Comorbidity in Adult ADHD

Dr Nasrin Dodangi
Child and Adolescent Psychiatrist
University of Social Welfare and Rehabilitation Sciences

Comorbidity in Adult ADHD

- Comorbidity is frequent in adults with ADHD
- A diagnosis of ADHD should always include assessment of comorbidity
- Comorbid psychiatric conditions can affect presentation and course of ADHD and may require treatment independent from ADHD

Comorbidity in adults vs children:

1 Adults: anxiety disorders, SUD, mood disorder and personality

Children: oppositional defiant disorder and separation anxiety

2. Adults with undiagnosed ADHD and comorbidities seek treatment because of comorbid disorders

Comorbidity in Adult ADHD

- Depression 20-55%
- Bipolar disorder 10%
- Anxiety disorders 20-30%
- Substance Use Disorder 25-45%
- Smoking 40%
- Cluster B personality 6-25%
- Sleep problems 75%
- Mood swings & irritability ???

Comorbidity in Adult ADHD

The other way round

- ADHD is comorbid in 20% of psychiatric patients
- SUD 20%
- Anxiety disorder 20%
- Bipolar II 20%
- Borderline personality disorder 33%

Comorbidity in Adult ADHD

- association with bipolar disorder is debated, but there is no doubt that mood dysregulation is a key component of ADHD

- The association of ADHD with neurodevelopmental disorders and traits (e.g. autism spectrum disorders, dyslexia, learning difficulties) is also seen in adults due to the lifelong nature of these impairments.

Comorbidity in Adult ADHD

- Significantly higher rates of personality disorders have been identified in clinical samples, especially antisocial
- Up to one third of personality disordered offenders screen positive for ADHD.
- Up to 45% of young people with ADHD receive criminal convictions
- The association between ADHD and crime has received considerable attention in recent years
  - one-quarter of adult male prisoners are estimated to have ADHD
  - they are younger at first offence, receive multiple convictions

ADHD or Borderline?

Overlap

- Impulsivity is hallmark of both
- Frequent mood swings & irritability in 90% of adults with ADHD

Differential diagnosis

- Inattention and hyperactivity only in ADHD
- ADHD starts in childhood, borderline in adolescence
- Emptiness, manipulative behaviour, all good-all bad patterns specific to borderline
- History of neglect or sexual abuse typical in borderline, not ADHD

Treatment of Comorbidity

- Which one first? or Both together?
  differ by the disorder
  should be indivitualized
  first: the most impairing disorder

- Selection of Medication???
  monotherapy

Comorbid Depression

- Shared symptoms:
  - poor self-esteem
  - irritability
  - poor concentration
- Diff. Symptoms:
  - episodic history
  - low mood
  - anhedonia

Treatment of Comorbid Depression

- Moderate to severe depression should be treated first
- Suicide must be assessed in all cases
- In case of mild depression may benefit from ADHD treatment first
- Stimulants may be combined with most of antidepressants
- CBT

Comorbid Anxiety disorders

- Shared symptoms:

  poor concentration

  restlessness

- Diff. Symptoms:

  specific thought contents

Treatment of Comorbid Anxiety disorders

- Treat most impairing disorder first
- In moderate to severe anxiety, first treat anxiety
- Stimulants may worsen anxiety, should be titrated
- CBT

Comorbid Bipolar Disorder

- Shared symptoms:

  hyperactivity/impulsivity

  affective instability

  low concentration/distractibility

  sleep problems

- Diff. Symptoms:

  episodic presentation

  severe irritability

  high self-esteem

  elevated mood

  reduced need to sleep

Treatment of Comorbid Bipolar Disorder

- Treat bipolar disorder first
- Mood stabilizers should be taken
- Treatment of ADHD can be offered when bipolar disorder is stabilized

Comorbidity with substance use disorder

- ADHD is more prevalent in populations of substance misusers .
- About one-half of adolescents with substance misuse and one-quarte of adults
- poly-substance use was related to ADHD symptoms with a large effect sizer of adults will have ADHD

treatment of ADHD in the presence of active drug and alcohol abuse

- 1. Consider stabilisation of ADHD with atomoxetine as the first-line drug treatment, because of the lack of abuse potential
- 2. If poor clinical response to atomoxetine, consider treatment with extended-release methylphenidate or lisdexamfetamine.

  If risk of stimulant abuse is high, consider bupropion
- 3. Combine medication with psychoeducation, relapse prevention and cognitive behavioural therapy.
- 4. More research is needed into the treatment of ADHD and substance use disorder.

Treatment of ADHD & SUD

- Patients who use recreational drugs need to be advised of possible interactions with their medication, particularly concurrent stimulant-type drugs.
- Use of prescription psychostimulants and illegal amphetamines may increase the risk of cardiovascular events including cardiac infarction, angina and arrhythmias.
- Stimulants, especially short-acting preparations, are best avoided in this population

Tic disorders and ADHD

- The prevalence of chronic tic disorders in children with ADHD is close to 20%
- Despite existing literature, recent research supports the idea that tics do not worsen with methylphenidate treatment in children with ADHD and chronic tic disorders
- Long acting formulations of methylphenidate can be used as first-line medication in this group of patients

Tic disorders and ADHD

- Clonidine and guanfacine have been used as monotherapy or in conjunction with stimulants with good results in comorbid Tourette's
- Atomoxetine can be useful in non-responders to methylphenidate. Atomoxetine neither improves nor worsens tics.
- Behavioural therapies can be a useful adjunct to pharmacological treatment in these children.

Summary

1. Co-morbidity is common in both childhood and adulthood ADHD, and may determine outcomes

2. Clinical assessment of ADHD needs to include careful evaluation for other disorders

3. Expression of ADHD and co-morbidities is highly heterogeneous, thus management needs to be individualized

Thank You