Navigating ADHD complexities and comorbidities

Bruce Leewiwatanakul, DO, MA (he/him)
Leewiwat@ohsu.edu

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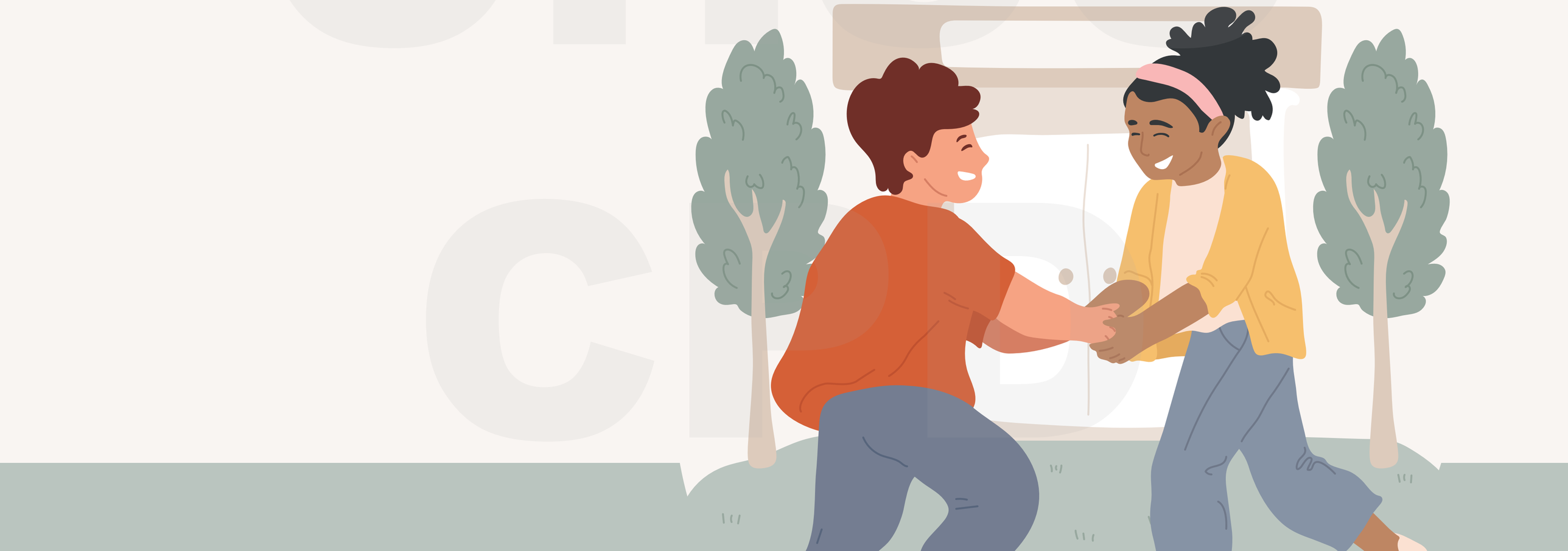
Disclaimers

There are no financial disclosures related to this presentation



learning objectives

- Review ADHD basics
- Recognize and manage side effects of ADHD treatments
- Troubleshoot difficult or failing to improve cases
- Understand the interface with academics and education system
- Evaluate for ADHD's comorbid diagnoses and identify treatment strategies

Quick ADHD review

ADHD: symptoms of inattention and/or hyperactivity/impulsivity beyond a youth's developmental level and impairing function in 2 domains

- symptoms present before 12yo
- difficult to diagnose in middle to late adolescence*
- hyperactivity diminishes with age

Diagnosis: relies on collateral informants, scales, and observations

- Vanderbilt (free), Conners, ASRS (free)

Treatment: stimulants, nonstimulants, and therapy

- MTA study guides treatment along with AAP, AAFP, and AACAP
- combination and medication alone are superior for core symptoms
- methylphenidate vs mixed salts
- alpha-agonist and SNRI
- parent management training, collaborative problem solving

Appetite and Growth

- Stimulant manipulation: short-acting, lower doses, different stimulants, breaks

- Increase nutrition: big breakfast, calorie dense foods, liquid calories, ice cream shakes, junk food

- More help: cyproheptadine, dietician, meds to treat comorbidities, different ADHD treatment

Sleep Problems

First steps

Stimulant manipulation

Routines: bedtime, meds, screens

Next steps

Melatonin, alpha-agonists

Therapy, comorbid disorder treatments

Tics + Tourette Syndrome

First steps

Stimulant manipulation

α-agonists

Next steps

AEDs, SGAs

Therapy: CBIT, habit reversal

Mood changes

Timing is *everything*

Increased irritability

End of stimulant dose

All the time

Dose peak

Dull mood/ “zombie”

All the time

During dose

What if it isn’t working?

