Life-Changing Interventions for the New AD/HD: Beyond the DSM-5

Extra Information Slides C

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Active Forgetting & CAM for AD/HD
AD/HD and Active Forgetting

• ADHD people appear to have more difficulty actively forgetting than the non-impaired because their prefrontal cortex is under activated when forgetting. Hence, their amygdali and hippocampus’ are not blocked and record the memories. Thus they have less control of their memories. As a result, they are more susceptible to distracting thoughts.

CAM Methods and AD/HD Treatment

“Free fatty acid supplementation produced small but significant reductions in ADHD symptoms even with probably blinded assessments, although the clinical significance of these effects remains to be determined. Artificial food color exclusion produced larger effects but often in individuals selected for food sensitivities. Better evidence for efficacy from blinded assessments is required for behavioral interventions, neurofeedback, cognitive training, and restricted elimination diets before they can be supported as treatments for core ADHD symptoms” (p. 275).
Sluggish Cognitive Tempo
“True Inattentive AD/HD” is a Separate Disorder from Combined Type AD/HD

It may be that “True Inattentive AD/HD” (Not sub-threshold AD/HD has as its major impairment poor working memory whereas the various Combined Type AD/HDs have as their major impairment impulsivity. True Inattentives have difficulty with underarousal. Those with Combined Type AD/HD have difficulty in their striatum (a frontal–striatal loop) and True Inattentives have difficulty...
“True Inattentive AD/HD” is a Separate Disorder from Combined Type AD/HD

...It appears the area of disturbance in True Inattentive is the frontal-parietal loop. “Individuals with ADD have difficulty maintaining a sufficiently high level of motivation to complete a task and grow bored quickly, perhaps tiring because the working memory demands of the task exhaust them. They go looking for something else to do or think about because they are bored, rather than being unable to inhibit the pull of distractions. Their problem is not so much that are distractible as that they are easily bored”.

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“True Inattentive AD/HD” is a Separate Disorder from Combined Type AD/HD

Sluggish Cognitive Tempo

“PI (Predominately Inattentive Type AD/HD, sic.) with high SCT had fewer problems with sustained attention, and more internalizing problems, anxiety/depression, and withdrawn/depressed behavior, and more executive problems with self-monitoring than the rest of the ADHD sample. Conclusion: This study supports revising subtype's criteria and further studying the hypothesis that ADHD with high SCT constitutes a separate clinical entity.”
“Confirmatory factor analyses (CFA) supported the presence of three separate, but correlated factors (SCT, inattention, and hyperactivity/impulsivity) in both parent and teacher ratings. As expected, SCT symptoms were greatest in youth with ADHD Inattentive type, but were also found in non-ADHD clinical groups. SCT symptoms were related to inattention, internalizing, and social problems across both parent and teacher informants; for parent reports, SCT was also related to more externalizing problems. Findings support the statistical validity of the SCT construct, but its clinical utility is still unclear” (p. 1097).

Sluggish Cognitive Tempo

“Children with the truly inattentive type of ADHD, rather than being distractible, may instead be easily bored, their problem being more in motivation (under-arousal) than in inhibitory control. Much converging evidence points to a primary disturbance in the striatum (a frontal–striatal loop) in the combined type of ADHD. It is proposed here that the primary disturbance in truly inattentive-type ADHD (ADD) is in the cortex (a frontal–parietal loop). Finally, it is posited that these are not two different types of ADHD, but two different disorders with different cognitive and behavioral profiles, different patterns of comorbidities, different responses to medication, and different underlying neurobiologies” (p. 805).

The LD/AD/HD “Identity”

- Rodis offered the Seven Stages of Identity Formation for Persons with LDs:
  1. The Problem-Without-A-Name Stage
  2. Diagnosis
  3. Alienation
  4. Passing
Identity (Continued)

5. Crisis and Reconfrontation

6. “Owning and Outing”

7. Transcendence

AD/HD Identity

“Consequently, some end up attributing their problems to characterological or moral defects in themselves, and pay a heavy emotional price as a result. This underscores the importance of reframing the disorder as neurobiological and not characterological, of rebuilding self-esteem and self-confidence, and instilling hope in the future” (p. 693).

ADHD Identity

Some AD/HD adults find themselves socially rejected. “In part, because of their impulsivity, interrupting, forgetfulness, inattention, hyperactivity, difficulty reading social cues, temper, and/or mood swings, adults with ADHD frequently report having difficulty maintaining relationships” (p. 693).

AD/HD Comorbidities
Comorbidities and AD/HD

- **75% of AD/HD Adults Referred to Clinics have a Comorbidity**

- **20% of AD/HD Adults have Two or More Comorbidities**
Comorbidities (Continued)

- Barkley wrote, “Up to 67% of ADHD children as adults are free of psychiatric diagnoses” (p. 207).


