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Managing and Treating ADHD from Childhood to Adulthood

Ashley Baker:
Welcome to NeuroFrontiers on ReachMD. I'm your host, Psychiatric Nurse Practitioner Ashley Baker, and here to discuss ADHD across a patient's lifespan is Dr. Timothy Wilens. Dr. Wilens is the Chief of the Division of Child and Adult Psychiatry at Massachusetts General Hospital and a Professor of Psychiatry at Harvard Medical School.

Dr. Wilens, thanks for joining me today.

Dr. Wilens:
Thank you very much for having me.

Ashley Baker:
Let's start with ADHD in childhood. How does it usually present in children? And what are the symptoms we should be looking for?

Dr. Wilens:
Yeah, so in children, most often people are presenting because of academic difficulties. It's really school is identifying things, or parents are seeing things occur at school. Some of the other reasons people may be referred in is disruptive behavior or very aggressive or very hyperactive in younger kids, like in kindergarten or so. And again, it's often parents talking to school, teachers, or even preschool previous to that getting experience that, "Hey, your kid is really active," or, "Maybe you may want to think about this disorder."

Most kids, or even older, who present with ADHD have what we call the core cognitive problems of ADHD. In fact, 95 percent do. And what that means is they have problems with inattention, easy distractibility, shifting activities frequently, not being able to stay fixed and complete a task, forgetfulness, organizational issues, things like that. Many of them also have what we consider the hyperactive impulsive component of ADHD, which would include overt hyperactivity—and you see a lot of that in younger kids—overactivity, impulsivity, jumping into things without understanding the consequences. You may see a lot of restlessness, fidgetiness, and things like that. You can have a lot of the attentional component of ADHD, and you may or may not have the hyperactivity/impulsivity component. It's rare just to have the hyperactivity/impulsivity component.

Ashley Baker:
How does gender play a role in the presentation of ADHD? Do you see a difference in the pediatric population between young girls or boys?

Dr. Wilens:
Yeah, gender is a very interesting subject, and I would say for many years we were under-identifying girls with ADHD. Oftentimes, girls may not manifest as much hyperactivity, impulsivity. They may not manifest as much of the aggressiveness that you often will see with boys. Often, in addition to that, if you look at co-occurring problems, which are frequent with ADHD, you tend to see less more externalizing things, such as conduct disorder or delinquency. You see less of that in girls than you do with boys. You tend to see less

oppositional behavior in girls than boys. And then finally, what I would say is you see a number of girls who may also have anxiety with ADHD or just ADHD more inattentive type that are what I call the silent sufferers. They may be dealing with this, but they hold it inside. It's hard to tease out these symptoms. You just know that they're underperforming academically, may be not happy, may be flaring up a little bit at home because they're trying to hold it together at school, and then all the sudden when you start digging a little bit deeper, you say, "Geez, there's been these longstanding attentional issues and maybe anxiety," and the girl's been dealing with this but really hasn't talked much about it.

Ashley Baker:
Dr. Wilens, how should we be treating pediatric ADHD once we have the diagnosis?

Dr. Wilens:
So I really appreciate you said "once we have the diagnosis" because it's really important to have a good diagnostic evaluation. Once you have the diagnosis, then you have to understand is it just ADHD, are there learning disabilities, is there learning styles, are there other psychiatric issues that are there, like anxiety, mood disruptive behaviors? And that's all part of that package.

I would say that you really need to think about do you need some type of accommodations in learning centers. So you said kids, so kids are either in school, in a structured school, or being home-schooled, but they're going to need some component of at least thinking about how are they functioning in the environment and what do we need to do in that environment to make them successful. So it may be as simple as saying, "This child needs to sit in the front of the class" so that they're not distracted by other kids; teacher can keep an eye on them. They need to have a buddy or some system that they get the instructions for whatever is due, the homework, or whatever is necessary, and/or they have a connection with the teacher to ensure that the teacher checks to be sure that A , they write down things and B, if they have had homework required, that they turn it in. Or it may be more complex where they have what's called a 504 plan, or it may even be a more significant individual education plan, an IEP, which is even going to narrow it further to ensure that there's specific interventions that are occurring with goals, with outcomes that are measurable.