- It's ok to call it quits! Don't do more work than the parents, most of the time
- Complementary interventions:
  - Sleep
  - Exercise
  - Mindfulness
  - Supplements
- Discuss the prognosis and reality of symptoms
- Consider therapy and how it is going

Academic environment

- A complete school history is important, especially when there are significant school concerns
- Medication handling
- Supports may include pull-outs, direct support, non-integrated classrooms
- Peers
- Write letters!

IEP vs 504

IDEA

- a funding statute requiring all states to follow conditions for funding special education
- 13 categories of disabilities. Must be eligible in one of these; "other health impairment," "emotional disorder," and "learning disability"
- Impairs educational performance and requires special education intervention

SECTION 504

- civil rights statute requiring all recipients of federal funds to provide non-discriminatory services, including reasonable accommodations
- Any child with an identified disability; limits major life activity.

ADVOCACY

FACT Oregon

Late diagnosis

- There IS a level of poor attention that we are seeing everywhere
- Consider history of difficulties
  - Parental reports
  - Additional caretakers
  - Old report cards
  - Strong family history
- Evaluate the level of dysfunction
- Evaluate for learning disorders
- Refer!

self-help

The explosive child

Your defiant teen

1-2-3 Magic!

Smart but Scattered Teens

How to talk...

The whole brain child

comorbidities and/or differentials

- Tourette syndrome
- Oppositional defiant disorder
- Conduct disorder
- Disruptive mood dysregulation disorder
- Impulse control disorder
- Intermittent explosive disorder
- Dyslexia/dyscalculia/learning disorder
- Mood disorders: anxiety, depression, trauma
- Bipolar disorder
- Developmental problems

Oppositional defiant disorder

- Hardly a standalone
- Symptoms that are directed at someone that is NOT a sibling
- Think about developmental appropriateness
- 50-60% with family history
- Environmental factors include: harsh/inconsistent parenting, maltreatment
- Psychosocial factors: irritability, impulsive, low frustration tolerance, peer rejection, poverty, neighborhood violence
- Treatment: therapy! (PMT, CBT, FT, CPS, etc)
  - Meds: none; but antipsychotic…

https://www.ncbi.nlm.nih.gov/books/NBK519712/table/ch3.t14/

Conduct Disorder

- More and more people could reach this dx
  - Changing social and societal norms
- Prosocial emotions
  - Remorse or guilt
  - Empathy
  - Concern about performance
  - Affect
- Biopsychosocial factors
- Up to 20% meet criteria for ADHD as well
- Treatment

https://www.ncbi.nlm.nih.gov/books/NBK519712/table/ch3.t13/

Impulse control disorder
Intermittent explosive disorder

- IED is an exaggerated outburst that is out of proportion; causes distress to patient and/or impairment
- IED is comorbid with another mental health diagnosis in >80%
- Treatment

- Impulse control disorder, less specific
- Treatment

https://www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t18 /

Disruptive Mood Dysregulation Disorder

- Developed out of erroneous BPAD diagnoses
- Chronic irritability
- Look for other and/or more specific mood disorders, ADHD, LD
- Treatment:
  - Meds: treat comorbidities
  - Therapy: DBT and/or CBT