Brown Estimated that 50% of AD/HD adult had Comorbidities.

AD/HD and Comorbidity

“Some of the more common correlates associated with ADHD in adults are low self-esteem, avoidance/anxiety, depression, school and job performance problems, marital/couple discord, poorer driving outcomes, and substance abuse” (p. 693).

Comorbidities and AD/HD

Pliszka indicated the following regarding comorbidities of adults with AD/HD:

Prevalence rates of adults with ADHD

- Antisocial Personality Disorder: 12% to 27%
- Alcohol and Drug Dependence: 27% to 46%
- Major Depressive Disorders: 17% to 31%
- Anxiety Disorders: 32% to 50%

Goldstein wrote, “Adult outcome of individuals with ADHD has not been proved to be solely tied to particular ADHD variables or treatment but likely interacts with a variety of life factors, with family issues paramount” (p. 73).

Comorbidity and AD/HD

Weiss and Hechtman after a 15 year follow-up study came up with the following groups that AD/HD adult fall into:

1. 30 to 40% Fairly Normal Group
2. 40 to 50% Significant Hyperactivity, and Social/Emotional/Interpersonal Problems
3. 10% Severely Antisocial and/or Mentally Disturbed

Comorbidity and AD/HD

“In general, there appears to be convincing evidence that ADHD increases the risk for certain psychiatric disorders. More than 80% of our ADHD groups had at least one other disorder, more than 50% had two other disorders, and more than one third had at least three disorders, these being markedly higher than our control groups in both studies” (p. 241)

Clinicians, AD/HD & Comorbidity

“Clinicians need to be aware of and specifically assess for high comorbidity of ADHD with other psychiatric disorders, particularly dysthymia, depression, ODD (Oppositional Defiant Disorder, sic.), conduct disorder, alcohol use disorders, and drug use disorders more generally. The elevated risk for suicidal ideation and attempts associated with the disorder is driven largely by comorbid disorders and not so much by ADHD specifically” (p. 243)

Psychiatric Comorbidity

Brown Indicated that 88.6% of those with AD/HD are at risk of having a comorbid psychiatric disorder in their lifetime which is 6.3 times higher than the general public.

Comorbidity and AD/HD (Continued)

- Those with Combined Type AD/HD have more Externalizing Disorders
- Those with Inattentive AD/HD MAY have more Internalizing Disorders

Comorbidities (Continued)

Hynd stated 40% of those with Inattentive AD/HD will have an Internalizing Disorder.

AD/HD & ODD
AD/HD and ODD in Children

“Over 65% of clinic-referred samples may show significant problems with stubbornness, defiance, or refusal to obey, temper tantrums, and verbal hostility toward others” (p. 191).

Oppositional Defiant Disorder and AD/HD

- 50% to 67% of AD/HD have ODD
- ODD is NOT limited to childhood and is more persistent than AD/HD
- Hot headed, angry, using anger as a social tool

Barkley, R.A. (2002) Mental and Medical Outcomes of AD/HD. Pre-Conference Institute, # TPA1, Thursday October 17, 2002, 14th Annual CHADD International Conference, Miami Beach, FL.
Adult ODD/CD and AD/HD

“Just as do children and adolescents diagnosed with ADHD, adult given the clinical diagnosis of ADHD have considerably higher amounts of comorbid ODD and CD than do either clinical control groups without diagnosis of ADHD or, typical nonreferred adults. Approximately, 24 –35% of clinic-referred adults, diagnosed with ADHD have ODD and 17—25% manifest CD, either concurrently or over the course of their earlier development” (p. 277).

Children with AD/HD + CD

- Those with AD/HD and CD tend to have significantly more severe symptoms
- Those with both CD and AD/HD have more antisocial behaviors than those with one other or the other disorder
- Those with CD and AD/HD have the lowest verbal I.Q.
- Those with both have the most severe difficulties with social interaction

Children with AD/HD + CD

- Those with both AD/HD and CD are most likely to have Antisocial Personality Disorder and psychopathic traits in adulthood.
- Those with both disorders have a much earlier onset and worse outcome in adulthood than those with one or the other disorder alone.

“To summarize, ODD and CD have a substantial likelihood of co-occurring with ADHD with the risk for ODD/CD being mediated in large part by severity of ADHD and its family genetic loading and in part by adversity in the familial environment”

AD/HD & ODD, CD

• “In the general population, oppositional defiant disorder co-occurs with ADHD in approximately half of the children with combined presentation and about a quarter with the inattentive presentation” (p. 65).

• “Conduct disorder co-occurs in a quarter of the children or adolescents, depending on age and setting” (p. 65).

