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ADHD in Older Adults: Key Diagnostic and Treatment Strategies

Ashley Baker:
Welcome to *NeuroFrontiers* on ReachMD. I'm psychiatric nurse practitioner Ashley Baker, and here with me today to discuss ADHD in older adults is Dr. David Goodman. Dr. Goodman is the Director of Suburban Psychiatric Associates, LLC and the Director of the Adult Attention Deficit Disorder Center of Maryland. He is also an Assistant Professor in Psychiatry and Behavioral Sciences at the Johns Hopkins School of Medicine.

Dr. Goodman, thanks for joining me today.

Dr. Goodman:
Thank you, Ashley. Thanks for having me.

Ashley Baker:
So let's dive right in, Dr. Goodman. How does ADHD typically manifest in older adults? And are there any unique symptom presentations or comorbidities to consider?

Dr. Goodman:
Well, this is an interesting area, Ashley, because it, heretofore, had not really been recognized. The literature in ADHD is well known for decades, but it's only been in the last 5, maybe 10 years that we recognized ADHD doesn't go away when you get discharged by your pediatrician, and it doesn't go away when you get your Medicare card. So it's a lifelong disorder, and to realize that is important because when older adults complain about cognitive decline or cognitive deficits, it's important to those who are evaluating to put ADHD in the differential diagnosis.

So adults with ADHD, the prevalence rate is about 2.5 percent internationally, which is fairly substantial when you consider the bipolar disorder prevalence rate in the United States is 2 percent, and ADHD prevalence rate in adults in the United States is 4.4 percent. So ADHD is actually much more common than clinicians realize, and that's because they haven't been trained in their professional programs.

So some of these clinical obstacles are an issue when diagnosing adults with ADHD who are older, but the adults with ADHD are going to complain about the same lifelong symptoms as other ADHD individuals. They are easily distracted. They can't stay on task. They can't keep track of time. They show up late. They're misplacing things. They're forgetful from day to day. They have difficulty recalling a conversation. They might get easily frustrated, impatient, and irritable. And so it's easy when somebody comes in at 55 or 60 complaining about this, the clinician says, "Look, you're not a spring chicken. This is a function of aging." And it gets discounted before you go through a comprehensive psychiatric and medical history in order to determine what factors are there.

Ashley Baker:
So a patient presents with the symptoms that you outlined. What assessment tools or diagnostic criteria do you find most effective with this population?

Dr. Goodman:
Well, the first thing I would ask clinicians to do is, before you make a presumption this is age related, back up, realize you heard this and say, "Okay, let me ask you a few questions about ADHD. Were you like this 20 years ago? Did you have problems in your job or in your responsibilities during the day where you were forgetful? You were losing things? You were inconsistent in follow-through? You lost track of time? You got easily distracted in conversations? It took you longer to get things done than other people? It was hard to

sequence a series of steps in a task?" The other aspect is if you're married, if you're living with somebody, if somebody has known you over the course of decades, their observations are also important. If they say, "Look, you've always been this way," then that's a good, premise to assume that maybe this person has ADHD.

The other factor in the diagnosis, although it's not part of the DSM-5 criteria, is family psychiatric history. So we know that ADHD is highly genetic. 75, 80 percent of the cause is genetic.

Now some clinicians will say, "Look, this is just too complicated. I can't figure this out. I'm going to send him for neuropsychological testing." Where does that come into play? And although people go for neuropsychological testing when they're older in life, the neuropsychological testing will simply show you the deficits. The deficits don't make the diagnosis. And so there are many studies now showing that neuropsychological testing in older adults to sort out those who have ADHD versus those who have other cognitive difficulties and etiologies is very difficult, so we're not at this time recommending that older adults get neuro-psych testing in order to determine whether they have ADHD. The neuro-psych testing will discern IQ and specific deficits, but it doesn't make a diagnosis, and that's what's very important to understand.

Ashley Baker:
Do you in your practice recommend for our listeners any other type of rating scale or evaluation that you would do in the office or send them home with that would be of more value for the clinical diagnosis?

Dr. Goodman:
So in my clinical evaluation, in addition to my interview and a comprehensive review of psychiatric comorbidities and medical issues and developmental history, I use the ADHD childhood rating scale, which allows the patient to complete it based on their recollection between the grades of 5 to 7. I don't say, "Let's talk about these symptoms when you were 10 years old." People are more often able to remember where they were in grades 5, 6, or 7, and now I'm looking for a childhood endorsement of symptoms. The other scale I use is the Adult Self-Report ADHD Scale, which is 18 items out of the DSM-5 rated on a frequency basis, and the patient gives me the ratings on each of these 18 items. And if they're highly rated by DSM-5 symptom count criteria, if you have 5 of 9 in inattention or 5 of 9 in hyperactive impulsive symptoms, then you've fulfilled the symptom criteria.

The other diagnostic criteria, however, is impairment. And so after I ask about symptoms and psychological experiences, I also ask, "How does this affect your functioning during the course of the day?" so that they can outline the impairments. The next question I ask them is to see whether the environment recognizes their deficits. So I say to them, "Do other people around you criticize or remark about your inefficiency, unreliability, and difficulty following through?" And they'll say their spouse, their coworker, their boss, or their supervisor has often remarked that it takes them longer to get things done. If you have the environment making remarks, it means your symptoms are so evident and your impairments are evident to other people that it is really a substantial set of symptoms that you have and suffer with.

