

ADHD and its COMORBIDITIES

KIDS ARE RARELY SIMPLE.....

Comorbidity is the norm!

Although we do see children and adolescents with “pure” ADHD and no other difficulties, such individuals are the exception rather than the rule.

Many children with ADHD have one or more other educational, behavioural, or mental health condition that must be taken into consideration when developing a treatment strategy.

Comorbidity is the norm!

Generally speaking, if the associated conditions are not adequately addressed, then the overall outcome is disappointing.

What other conditions do we commonly see in patients with ADHD?

Common Comorbidities

Learning disabilities

Oppositional Defiant Disorder

Conduct Disorder

Disruptive Mood

Dysregulation Disorder

Intermittent Explosive
Disorder

Depression

Anxiety

Obsessive Compulsive
Disorders

Bipolar disorder

Tic Disorders

Learning Problems

Many studies have looked at how commonly individuals with ADHD also have learning disabilities.

Results vary widely, but most suggest that 30-40% of individuals with ADHD also meet criteria for a learning disability.

If one includes those individuals who are slow learners as opposed to truly learning disabled, the number of ADHD individuals with learning problems approaches 50%.

Learning Problems

Fewer studies look at the problem the other way around (how many individuals with learning problems also have ADHD).

Available data suggests almost the same proportion: 30-45%.

Learning Problems

Clearly, many children have both ADHD and learning issues.

Equally clearly, many children have just ADHD, and many children have just learning issues.

Why is this a problem?

Learning Problems

An individual with a learning disability will often appear inattentive in class. Most of us have difficulty focusing on things that are not making sense to us!

Similarly, an individual with ADHD often performs academically less well than would be predicted by their IQ. One of the definitions of a learning disability is academic achievement out of keeping with IQ.

Why is it critical to sort this issue out?

Treating a learning problem with medication is folly!

Treating an attention problem with extra academic supports is actually very helpful, although may turn out to be quite frustrating for all involved.

For those with ADHD and a learning problem, treating the ADHD will not cure the learning problem, but it may make the learning problem easier to address.

The limitations of a physician

Although we often suspect a learning disability, this is not a diagnosis that a physician generally makes.

Learning disabilities are psychological diagnoses as opposed to medical ones.

Treating learning disabilities falls into the area of expertise of educators, not physicians.

"I am a doctor not a teacher"

Disruptive Behaviour Disorders

This term describes the collection of "conditions" characterized by difficult, noncompliant, or aggressive behaviours.

Most frequently seen in paediatric practice are oppositional defiant disorder, conduct disorder and intermittent explosive disorder.

Although not truly a disruptive behaviour disorder, I will include disruptive mood dysregulation disorder in this discussion.

Oppositional Defiant Disorder

Incredibly common.

- Angry irritable mood

Often loses temper, touchy or easily annoyed, angry and resentful.

- Argumentative/defiant behaviour

Argues with authority figures, deliberately annoys others, blames others for mistakes or misbehaviours.

- Vindictiveness

Spiteful or vindictive at least twice in the past six months

Conduct Disorder

Much less common

- Aggressiveness towards people or animals (bullying, initiating fights, using weapons, aggressiveness during criminal activity)
- Destruction of property
- Deceitfulness (con artist) or theft
- Serious violation of rules (staying out all night, running away from home, chronic school truancy)

Intermittent Explosive Disorder

This diagnosis is just recently appeared in the psychiatric diagnostic manual.

- Frequent verbal aggression and occasional physical aggression or destructive behaviour
- The magnitude of the outbursts is completely out of keeping with the precipitating event.
- The outbursts are impulsive and not premeditated
- After the event, the individual frequently experiences significant distress.

Disruptive mood dysregulation disorder

Another new addition to the psychiatric manual

- Recurrent verbal or physical outbursts, out of keeping with situation or provocation
- The mood between temper outbursts is persistently irritable or angry
- Present in multiple settings, onset before age 10 years.

Are these labels helpful?

These labels accurately describe behaviours that we frequently see in the office.

That being said, carrying one or more of these diagnoses is not particularly helpful from a management point of view.