Larson, et al (2011) reported that 27.4% of children with AD/HD meet criteria for Conduct Disorder compared to 2.1% of children without AD/HD.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3065146/#!po=2.38095.
TV, Electronic Games & Conduct

“TV but not electronic games predicted a small increase in conduct problems. Screen time did not predict other aspects of psychosocial adjustment.”

Depression and AD/HD

NORMAL FORMS OF DEPRESSION


* Ratey and Johnson spoke of “Shadow Syndromes” which appear as, “…behavior that fits only part of a syndrome or disorder, but not all” (p. 13).

AD/HD, “The Blues” & Grief
2. Bereavement – The normal grief reaction to a traumatic life event (i.e. death of a loved one, being diagnosed with a disorder, etc.).

- Symptoms: Loss of interest in things on typically finds pleasurable, depression, sluggishness, problems with sleep and/or appetite, guilt, suicidal thoughts.

- Complicated Bereavement- includes the above symptoms with a Major Depressive Episode.
Grief and AD/HD

Goldstein spoke of adults with LD and/or AD/HD who struggle with.. “prolonged grief. It has been reportedly suggested that adults with AD/HD and LD struggle with grief over their perceived incompetence and a lifetime difficulty with meeting everyday expectations” (p. 260).

Grief and AD/HD (Continued)

Murphy and LeVert wrote of the stages of coping with being diagnosed AD/HD:

Stage 1 - Relief and Optimism
Stage 2 - Denial
Stage 3 - Anger and Resentment
Stage 4 - Grief
Stage 5 - Mobilization
Stage 6 - Accommodation

Grief and AD/HD

Some AD/HD adults may not be able to find the words to express their grief due to “ALEXITHYMIA.”
AD/HD & Alexithymia
What is ALEXITHYMIA?

Coleman wrote, "Grey emotional flatness exemplifies what psychiatrists call alexithymia...Such people lack words for feelings. Indeed they seem to lack feelings altogether, although this may actually be because of their inability to express emotion rather than an absence of emotion altogether" (p. 51).

Alexithymia (Continued)

Coleman continued, “..the alexithymic’s dilemma: having no words for feelings means not making the feelings your own” (p. 53).

Alexithymic’s

1. Tend not to have fantasies, no feelings, and sharply limited emotional vocabulary.
2. They have colorless dreams.
3. They cannot tell bodily sensations from emotions and are baffled by them.
4. They cannot make decisions because they have no “Gut Feelings”

Alexithymia

Lane wrote, “Several neuroimaging studies reveal that an area of the medial prefrontal cortex very close to that identified in our attention to emotional experience study has been implicated during the performance of theory of mind tasks...these findings suggest that the neural substrates of the mental representation of one’s own and other’s mental states are closely related” (p. 18). Lane continued that several studies of brain injured individuals when coupled with the above appeared to indicate, “...that successful social adaptation requires the ‘dual task’ ability to stay in touch with the needs of others while paying due attention to one’s own needs” (p. 20).

Alexithymia **MAY** BE A NEUROBIOLOGICAL DISORDER!

25% OF THOSE WITH AD/HD HAVE ALEXITHYMIA.

“Studies show that the capacity to imitate the actions of others is now virtually an instinct at the level of neuronal functioning. The PFC (Prefrontal Cortex, sic) responds to viewing others’ actions by activating the same sensory-motor regions of the brain as the acting person is using to create the behavior. The mirror-neuronal system has been linked to theory of mind and to empathy, among other human attributes related to EF (Executive Functions, sic.)” (p. 117).

How does the following relate to AD/HD?:

“If the mirror neuron system serves as a bridge in this process, then in addition to providing an understanding of other peoples intentions, it may have evolved to become an important component in the human capacity for observation-based learning and sophisticated cognitive skills.” (p. 61)

Mirror Neurons

How does this relate to ADHD?

Barkley (2008) said that those with Combined Type AD/HD and comorbid Alexithymia typically have intact mirror neurons, they just do not use their mirror neurons due to their frontal lobe difficulties.

AD/HD & Internalizing
Internalizing and AD/HD

“We found that the internalizing disorders of MDD (Major Depressive Disorder, sic.) dysthymia, and anxiety disorders are more likely to occur in ADHD cases referred to clinics over that risk seen in the Community control group” (p. 241)

Barkley said Affective Disorders are common in AD/HD Adults

- 30-35% Have Generalized Anxiety Disorder
- 25-35% Had Major Depressive Episode
- >50% Dysthyemic Disorder

AD/HD and Mood Disorders

Brown indicated that those with AD/HD have a 38.3% chance of having a mood disorder during their lifetime which is 5 times more likely than in those without AD/HD.

AD/HD and Depression, Anxiety

- Anxiety disorders and major depressive disorder occur in a minority of individuals with ADHD but more often than in the general population” (p. 65).