Dr Anthony MANDER

# ADHD Newsletter 10
# Anxiety, Depression and ADHD

## Depression

Is more common in those with ADHD. In some cases, an individual has both conditions, in others the depression is secondary to the chronic frustration and disappointment that those with ADHD must contend with daily.

Challenges with school, work, family, and social relationships, may lead to a lack of confidence and low self-esteem. The less one does, because of a fear of failure, the less one is likely to try.

To complicate the picture, if an individual has gone to a specialist not used to treating ADHD, only the depression may be recognised. My experience is that in such situations the depression often does not respond to treatment. Individuals can be very frustrated as they have repeatedly told their doctors they do not feel depressed.

Emotional dysregulation is a central part of ADHD in many sufferers. They can experience intense waves of emotion, such as anger. It may take longer to settle, and this can add to the experience of hopelessness and, in turn, depression.

In my practice, consistent with the literature, I treat the ADHD first. This allows any additional condition to be more accurately characterised. If the individual is already on an antidepressant when I see them for the first time, which is common, I delay any adjustment to the antidepressant to ensure the clinical picture is not unnecessarily complicated. Treatment of the ADHD often results in a significant improvement in the (apparently) comorbid condition. Since comorbid conditions are common (present in approximately 80% of adults), it is appropriate to think in terms of an ADHD syndrome. Where depression remains, it does of course need treatment, using psychotherapy and pharmacotherapy. I have found appropriately trained ADHD coaches to be particularly useful. Most antidepressants work well in conjunction with stimulants. Dexamphetamine does, of course, have recognised antidepressant properties of its own.

## Anxiety

If you are having difficulty managing the vicissitudes of life, cannot complete tasks, are forgetful and chronically late, it is not surprising that anxiety may be the result. Chronic ruminations are a common symptom in ADHD as the individual worries about trying to keep track of everything. This self-imposed pressure, coupled with a sense of inadequacy, can lead to psychological paralysis and a deepening spiral. Perhaps half of the patients that I see with ADHD have significant anxiety symptoms which present with classic changes in physiology, cognition and behaviour. When it is difficult to relax

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and fully participate in life, avoidance is a common outcome. Like depression the anxiety can occur independently or can be the result of living with ADHD. Even the fear of forgetting and repeated checking may cause anxiety. Treatments can be challenging because the medications used to treat ADHD can cause symptoms of anxiety, or of arousal, which can be mistaken for anxiety.

In my practice the ADHD is treated first with warnings to the patient about the possibility of anxiety symptoms worsening. The old adage of " start low, go slow" is particularly important when using stimulants in this situation. Once the ADHD has been stabilised the classic approaches of CBT, relaxation, and medication are relevant for the anxiety state. Lifestyle changes related to sleep, exercise, and nutrition help both conditions.

## Final Thoughts

Dexamphetamine is usually the best medication for adults with ADHD. My preference is to start with Vyvanse. This long-acting medication is better tolerated, with fewer side effects, than the standard preparation. It is now available on the PBS for adults although there are restrictions. The treatment pathway that I give individuals stresses medication before behavioural intervention and a focus on the ADHD before the apparent comorbidities. This helps individuals realise that the initial assessment is the start, not the end, of a process. The goal is to optimise an individual's functioning.

ADHD is delightful to treat. Most patients improve. In some cases, their life is transformed. Their secondary conditions are more accessible.

There are challenges with those who have bipolar disorder. That must be stabilised before stimulants are offered because of the risk of affective destabilisation from stimulants. Similarly, stimulants cannot be given to those with an active substance abuse problem. The Health Department uses a period of 5 years before they will consider an individual fits the open criteria for stimulants if they have been a substance abuser in the past.

It can be difficult to manage those with personality disorder. Such patients present as a challenge to many doctors.

Finally, medication increases pulse and blood pressure. I stress the importance of monitoring these. For those with cardiac conditions the input of a cardiologist may be necessary.

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