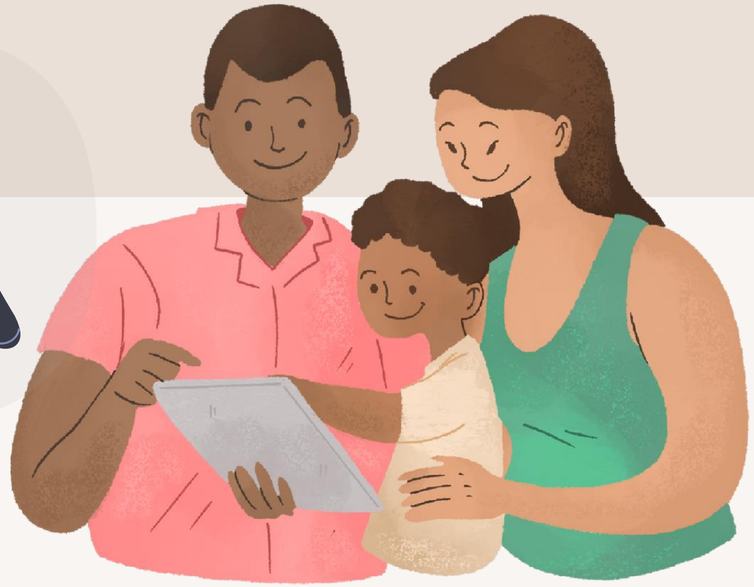
https://www.nimh.nih.gov/health/publications/disruptive-mood-dysregulation-disorder

Question of bipolar disorder

- Large overlap in symptoms
- Clear history is important to differentiate DIG FAST from impulsive behaviors
  - Changes in affect
  - Energy
  - Goal-directed activity
- Always question the family history

Referred and waiting?

- Therapy, therapy, therapy
- Switching medications – and document
- Evaluating for mood disorders
- Evaluating and treating sleep
- Talking to the school including counselors, vice principals, teachers
- Talk to parents about Parent Management Training – may be called other nicer names like Behavior Management Training
- REALISTIC goal setting and helping parents problem solve



Pillar of parent management training

- Building a solid and positive foundation
- Controlling obnoxious behavior
- Managing testing and manipulation
- Encouraging good behaviors
- Strengthening relationships

Prevention?

Sources: Bhushan D, et al. The Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health. Office of the California Surgeon General. 2020 DOI:10.48019/PEAM8812; Gilgoff et al. Adverse Childhood Experiences, Outcomes, and Interventions. *Pediatric Clinics* 2020; **67**(2): 259-73.

Foundations To Thrive

A framework of ideal conditions to promote **thriving children**, **supported parents** and **healthy & resilient communities.**

Trauma-preventive:
Preventing ACEs & Building Resilience

Trauma-informed:
Screening for ACEs & Building Resilience

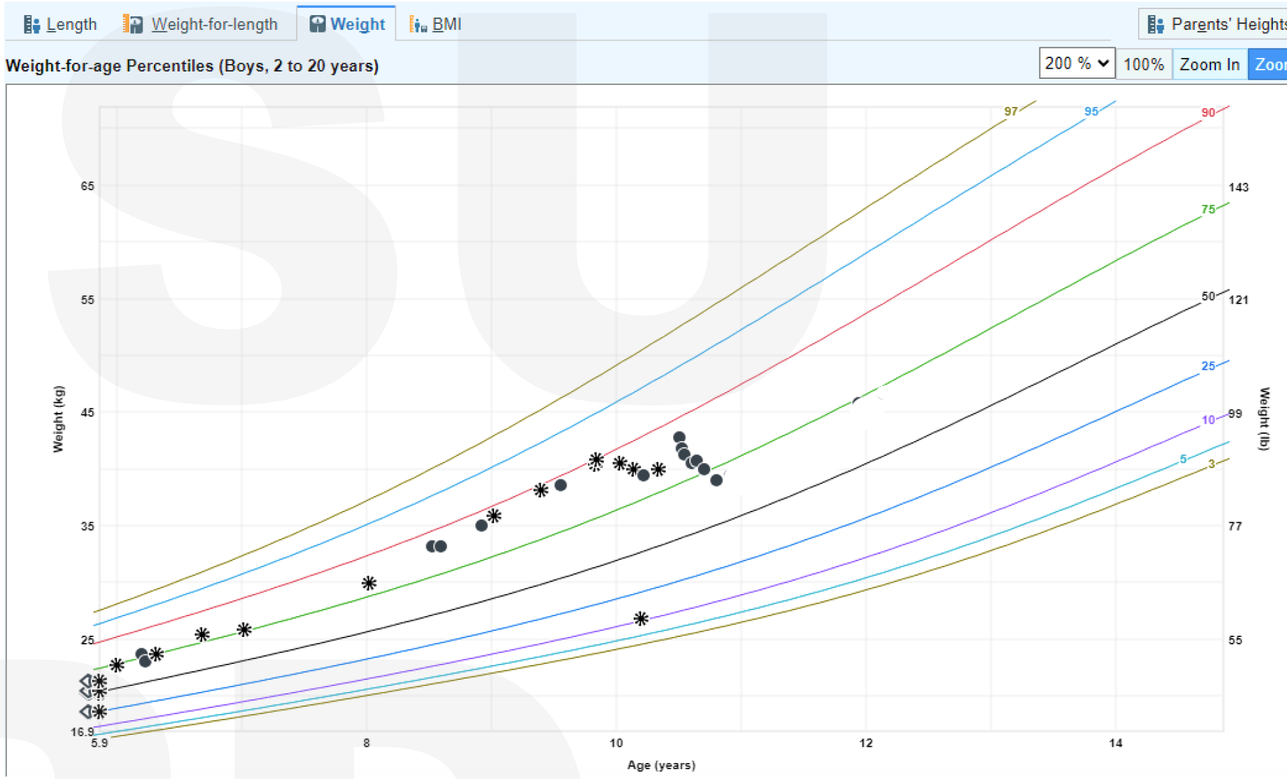
Trauma-specific:
Treating ACEs & Building Resilience

