Anxiety & Depression in Adult ADHD

Dr Shabeer Jeeva

Child & Adult Psychiatrist, Melrose Arch, Johannesburg

ADHD is a disorder that is common throughout the lifecycle. Although it is recognized that between 5-8% of children suffer from ADHD, it is a lesser known fact that 60% of these experience continued symptoms into adulthood. Both in children and adults, ADHD can be classified into four subtypes: hyperactive, inattentive, mixed hyperactive-impulsive or ADHD not-otherwise specified (NOS). While a small proportion of children with ADHD have comorbid anxiety and mood disorders, the prevalence increases dramatically during adolescence and continues to do so into adulthood.

ADHD, Anxiety, Depression Highly Comorbid

Approximately 80% of adult ADHD patients suffer from comorbid psychiatric disorders and while many have clear symptoms of anxiety and depression, these often fail to meet the full Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for anxiety, major depressive disorder, or dysthymic disorder. Since the presence of comorbid anxiety or depression can complicate the diagnosis of ADHD and further impair patients' functioning, separating and treating these symptoms is critical.

Symptoms of anxiety and major depressive disorder (MDD) are present in 40% and 35% of adult ADHD patients, respectively. Fully, 15% percent of ADHD patients also suffer from bipolar disorder meeting DSM-IV criteria. Conversely, approximately 20% of patients with a primary diagnosis of generalized anxiety disorder or MDD each also have ADHD, and 15% of patients with a primary diagnosis of bipolar disorder have symptoms of ADHD.

There is a growing recognition of these comorbidity rates among subspecialty organizations like the Canadian and American paediatric societies and the American Association of Child and Adolescent Psychiatry (AACAP). Furthermore, they represent a growing consensus that the presence of a comorbid disorder presents a major challenge to treating ADHD effectively and that an imperative to treat depression and anxiety in the ADHD patient exists. Nothing less than the "full assessment of the patient" is required ("American Academy of Child and Adolescent Psychiatry. Practice parameter of the use of stimulant medications in the treatment of children, adolescen ts, and adults" *J Am Acad Child Adolesc Psychiatry* 2002; 41[suppl]:26S-49S).

Diagnosis of Comorbid Anxiety and Depression

Guidelines issued by these organizations agree that MDD is a significant psychopathology and requires effective treatment in the ADHD patient. This is because there is a high suicide risk of among those with comorbid ADHD and MDD.

Regardless of the condition, recognizing all comorbid disorders requires first and foremost conducting a careful and detailed patient history. Formal symptom rating scales can also aid in the diagnostic process, helping to distinguish ADHD from symptoms of anxiety and depression (Turgay et al., *Can J Psych* 1998; 43:623-628). Furthermore, these scales also help the clinician to quantify the intensity of treatment required.

Significantly, uncontrolled ADHD symptoms can impair quality of life. Both as a primary and secondary disorder, active symptoms can have a profound impact on the patient's family functioning, particularly when compounded with the effects of untreated symptoms of depression or anxiety.

Treatment of Comorbid Anxiety and Depression

Some patients with comorbid depression and anxiety

may in fact experience clinical response to treatment for ADHD alone. For example, patients with mild anxiety or MDD seem to improve dramatically when their ADHD symptoms are under control. Still others may respond to combined psychotherapy and psychosocial treatment.

The first line of medical treatment of patients with ADHD and comorbid depression or dysthymia should include those medications that interfere as little as possible with cognitive functioning. Among the newer medications, the anti-depressants buproprion (Wellbutrin XR), imipramine (Ethipramine), desipramine (Norpramin),or venlafaxine (Efexor® XR) fit this criterion. Buproprion is an especially preferable option, since it has both anti-depressant and anti-ADHD properties. However, it is not as effective as the psychostimulants (such methylphenidate) or the non-stimulant atomoxetine (Strattera) in treating ADHD.

In patients who do not experience improvements in their depression and anxiety symptoms with these medications, a drug from the class of selective serotonin reuptake inhibitors (SSRIs) should be considered. Among the SSRIs, fluoxetine (Prozac, generics) is effective and is also advantageous since it can be combined with any of the psychostimulants or any other anti-depressant, with the exception of monoamine oxidase inhibitors (MAOI).

In ADHD patients with comorbid aggressive behaviour, conduct disorder, oppositional defiant disorder (ODD) or antisocial personality disorder, ADHD-specific medications may not be effective. For these subsets of patients, the atypical anti-psychotic risperidone (Risperdal) has anti-manic, anti-ADHD and anti-anxiety properties and also enhances the effects of anti-depressant medications, making it most preferable for these patients. (Reference: Turgay A, Binder C, Snyder R, Fisman S. "Long-term safety and efficacy of risperidone for the treatment of disruptive behaviour disorders in children with subaverage IQs" *Pediatrics* 2002;110:e34.)

Treating ADHD in the Comorbid Anxiety/Depression Patient

After a patient's anxiety or depression is well controlled, their ADHD symptoms should be reassessed. If such symptoms are still present, the addition of a psychostimulant is often effective. However, since methylphenidate can increase symptoms of anxiety, a good choice in ADHD patients with comorbid anxiety symptoms or anxiety disorders is atomoxetine.

In patients with bipolar disorder and ADHD, controlling bipolar symptoms first by using mood stabilizers such as lithium carbonate and valproic acid is important. If these fail, risperidone or another atypical antipsychotic may lead to symptom control. After symptoms of MDD and hypomania stabilize, remaining ADHD symptoms should be treated. While there is a risk that psychostimulants will lead to hypomania, limited treatment options make them worth trying cautiously.

TABLE: World Health Organization Adult Self-Report Scale - V 1.1 Screener

1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?
3. How often do you have problems remembering appointments or obligations?
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?
5. How often do you fidget or squirm with your hands or your feet when you have to sit down for a long time?
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?

Other common scales include:

- Gadow-Sprafkin ADHD Symptom Checklist-IV (*J Emotional Behavior Disorders* 2001;1:182-191)
- DuPaul ADHD Rating Scale (Barkley RA, DuPaul GJ, McMurray MB. Comprehensive evaluation of attention deficit disorder with and without hyperactivity as defined by research criteria.

J Consult Clin Psychol 1990 Dec;58(6):775-89).