Ashley Baker:
Working in outpatient psychiatry, you never know what's going to walk through your door. When you're dealing with the pediatric population, you're interacting with the entire family, essentially. When you're trying to diagnose ADHD for the first time and you're coming up with your differentials and you're doing your assessment, what are the most important pieces of the puzzle for you in terms of interviews, assessment tools, evaluations collaterals? What would be the most important things for you?

Dr. Wilens:
Yeah. So when diagnosing it, you really want to understand the child, so you want to sit there and get a good sense of what are the current problems that the child is exhibiting, who's reporting what, who's seen what. So you try to get a sense of the different symptoms. If it's ADHD, then you're going to want to really focus on ADHD symptoms. There are a number of rating scales that you can give to parents, give to schools, that can be very helpful in terms of elucidating the symptoms.

But in addition to the ADHD, you're going to be looking for other learning issues. Is this a learning disability? Is this the ramifications of that? Is this a learning style? Do they have problems reading? Do they have problems speaking? Do they have problems with math? And then you're looking at psychiatric other disorders, such as anxiety, depression, oppositional or conduct disorder, disruptive disorders, if they're older. Do they smoke? Do they have substance issues? And you're trying to get a good sense of what's happening from the psychological psychiatric sense.

And then kids live in family systems. How are the family doing? Are there issues going on in the family? Is this a child developmentally that's been this way forever, or is this out of nowhere? If it's out of nowhere, is there a reason that it came out of nowhere? Almost always there's a track of some sort. You're trying to establish, developmentally, patterns that may also coexist in this kid currently.

You're looking to examine, are there medical issues that may overlap with this? Sudden-onset symptoms in somebody who may be seven or eight, and then you find that they've moved somewhere and they haven't had a lead test. That may warrant something like that. It's not common, but things like that need to be thought about How does this child eat? How does this child sleep? Sleep is another one that can be a real irritant. Some people say causative of symptoms. I think it's more of an irritant of ADHD or could be

secondary to ADHD.

And finally, you're looking at family histories of medical conditions that may affect this kid, including ADHD, learning issues, but other things that may intervene, may be co-occurring, or may occur down the line in this individual.

I would also say we don't want to just hit all of the weaknesses of the child. We want to try to exploit what are the children good at, what are their strengths because you find it's helpful for these kids because they're already dealing with some adversity if they have ADHD. And what are they good at? And what do we want to help strengthen in this child? What habits do they have that are good? What habits are habits that we may want to start to extinguish because we're concerned about it? So that is really the consideration of that.

Ashley Baker:
Let's transition to treatment options for pediatric ADHD.

Dr. Wilens:
So in terms of treatment for the core symptoms of ADHD, you really are thinking of two things—one, is there a psychotherapy that can help? And for younger kids, like preschoolers, we almost always say let's start with a real behavioral approach to try to accentuate what they're doing positively and extinguish some of the negative behaviors. Once you sort of get older than that pharmacotherapy really is first-line for ADHD.

From a pharmacologic standpoint, really the stimulant medicines and the nonstimulant medications are among first-line treatments. It really depends on the presentation. A lot of people for more garden variety ADHD without other things, without medical concerns or anything else, like to start with stimulant class medications because they're the most effective agents we have for ADHD, and quite honestly, they're the ones we have the most data on. But also the nonstimulants can be very helpful, especially in cases where there's co-occurring problems, anxiety, mood, and things like that.

The medications typically are titrated over the first month or so of treatment. It's a little bit trial and error. There's two major classes of stimulants—methylphenidate class agents, which include medicines, like Ritalin, Concerta, Focalin—and we have amphetamine class agents, sister medicines that include Dexedrine, Adderall, Adderall XR, Vyvanse, and practitioners start with one or the other. If one class doesn't work, we shift to the other. We have both short and extended-release types of medicines, so there's an awful lot of flexibility we have with stimulants. The non-stimulant medications tend to work through the day. They tend to not have an on and off phenomena. But again, they're a little bit less efficacious for the core symptoms of ADHD.

Ashley Baker:
What happens if ADHD is missed and is not adequately diagnosed in the pediatric stage? How could this impact a person as they move into adolescence and adulthood?