Ashley Baker:
For those just tuning in, you're listening to *NeuroFrontiers* on ReachMD. I'm psychiatric nurse practitioner Ashley Baker, and I'm speaking with Dr. David Goodman about how we can better manage ADHD in older adults.

So once we diagnose an older adult with ADHD, Dr. Goodman, which treatments are recommended?

Dr. Goodman:
So this very much depends on the patient. It's a collaborative effort. I offer the education of what I think the diagnoses are. Then I walk through the options, which include psychotherapies. That would be organizational techniques or compensatory mechanisms, having an assistant provide some oversight. And then we have medication. So in the realm of medication, you have over 30 different preparations of stimulant medications. You have nonstimulants, of which there are two. Then you have alpha-2 agonists, which there are two, but none of which are approved for adults. The alpha agonists, guanfacine and clonidine, are only approved for children and adolescents. And then you have off-label use of bupropion, more often for those with ADHD and depression.

For the older adults, the consideration of medication takes into account the medical issues, and the most important medical issue for older adults if you're writing stimulant medications is cardiac and understanding where the cardiac issues are. We know that stimulant medications run the risk of increasing blood pressure and pulse. That can be monitored on a regular basis if you have preexisting hypertension and you're treated for that. Again, my patients regularly check blood pressures and pulses and then report these numbers to me as I'm changing doses. If you have patients with more severe cardiac issues—that is post stents, post MI, or atrial fibrillation—then they are often treated by a cardiologist, and coordination of psychostimulant prescriptions with a cardiologist is prudent. I do that frequently with my patients.

So these medications really work well for older adults. There is much less research on the nonstimulants and the alpha-2 agonists in older adults, but we have a fair body of literature now for the use of psychostimulants that treat ADHD and using them in older adults. The dosing tends to be about the same, and you titrate the dose upward for the response to the cognitive symptoms and the side effects. Some of the side effects commonly are decreased appetite, difficulty falling asleep, and dry mouth—or hand tremor, worsened by caffeine, so if my older adults go on psychostimulants, I really tell them to cut down and eliminate, if possible, their caffeine load. And patients respond well. Usually, response occurs within a day or a week at any given dose. You increase accordingly and have the patient report back.

If you will recall, I suggested using the adult ADHD rating scale at the inception of treatment. I then come back to that, and patients will fill out that rating scale while they're on medication. The advantage here is that I have objectively documented their subjective change in the frequency of these symptoms, but the other more important aspect is they often forget how they filled it out when I first saw them, and when they notice the difference in the rating scales, they say, "Wow, this really is working." The other element for input is to get collateral information from a spouse, a partner, or somebody else who's working in the environment who can give the patient feedback as to what they've noticed has improved or not improved.

Ashley Baker:
How effective is therapy interventions targeting executive function for the older adult population? I know that in pediatrics it's a different world because their neuropathways are still developing and it can be quite impactful, but what about the aging population?

Dr. Goodman:
So for the aging population, it's always helpful. You're going to recommend what you would recommend to anyone who's having some cognitive decline as they get older: writing lists, not relying on your memory, using your cell phone to dictate reminders and appointments, having alarms, or having visual cues, that is notes in different areas or auditory cues that reorient you to time and where you're supposed to be. If you are living with someone, that someone can also be helpful in reorienting. The issue with getting help from a partner is that you really have to see it as assistance to help you and not criticism and nagging. And that's important in the therapy of a couple because if the ADHD person sees this as nagging, they will grow irritable and eruptive; and if the assisting partner is framing it with an intonation that's pejorative, then it's experienced as critical; so working with couples who are living together and older is also part of a therapy and education program for older adults with ADHD.

Ashley Baker:
Before we end our discussion, Dr. Goodman, are there any other final thoughts or special considerations that you would like to leave our audience with today?

Dr. Goodman:
I think my final thought is that if you're a clinician listening to this program, I thank you for your time and listening, but I would also add that ADHD in older adults is a very significant issue. If you are fortunate enough to make the diagnosis of ADHD in a 63-year-old or a 68-year-old and they improve substantially, you will not only have improved the quality of life, but you will have extended the quality of life for this individual. I can't tell you how many older patients I've seen who have been discounted as age-related cognitive decline or mild cognitive impairment for which you get a diagnosis but there's no treatment. If you do have ADHD and it gets diagnosed and treated effectively, the patient is appreciative, and the clinician feels good that they have delivered the best quality of care and were accurate in their diagnosis.

Ashley Baker:
With these final thoughts in mind, I'd like to thank my guest, Dr. David Goodman, for joining me to discuss ADHD in older adults. Dr. Goodman, thank you so much for all of the great information today, and it was great speaking with you.

Dr. Goodman:
Ashley, thank you for having me and covering this important issue.

Ashley Baker:
For ReachMD, I'm Ashley Baker. To access this and other episodes in our series, visit *NeuroFrontiers* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.