

# Stonebriar Psychiatric Services

## News & Views

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#### **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...(continued)**

In last month's newsletter, we were looking at how ADHD is no longer viewed as a problem only of childhood but rather one whose symptoms and problems generally occur across one's lifespan. We also discussed how many of the diagnostic criteria were originally established based upon childhood symptomatology, so therefore diagnosis in adults is a bit less defined in terms of current psychiatric diagnoses as established by the DSM-IV-TR manual. However, for those of us working in the field, it is quite clear that adult ADHD is alive and well for many.

One of the factors that makes diagnosing ADHD in children or adults difficult is that there is no particular test, either written or medical, that clearly defines it. It is still based primarily upon clinical history, and there are other disorders which can mimic it or coexist with it. For example, anxiety disorders may coexist in 43-52% of children with diagnosed ADHD, major depressive disorder in approximately 31%, oppositional defiant disorder in 29%, conduct disorder in 20%, and alcohol and substance abuse issues in 27% and 18%, respectively. In those with adult ADHD, there are accompanying mood disorders in approximately 38%, anxiety disorders in 47%, impulse control disorders in almost 20%, and substance use disorders in approximately 15%. One that is not at all uncommon, but often difficult to tease out in terms of the contribution of each disorder to an individual's symptoms, is that there is a fairly high coincidence of ADHD and bipolar spectrum disorder, both of which may have a number of symptoms in common.

Although malingering has been reported as an important issue in a number of studies, and at times could be quite difficult to differentiate from legitimate symptoms, in my experience it has not been my impression that it occurs that often. Certainly the diagnosis of ADHD can provide certain benefits, including access to stimulant medication, academic accommodations for students, and even at times perhaps some disability related benefits. In adults, it is often difficult to obtain corroborating history in terms of earlier years, teacher evaluations and observations, etc., along with the fact that there is no single test which definitively defines this disorder. Screening instruments may help, but again it eventually comes down to clinical history and professional experience by the one doing the evaluation.

Because of the impact ADHD can have on the individual, I feel that it is important to not assume that individuals are "trying to pull one over on you," but that rather this is a very real disorder that causes very real problems for many and deserves careful assessment. Many of these issues were discussed last month, and across the lifespan may include academic problems, low self-esteem, interpersonal relationship problems, and increased incidence of alcohol and substance abuse, motor vehicle infractions and accidents, along with legal and occupational difficulties.

Many studies provide evidence that there is a strong neurobiological component to ADHD coupled with the influences of environmental and experiential factors. Many regions of the brain are potentially involved with various symptoms, although much of this remains in the clinical research stage. Brain imaging studies hold particular promise, and yet most still require further validation for general clinical use. We know that many of the pathways that may be involved operate through the neurotransmitters, dopamine and norepinephrine, which also are frequently the neurotransmitters affected by the stimulants and other medication that are used to treat ADHD. ADHD also seems to have a strong genetic component, which certainly seems borne out in my clinical experience regarding multiple family members being affected, whether diagnosed or not. Twin studies indicate a mean heritability of 77%, which translates into 15-25% of first degree relatives of children with ADHD also having the disorder. Another way of looking at this is that ADHD may occur in up to 50% of children whose parents have ADHD. Research is also being done extensively looking at the molecular genetics of this disorder.

## *Treatment and Treatment Goals*

In looking at treatment goals, the focus is both on reducing symptoms and increasing and improving overall function. This also involves looking at the specific strengths and weaknesses of the family and its management of behavior, along with intervention in the school and community when possible. Although formal guidelines have been established regarding treatment in school-age children, there are no specific guidelines yet developed for adults, in part because it has not yet been clearly defined in official diagnostic manuals. However, there have been numerous studies providing guidelines for the treatment of adults, which tend to be very effective.

Most studies generally indicate that a combination of medication and therapy provides optimal treatment. Although medication frequently helps improve many of the core symptoms of ADHD, the counseling often helps translate this into other behavioral changes, along with helping the individual learn general social skills and coping strategies, which often they have not had the chance to do. However, large studies have shown little benefit for psychosocial interventions alone, but clear benefit with pharmacotherapy in over 70% of children. The stimulants, including methylphenidate and amphetamine related medications, along with certain antidepressants, antihypertensives, and atomoxetine (Strattera) are the primary medications used. The stimulants, however, whether those related to methylphenidate or the amphetamine group, remain the primary first-line treatment with atomoxetine being considered if these are not successful. There is some evidence that some of the antihypertensive related medications, such as the new time released Intuniv, may be useful particularly with hyperactivity or oppositional defiant states.

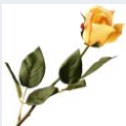
Research continues to look for possible herbal treatments for ADHD. Recent studies with St. John's wort indicated no benefit in short-term treatment trials. There also do not seem to be any significant differences in benefit from pharmacotherapy interventions for ADHD in adults versus children, although fewer adult studies have been performed. Because of potential cardiac side effects, it was once suggested by the American Heart Association that preliminary EKGs should be done before initiating stimulant therapy in children, although the American Association of Pediatrics subsequently stated that routinely EKGs were not necessary. The basis for this position is that sudden cardiac death with people taking medication for ADHD is extremely rare and occurs at no higher rate than the general population and that baseline EKG's would not be generally useful. The most common cardiac side effects may include slight increases in pulse rate or blood pressure, but even this is unusual.

Perhaps the most important aspect of treatment is the willingness of the patient, whether child, teenager, or adult, to take the medication on a regular basis. This represents a similar problem to that of most chronic illnesses. My experience is that once the individual has seen the benefit and dosage has been adjusted to minimize any potential side effects, he would see the benefits and is generally quite willing to take medication. Some individuals do not find it necessary to take it daily, but rather take the medications for specific activities which require focus and concentration, such as meetings, studying, or preparation of projects, etc. I have found that some individuals with ADHD have difficulty taking short acting preparations, because they forget to take it or to have it with them when needed, and therefore time released preparations may be more practically useful. This is certainly one of the benefits of the longer acting preparations, which may ideally provide coverage from breakfast through approximately dinnertime.

Overall, I find working with individuals with ADHD extremely rewarding. Without treatment, many individuals often grow up thinking that they are either "bad kids or dumb kids," and the fact is that they are neither one. My experience is that most have greater than average intelligence, some very much so, and are quite appreciative of the gains that they experience with treatment, as they are able to work and function more effectively in utilizing their God-given gifts and talents.



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



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