

Stonebriar Psychiatric Services News & Views

ADHD Across a Lifetime

APRIL, 2010

VOLUME 6, NUMBER 4



**David T. Tharp,
M.D., M.Div.,**

**Board Certified
Psychiatrist**

Medical Director

**Stonebriar Psychiatric
Services, PA**

3550 Parkwood Blvd.
Suite 705
Frisco, TX 75034

Phone
972-335-2430

E-mail
NewsletterQuestions@
stonebriarps.com

We're on the Web!
www.stonebriarps.com

Services We Offer

Individual Therapy
Marital / Couple's
Family Therapy
Personal Life Coaching
Group Therapy
Medication Management
Speaking
Seminars

Treatment for

Depression
Anxiety / Panic Attacks
Eating Disorders
Bi-polar Disorder
Obsessive - Compulsive
Disorder
Compulsive Behaviors
such as sexual
addiction
Post-traumatic Stress
Disorder from past
abuse
Relational issues
Adjustment to life
changes

Ages Served

Adult
Adolescent
Children ages 10 & up

You Don't Just Grow Out Of It...

Over the years, the concept of ADHD has gone through a number of changes as our understanding of it has grown. It has also gone through a number of name changes, beginning with the term "minimal brain dysfunction" back in the late 60s and early 70s, to hyperkinetic syndrome, attention deficit disorder, and now ADHD with specifiers indicating either inattentive type, hyperactive/impulsive type, or combined type, which has elements of both. It was also thought that individuals would tend to outgrow it as they got into their teenage years. This was primarily due to the fact that originally it was primarily recognized and characterized by the hyperactivity, predominantly in boys, and that is one of the symptoms that frequently does lessen as one gets into adolescence. But more recent understanding has shown that ADHD with its various symptoms and problems tends to represent a lifespan disorder affecting children, teenagers, and adults.

Prevalence and Presentation

According to the American Academy of Pediatrics, ADHD is the most prevalent chronic health condition affecting school-age children and the most common neurobehavioral disorder of childhood. In contrast to what some might argue, studies repeatedly indicate that it tends to be under diagnosed rather than over diagnosed. Studies examining community samples of school-age children find rates varying from 4-12% with a probable prevalence of 8-10% overall. Studies have indicated a 9.2% prevalence in males and a 2.9% prevalence in females, although the inattentive type still tends to be the predominant form found in girls. The inattentive symptoms also tend to be most likely to persist into adulthood relative to the hyperactive/impulsive symptoms, although frequently the impulsivity can cause significant problems later in life when it does persist.

A recent study regarding ADHD and 18-44 year-olds was conducted in 2006 and indicated an estimated prevalence of current adult ADHD at 4.4%, but only 10.9% of these individuals had received treatment in the prior 12 months for this. When one considers that the presence of untreated ADHD is associated with a higher incidence of alcohol and drug abuse, traffic accidents and/or violations, job loss or frequent job changes, as well as divorce and relationship instability, this represents a significant problem that is frequently not being addressed adequately. Some of the typical problems that present in adolescence with ADHD include an inner sense of restlessness or even hyperactivity, problems in school with organization and completion of work, risky behaviors such as speeding violations, lowered self-esteem with poor peer relationships, and frequently difficulty interacting with authority figures. In adulthood, this may present as general problems with attention/concentration, problems with organization and task completion affecting work as well as personal life, frequently seeming quite forgetful regarding commitments and follow through, frequent losing or misplacing of items, difficulty with procrastination and completion of tasks, frequently being late for appointments and other obligations, impulsivity regarding decision-making, and job and relationship instability. As one can imagine, these represent difficulties not only for the individual with ADHD but for the loved ones involved in her life.