Disorder	BD	DMDD	ODD	IED	ADHD	MDD/GAD/ASD	CD
Characteristics of irritability	Episodic irritability	Chronic irritability; most of day most days	Irritability common; not required	Not persistent between outbursts	Irritability common; not required	Irritability occurs in relation to context	Irritability Common; not required
Characteristics of outbursts	Fluctuating mood	Severe; developmentally inconsistent	Outbursts occur less frequently	Infrequent but aggressive	Outbursts common but not required for dx	Outbursts occurs in relation to context	Severe physical aggression
Eventual age limit	None	Onset <10; 6-18 years old	None	At least 6 years old	Age of onset < 12yo	None	If >18, must not meet criteria for APD
Duration		12 months	6 months	3 months	6 months		12 months
Treatments	Pharm	1: CBT/DBT/PMT 2: Pharm*	1: PMT/PCIT 2: Pharm*	Pharm*+CBT	Pharm		1: PMT/CBT 2: Pharm*

Thank You

Case 1

A is an 11yo male with ADHD-Cwith decently controlled symptoms on Concerta 54mgdaily with the attached growth chart…what would you do?



Case 2

B is an 8yo female with ADHD-C now on Focalin XR 10mg daily, symptoms are mildly controlled but patient is having worsened insomnia…what can you do next?

Case 3

C is a 15yo male with ADHD-C and tics, treated with Adderall XR and guanfacine ER; his Adderall XR increased to 40mg from 30mg 2weeks ago and his guanfacine ER is4mg nightly. He is coming in due to worsened tics throughout the day…what next

Case 4

D is a 12yo female with ADHD-C, diagnosed at 7yo, currently taking Vyvanse 40mg daily and clonidine 0.1mg BID. Family's complaint is patient's level of agitation especially afterschool…what next

Case 5

E is a 16yo male with ADHD-C and ODD, started treatment since 4yo – currently taking Adderall XR 40mg, Adderall IR20mg BID, clonidine 0.2mg TID, melatonin 6mg. Mom's c/o is poor school performance, truancy, possible cannabis and other drug use, and aggressive behaviors towards mom, MGM, and siblings and punching holes in walls; what specific things should be done?

Case 6

F is a 13yo male with ADHD-C and is on Concerta 54mg and clonidine 0.2mg qHS. He had also previously been Focalin XR 30mg as well as Ritalin LA. He and his parents are coming in because he continues to have behavioral issues both at school and at home. He is doing poorly in a majority of his classes, behaviorally disruptive, and getting into fights with peers after school. At home, he is constantly arguing with his siblings and argue often with his mom – resulting in significant outbursts that lead to items being thrown, broken, punching walls, and aggressive with body towards mom. What can you do…