Comorbidity in MTA study

- Did not include learning disorders
- selected only combined type ADHD
- Included only 7-9 yo children
- Cross sectional (6-12 mos)

Lifetime Psychiatric Disorders in Adolescents (13-18 yrs) (n=10,123)

- Any mood disorder 14.3%
- Any anxiety disorder 31.9
- Any behavior disorder 19.6
- Any substance use disorder 11.4
- Eating Disorders 2.7
- Any disorder 45%

1 class: 58% 2 classes: 24% 3+ classes: 18%

Merikangas, et al, 2010

Psychiatric Comorbidities in adults with ADHD

	12 mo.		Lifetime	
	%	OR	%	OR
Any mood	25.5	3.5	45.4	3.0
Any anxiety	47.0	3.4	59.0	3.2
Any substance	14.7	2.8	35.8	2.8
Any impulse[1]	35.0	5.6	69.8	5.9
Any psychiatric	66.9	4.2	88.6	6.3

([1]impulse = antisocial pd, ODD, CD, Intermittent explosive disorder, bulimia, gambling

(from Ntnl Comobidity Survey-Replication data presented by R.Kessler at APA, 5/1/04)

i

Comorbidity in NCSR

- Included any disorders at any point in entire lifetime
- Included only 18-44 year old adults
- Did not include learning disorders
- Based on self-report of sx

PUZZLING QUESTIONS!

Why are there such high rates of comorbidity between ADHD and so many other disorders?

Why is an adult with ADHD 6 times more likely to have at least one additional DSM-IV disorder at some point in life?

"Fruit Salad" Theory of Comorbidity

- Each of 200+ disorders in DSM-5-TR is seen as a discrete entity—like a separate tree producing its own fruit
- Comorbidity is seen as chance convergence of genetics
- No recognition of overlap between disorders or hybrid variants

A Conceptual Growing Edge…

Understanding of ADHD as developmentally impaired Executive Functions has broad implications

- Exec functions cross boundaries of disorders, brain structures and the boundary between pathology and normality

- ADHD is not just one disorder among many----it cross-cuts other disorders

An Alternative Theory of Comorbidity

- ADHD = developmental impairment of executive functions
- ADHD is not just one disorder among many
- ADHD is a foundational disorder that cross-cuts other disorders
- ADHD increases risks of other disorders

General and Specific Factors

Comorbidity involves both:

-some level of general EF impairment

-specific impairments of:

information processing

arousal/motivation

social-emotional regulation

that differ from EF in quality or degree

Boundaries between ADHD & other disorders?

"Many deficits of ADHD are shared with other disorders and some differences between ADHD and other disorders may be quantitative rather than qualitative"

(Banaschewski, et al, 2005)

e.g. "irritability"

ADHD (+)
depression (++)
bipolar (+++)

Mick, et al, 2005)

Anxiety & Depression with ADHD

	Children	Adults
Anxiety	9%-34%	28%-47%
Depressive	14-22	38-63

Many individuals have more than 1 with ADHD

Treat most acute problem first (suicidal, veg, panic)

Stims may worsen or alleviate anxiety/irritability

Watch “attentional bias” & working memory in both

Bipolar Disorder with ADHD

	Children	Adults
Bipolar	2-21%	3-17%

Estimated rates vary widely depending on operational definition, especially re: requiring episodicity

Involves not only ability to regulate emotions, but also to a) inhibit and manage actions b) manage arousal

If level of arousal is chronically too high or exacerbated by stimulants, guanfacine or mood stabilizers may be preferable. If needed, stimulants may be added when mood/arousal are stabilized

Differentiating ADHD & Bipolar Disorder

Symptom	ADHD	Bipolar
Irritability/Rage	+/–	+++
Hyperactivity	++	+++
Inattention	++	+++
Depression	+/–	+++
Sub abuse	+	+++
Psychosis	–	++

Legend

+ = Presence
++ = More present
+++ = Most present
- = Absence
+/- = May be present

Wilens TE, Biederman J, Wozniak J, et al. Biol Psychiatry. 2003;54:1-8. Wilens et al. ADHD. In: Hendren, ed. Disruptive Behavioral Disorders in Youth. APA Press; Washington, DC; 1998.