Diagnosis

One of the diagnostic challenges currently faced is that most of the diagnostic criteria in the DSM-IV TR, which is the current diagnostic manual for psychiatric disorders, are based upon childhood evaluations and presentations. We have discussed these in previous newsletters, but I will quickly summarize them. Symptoms of inattention include difficulty with maintaining attention and focus, forgetfulness, and distractibility. This may come out in the classroom with what might be considered daydreaming, drifting off, or just not paying attention. Reading is often difficult for these children because of the distractibility and often having to reread material. I have worked with extremely intelligent adults who have commented, and I believe without exaggeration, that they have never finished a book in their life. The hyperactivity in

children is often characterized by fidgeting, talking excessively or impulsively answering questions out loud, difficulty in waiting one's turn, and frequently interrupting others or finishing their sentences. It may also be characterized by what some might call "daredevil" behavior in terms of taking chances that might result in injury to them or others, such as climbing on roofs and jumping off, riding their bicycle in ways that would be unsafe, etc. By current definition, symptoms should be present by age 7 with impaired functioning in at least two settings and having occurred for more than six months.

Current diagnoses are stipulated as ADHD, and either inattentive type, hyperactive/impulsive type, or combined type, which has elements of both. As noted, males tend to predominate over females approximately 3:1, although most studies suggest that girls more commonly have the inattentive type, while boys may tend to be more hyperactive and display more disruptive or oppositional types of behaviors. Because the girls often do not present as behavior problems but may just represent that child who sits quietly in the corner daydreaming, it is felt that they frequently are unrecognized and yet still are significantly affected, particularly regarding academics. Because the inattentive type is becoming more recognized, I would estimate that in my practice males and females, whether children, teenagers, or adults, are approximately equally represented.

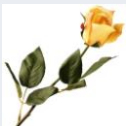
One of my greatest concerns regarding ADHD is that often, when it is unrecognized, these individuals grow up believing that they are either "bad kids or dumb kids," and the fact is that they are neither. My general impression based upon 30 years of practice is that most individuals with ADHD tend to be above average, with many far above average, in terms of intelligence, and that frequently the trouble that they get into if often a result of their poor decision-making and impulsivity. I have worked with a number of individuals who may have been average students in high school, often feeling quite frustrated in the process, may have tried college multiple times but dropped out or quit going to class, and yet once diagnosed and treated became active and interested students making A's and B's. The struggles that they may have in younger years also can frequently have consequences as they get older, whether it is related to self-esteem, legal problems, or general instability in their life.

One reason for their being some controversy regarding adult ADHD is that the established diagnostic criteria were primarily based upon the symptoms and environments of children without full validation studies being conducted with adults. This has been modified over time through a number of studies on adults, but has not yet been translated into "official" diagnostic criteria. It is felt that this will occur when the next diagnostic manual comes out. An example is how adult symptoms, such as procrastination, poor motivation, sleep problems, low frustration tolerance, as well as problems with time management/organization, are not clearly defined in the childhood criteria in DSM-IV TR. There are also many, including myself, who would question whether the evidence of symptoms by age 7 should be a necessary criteria. Although it is my impression that the symptoms, although subtle, are generally part of the "built in wiring" at birth, frequently individuals may not clearly show symptomatic problems until they are older and encounter situations that their innate intelligence and other abilities cannot overcome adequately. This is why I often may see individuals from various ages being first diagnosed when it appears as though they were functioning without difficulty earlier on. Many are bright enough that they can breeze through the early grades without studying, but as the work gets harder and the projects require more organization and teachers are less willing to oversee the handing in of assignments, they may falter. I have also not infrequently had homemakers come in who may have finished college and done relatively well, even though they felt they had to work harder than others, but now are feeling quite overwhelmed by managing the activity schedules of five children along with organizing their other responsibilities. It can all be rather "discombobulating", to say the least.

Needless to say, ADHD represents a relatively common problem for many and is often unrecognized. It may be further complicated by other problems that can occur with it. But the reality is that it frequently can be successfully treated, often using medication and counseling. Next month we will look at some of the treatments available, along with some of the predisposing factors influencing the development of ADHD. I would like to conclude this newsletter, however, on a very optimistic note in that I greatly enjoy working with individuals with ADHD, as the likelihood of successful treatment is generally quite high and the impact made on one's quality of life quite positive.



Do you have topical requests for future newsletters? Let us know at: NewsletterQuestions@stonebriarps.com



Stonebriar Psychiatric Services, PA

3550 Parkwood Blvd. Suite 705 Frisco, TX 75034

972-335-2430

www.stonebriarps.com