There is limited evidence that some medications (Risperdal and relatives) are somewhat beneficial for aggressive and impulsive behaviours, although the effect is modest.

Generally speaking, the main intervention for these conditions is behavioural, not medical.

ADHD and its COMORBIDITIES (partII)

KIDS ARE RARELY SIMPLE.....

Depression

Depression is clearly a medical condition that is genetically based and has well defined symptoms. It is not just "being in a bad mood".

We see depression quite frequently in the office. It often presents initially as behavioural issues, academic problems, or problems with substance use.

It is important to think specifically of depression when any of these symptoms appear in an individual who had been doing well previously.

Depression

- Depressed mood
- Decreased interest in pleasurable activities (the biggest red flag in teens)
- Weight loss or weight gain
- Increased or decreased sleep
- Increased or decreased motor activity
- Fatigue
- Feelings of worthlessness or guilt
- Decreased focus
- Thoughts of death

Depression

Beware of the teenager who no longer wants to go out and have fun.

Beware of the student who suddenly "develops ADHD" when no symptoms were present when he was younger.

Beware of the individual who "self treats" either with substances (especially marijuana) or self abusive behaviour (cutting).

Depression

Treatment is definitely possible and often helpful.

It should always include attention to personal habits (diet, sleep, exercise).

It should often include "talking" therapy (counselling, cognitive behavioural therapy)

It may sometimes include medical therapy (antidepressants).

Anxiety

Like depression, anxiety is a genetic and clearly medical condition. One does not need a "good reason" to be anxious.

We see it extremely commonly in both the teenaged group and in the younger children.

Treatment is once again quite possible and often helpful.

Anxiety

- Multiple subtypes (generalized, social, panic -related, separation, selective mutism, specific phobias)
- Excessive anxiety and worry occurring on most days
- Worry is difficult to control
- Associated with restlessness, fatigue, difficulty concentrating, irritability, muscle tension, sleep disturbance (any of the above)
- Symptoms cause significant impairment

Obsessive Compulsive Disorder

- Similar in many ways to anxiety
- Obsessions are recurrent unwanted thoughts
- Compulsions are recurrent and generally unwanted behaviours. Washing, counting, checking, doing things a certain number of times are all frequently seen in the paediatric population.
- Treatment is similar to anxiety.

Bipolar Disorder

Not someone with mood swings

- Very difficult diagnosis to make with certainty in the paediatric population
- 90% of individuals with bipolar disorder in the paediatric population also meet criteria for ADHD
- Most frequently, paediatric patients with bipolar disorder demonstrate predominantly depressive symptoms with occasional "highs".

Bipolar Disorder

Manic/hypomanic symptoms can be very difficult to differentiate from ADHD symptoms.

- Bipolar individuals have at least some periods of elevated self-esteem while ADHD individuals tend to have low self-esteem
- While ADHD patients often have difficulty with sleep, they rarely approach the manic individual who may just sleep a couple of hours a night and then be full of energy.
- High levels of goal-directed behaviours are not frequently seen in ADHD individuals.
- Sexual acting out more frequently seen in bipolar individuals

Tic Disorders/Tourette's Syndrome

Simple tic disorders are much more common than complex syndromes such as Tourette's

Common motor tics include eye blinking, facial grimacing, neck flexing/twisting, and shoulder shrugging.

The most common vocal tics are guttural sounds in the back of the throat, and sniffing.

Saying complete words is actually quite rare in the paediatric population

By definition, Tourette's includes multiple vocal and motor tics over time.

Tic Disorders/Tourette's Syndrome

Tics are not dangerous, but can be embarrassing and disruptive for the individual involved.

Treatment is frustrating and often unsuccessful.

These conditions tend to get better and worse over time. As a result it can be very difficult to determine whether any treatment is helpful, or whether the condition simply got better on its own.

In Summary

The list of conditions which may occur at the same time as ADHD is quite extensive.

A complete assessment of a child or adolescent with ADHD must include a screen for these comorbidities.

For any treatment plan to be optimally successful, one must consider the comorbidities and treat accordingly.