Oppositional Defiant Disorder with ADHD

Chronically angry/irritable;

Defiant, headstrong; Vindictive

Incidence 35-50% (usually combined type ADHD)

May be quick/impulsive or sullen/sustained

Not just feelings, overt verbal/physical actions

Onset usually ~ 12 yrs; Duration ~ 6 years

>70% not CD by 18 yrs; Most never dx CD

May respond to stims and/or guanfacine

Conduct Disorder with ADHD

Adolescent lifetime incidence = 6.8%

Serious delinquent behavior:

Physical cruelty to people, theft w/confrontation of victim, fire-setting, persistent truancy

higher risk of substance use disorder

Stims and/or guanfacine mb useful

ADHD + Sleep/Arousal Probs

Falling asleep, awakening, daytime alertness

- may be primary, or secondary to other dx: MDD, anx, substance abuse, sleep apnea
- late aft stim dose may cause or help dfa
- assess sleep schedule and sleep “hygiene”

consider anxiety, breathing problems, OSA

dfa: Melatonin, Benadryl, clonidine, Klon

daw: in-bed stim dose 1 hr before get-up; small dose of Daytrana MPH patch during night

OCD with ADHD

Normal obsessions/compulsions vs disorder (OCD in 10-30% of ADHD v 4%)

- obsessions: variable “overfocusing”
- compulsions: rituals/ perseveration”
- Excessive perfectionism, e.g. in writing
- stims may worsen
- SSRI useful for OCD, not for ADHD
- Stims + SSRI
- and/or behav tx for OCD

Substance Use Disorders with ADHD

Odds ratio for SUD in adults with ADHD

- Nicotine 2.4-2.8
- Alcohol 1.4-1.7
- Marijuana 1.5-2.3
- Cocaine 2.05
- Any SUD 2.6-3.4

ADHD meds alone do not alleviate SUD

Childhood med tx for ADHD may reduce risk

Education & 12 Step Programs

“clean” before med treatment: How long??

“Abstinence” vs “Harm Reduction”

rehab vs outpatient relapse prevention

Autism Spectrum Disorders with ADHD

- 20-50% of those with ADHD have ASD
- If signif. ADHD sx in ASD, consider ADHD tx
- significant social impairment (poor in: empathy, non-verbal communication, developing friendships); pragmatic language; all-absorbing interest
- spectrum of sx severity & cognitive abilities
- need school supports
- social skills instruction
- Stimulants->ADHD sx (titrate cautiously)->ATX
- ?SSRI for OCD, anxiety

Differential Dx vs Multiple Diagnoses

- Multiple perspectives on presenting sx and priorities: (Pt view? Others' Views)
- Time frames for presenting sx?
- Aspects of functioning going OK?
- Wide screen for possibly related disorders
- Which meet full dx criteria? Impairment?
- Either/or vs Both/and ---> Priorities??

Complicated ADDs

- Expect complications in >50% cases
- complicating factors often interact
- family stress: contributory & reactive
- individual probs may mask other probs
- setting may make big difference +/-
- monitor meds carefully, ?change/combine
- attend to health as well as illness
- improvement is often slow and mixed

Realistic & Unrealistic Hope

- Unrealistic Hope: ignores reality of what it takes to meet challenges and suggests “you can do anything you want” as though just wanting does it.
- Realistic Hope: recognizes realistic requirements and utilizes resources to select realistic goals and to support efforts needed to meet challenges in short-term and longer term.

AUDIENCE Q&A

FINAL THOUGHTS

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- Take our survey immediately after the webinar has concluded.

THANK YOU!

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