

## ADHD COMPLEX – ADOLESCENTS

### Preamble

- Always re-evaluate the clinical findings as the primary diagnosis may not be ADHD. HINT: The ADHD symptoms should predate the onset of any other comorbid condition.
- Only one suggestion for treatment is provided based on the clinical experience of the authors and the current literature.
- If there is a treatment failure after the first treatment strategy, refer the patient to a specialty clinic.
- All medical treatment options are summarized in Appendix 16.

### DISORDER-BASED DIFFERENTIATION

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#### 1. ADHD + Oppositional Defiant Disorder (ODD) [42]

25 – 75% of adolescents with ADHD may have concurrent ODD (21). Distinguishing between normal adolescent self-assertion and ODD may not always be easy. Treatment of the ADHD may not resolve all ODD symptomatology, which may require additional individual and family interventions.

#### 2. ADHD + Conduct Disorder (CD)

The common symptom of impulsiveness may push ADHD patients to CD. New CD may be a signal of a masked mood disorder and this should be carefully reviewed.

### SYMPTOM-BASED DIFFERENTIATION

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#### 1. ADHD + Anxiety

##### a. ADHD may present with anxiety or other internalizing symptoms

- Use the same algorithm as ADHD Uncomplicated but monitor for worsening of anxiety.
- May consider the use of an SSRI if the anxiety is significant.
- Patients with ADHD and anxiety may benefit from stimulant treatment as well as combination treatment, by adding treatment for the anxiety itself.

##### b. Generalized Anxiety Disorder

- Cognitive behavioural therapy and relaxation therapy is the treatment of choice when available.

- Generalized anxiety disorder may respond to SSRI treatment, but monitoring for suicidal ideation is

needed.

iii. Early studies suggest that patients with ADHD and anxiety may experience improvement in both disorders with atomoxetine [45], however, a recent meta-analysis [46] does not show additional benefit for ADHD plus anxiety though replication of the original data must be made. Clinically, there does seem to be some benefit [CB].

#### c. Social Phobia

i. Behavioural treatments are usually sufficient with an emphasis on improving self-esteem.

ii. There are clinical trials demonstrating that social anxiety in children can respond to SSRI treatment [47, 48].

#### d. Post Traumatic Stress Disorder (PTSD)

i. May be the primary diagnosis and misdiagnosed as ADHD as there are similar arousal factors. PTSD is likely if there is no clear family history of ADHD or pre-morbid symptoms of ADHD prior to the abusive situation.

ii. Psychological treatment (individual or group) is an important first line treatment.

#### e. Obsessive-Compulsive Disorder (OCD)

If OCD exists then the combination with ADHD may be part of a Tic Spectrum Disorder (e.g., Tourette's syndrome) so it is important to look for motor and phonic tics. It may be the beginning of what will emerge as a paranoid illness (thought disorder) [49]. Treatment for both ADHD and OCD may be needed and due to the complexity of the treatment, a referral to a specialist is indicated.

### 2. ADHD + Aggression

#### a. Bipolar Affective Disorder (BAD) [50]

BAD should be considered as the primary diagnosis if there are prominent, episodic, cycling mood symptoms. BAD may be suggested by the following: a) a strong family history of BAD or depression, b) paradoxical response to stimulants (worsening of mood or rage symptoms), c) a tendency to go to high dose stimulants to get a treatment effect or d) if the rage symptoms lead to a resolution phase of lethargy and depression.

i. Treatment of BAD or BAD with ADHD should be referred to experts and may include mood stabilization with atypical neuroleptics, lithium, or anticonvulsants prior to, or along with, ADHD medications.

#### b. Post Traumatic Stress Disorder (PTSD)[51]

The PTSD may be the primary diagnosis. The individual may be aggressive as they are expressing their rage of being victimized. Careful history should expose any traumatic episodes. If comorbid, small doses of an atypical neuroleptic (eg., risperidone) may be used.

#### c. Pervasive Developmental Disorder (PDD)

PDD presents with speech/language problems, poor socialization and atypical behaviour (e.g., repetitive, self-stimulating, self-mutilating, fantasy-based, or odd). Clinical symptoms of PDD supersede that of ADHD and should be the primary diagnosis and can co-exist [CB]. The FDA recently approved the use of risperidone in controlling aggressive and self-injurious behaviour and irritability [52].

### 3. ADHD + Substance Use/Abuse (SUD) [53, 54]

The chronic use of illicit substances may create an amotivational motivational syndrome that may appear similar to the motivational problems seen in ADHD. ADHD patients are also at significant risk of using illicit substances, particularly cocaine and cannabis. It is important to dispel their belief that the use of illicit substances has a positive therapeutic benefit. It is therefore essential that a history for substance abuse be explored with the individual alone.

*Practice point: Ask whether their friends use drugs or alcohol first. A positive response suggests they are likely a high risk candidate. Where substance abuse exists, the CAP-G Committee feels it is important to treat the SUD first although it is recognized that ADHD treatment might be required subsequently.*

### 4. ADHD + Depression

According to the Ontario Child Health Study [55], 85% of adolescents who are depressed do not seek out medical treatment. Poor concentration may be part of a clinical depression and the physician should determine if depression is part of a primary diagnosis that should be treated accordingly. A primary diagnosis involves both a) depressed mood of more than two weeks in duration more days than not and b) anhedonia. The stimulant medications may produce a dysphoric look in 30% of patients even though the patient is not clinically depressed. Adjustment of dose may improve the dysphoric symptoms; failing that, switching to a different ADHD medication may be successful.

#### a. ADHD + Major Depression (MD)

Treatment of the most disabling condition should be undertaken first. This is particularly true in the presence of suicide risk. If the MD continues to be impairing or worsens, referral is recommended. Stimulants may produce a mild antidepressant effect in some patients, while they may worsen mood in others. All of the drugs used to treat ADHD have the potential to unmask a mood disorder or to cause mood symptoms.