Dr. Wilens:
It's a great question to ask about what happens in some ways to untreated ADHD, and we have data longitudinally following kids over time, and we have a lot of data talking to adults about what happened to them. And across the board, studies show things such as higher rates of psychiatric disorders, like depression, bipolar, more suicidality, but also more injuries, more traumatic brain injuries, more motor vehicle accidents as you get older and start to drive. These are individuals who have higher rates of cigarette smoking and substance use disorders. They do less well academically, lower GPAs, lower grade completion, based on their intellectual capabilities. They have more peer interaction difficulties, more separations, more divorces. As they become adults, they earn less money based on what they should earn. Life is a lot harder on you.

I do want to say, and we've studied this and published this, that if you look at all of those outcomes, virtually all of those outcomes are mostly reversed by treatment. So when you use medications you find improvements in all of those sequelae that happen if you don't treat ADHD, so it's a very powerful argument for why we like to treat ADHD, get the medicine treatment correct, and continue people on their medication as long as they need it.

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. Timothy Wilens about the course of ADHD over a patient's lifespan.

Sticking with the transition from childhood to adulthood, Dr. Wilens, how would you approach medication management during this period? And how may this differ from straight pediatrics?

Dr. Wilens:
That is an absolutely great question and one that I think our field has not done an adequate job getting out into the ethos. We really need to do better. Number one, I comment now on the transition, like college-age kids, those conversations need to start in middle school. We need to start good learning styles, getting kids used to working, doing their academics or work when they're treated during the day, getting very serious about what they're doing, so good habits start early. We don't wait until they're a junior or senior in high school to have these conversations now. I start conversations with middle school kids and parents about why I want certain good habits to start now.

We need to think about, first of all, treating the kids and helping the kids learn how to take their medicines and/or ask for therapy based on their symptoms. They understand what the problems are, they understand what treatment helps, and they also understand what treatment doesn't help, and they start learning their strengths and weaknesses. And they start to learn to self-administer, and they're responsible for that, and that has to be a very important component of their transition as they leave the home. And that doesn't happen in a day. It takes longer. We know that the brain develops a little bit later in ADHD, so it's going to be a longer launch for parents. They're going to have to be more involved with their kids and more ensuring that the kids are getting a better sense of their treatment, they're taking their medicines; they're asking when they need refills; they're starting to go to appointments by themselves; or they advocate for accommodations if they're struggling. If they're in college, in trades, and they have got to ask for help if they're having problems with these big books that they're getting and working with other senior people, that they need to advocate a little bit for areas that they may have deficits in.

So the transition is a really critical time, and this is also a time when we start to see more driving accidents, more substanceuse disorders, more sexual indiscretion. Kids have problems with monitoring and managing their money. All of these areas compound it and are harder with kids with ADHD.

Ashley Baker:
So you mentioned substance abuse disorders. Dr. Wilens, what are some challenges of treating ADHD in this context?

Dr. Wilens:
So first of all, we know that ADHD doubles to triples the likelihood that you're going to smoke or vape nicotine and/or use cannabis, alcohol, and other drugs, so a much higher risk, so all kids need to be informed of that risk. You need to have that conversation early when they're in fifth or sixth grades in front of their parents to help kids realize you've got to be very careful around substances. Our sense is, if your kids are using substances but don't have a use disorder, we pretty much recommend continuing to treat because we're concerned if we don't treat, those can spin out of control rapidly.

If a kid or young adult now has a full substance use disorder experts in the field really believe that you're probably going to want to get that addiction treatment started. If you just try to throw treatment medication at it, there's a chance they could misuse the medicine. But by using very structured therapies, like cognitive, behavioral and others, it helps ADHD. It helps substance use. It helps get kids on the way. And then once they engage in treatment, then we go ahead and use medication. But we really do recommend if there's an out-of-control addiction that needs to be addressed, and then treating ADHD occurs rapidly because we have very good data we published recently showing that people who are in treatment for substance use who have ADHD are much more likely to stay in treatment and do well over time than those people with ADHD who aren't treated for their ADHD. They don't stay in treatment. They drop out.

Ashley Baker:
With those final approaches in mind, I'd like to thank my guest, Dr. Timothy Wilens, for sharing his valuable insights on a patient's journey with ADHD.

Dr. Wilens, it was great speaking with you today.

Dr. Wilens:
Thank you so much for having me.

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.