Warn Older ADHD Teens About Addiction Risks

BY DAN HURLEY

NEW YORK — Managing adherence, selecting the proper agent, and keeping a keen watch out for the risk of substance abuse are key to successfully treating attention-deficit/hyperactivity disorder in older adolescents and adults, according to Dr. Timothy E. Wilens.

"One thing we don't talk enough about is adherence," Dr. Wilens, associate professor of psychiatry at Harvard Medical School, Boston, said at a pharmacology update sponsored by the American Academy of Child and Adolescent Psychiatrists. "You can do everything right, and still, when you look at adherence, it's terrible."

He cited a study presented in 2005 at the annual international conference of Children and Adults with Attention Deficit/Hyperactivity Disorder showing that among 5,600 patients prescribed medications for ADHD, 50% stopped taking the drugs within 3 months, and 80% discontinued by 18 months.

Perhaps the gravest risk in treating older adolescents and adults for ADHD, and one which Dr. Wilens has studied extensively, is the abuse of substances—whether cigarettes, marijuana, or the very medications being prescribed for the ADHD. "Substance abuse is a major consideration," he said, citing a study he presented last year at a meeting of the American Academy of Addiction Psychiatry showing that 20% or so of ADHD patients are dependent on an addictive substance at the age of 25. That comes to more than twice the rate of controls.

Because most ADHD patients are treated well before adulthood, he said, talking with patients early about substance abuse as a risk factor is important. "ADHD doubles their risk of having substance abuse 10 years later," said Dr. Wilens, who also serves as director of substance abuse services, clinical and research programs in pediatric psychopharmacology at Massachusetts General Hospital. "Fifty percent of the kids who have ADHD and are smoking will go on to substance abuse. I say to them when they're young, 'I'm really concerned that you have twice the risk of becoming an addict with marijuana if you begin using it.' I tell them this over and over, 'You cannot do like your friends.' "

A reassuring result was seen in a case-controlled, prospective study led by Dr. Wilens involving 114 female adolescents diagnosed with ADHD. Five years after initial treatment, those who had received stimulant medications were significantly less likely to be smoking, drinking alcohol, or abusing drugs than were those who had not undergone treatment with stimulants (Arch. Pediatr. Adolesc. Med. 2008;162:916-21). "Treatment reduced cigarette smoking and substance abuse," Dr. Wilens said. "That is great news."

Other studies tracking such patients into adulthood, he noted, have likewise found that stimulant treatment for ADHD does not raise the subsequent risk of substance abuse, although most have found that it does not lower the risk, either.

For patients already diagnosed as substance abusers, Dr. Wilens said, there have been four double-blind studies showing that treating them with stimulants for ADHD results in no significant improvement of either condition.

"From the safety side, there was no worsening of substance use," he said. "But it's not doing much. So if you have an active abuser who comes to you and says, 'You need to treat my ADHD so I'll get better,' don't fall for that."

For patients who admit to using marijuana, he recommended asking about weekly frequency. "I would not refuse to treat their ADHD because they're smoking marijuana on weekends," Dr. Wilens said. "But if they're smoking seven to eight joints a week, there's no evidence that treating for ADHD will benefit it. And telling them you won't treat until they stop gives them a message."

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DR. WILENS

If a physician suspects that a new patient is seeking ADHD medication merely to abuse or sell it, Dr. Wilens said: "Have them come back for a second session before you give them a prescription. Slow down the evaluation process. Ask them to bring in something from their parents or elsewhere to confirm the diagnosis. If they're trying to scam you, if they think you're onto them, they often won't come back for a second visit."

When prescribing a stimulant to ADHD patients in whom the potential for abuse is suspected, he added, "I like to use extended release. Don't hand somebody you're worried about an immediate-release methylphenidate. If you do, you might as well hand them a mortar and pestle." Indeed, while 11% of patients he's been tracking in an ongoing study have sold the stimulant medications they were prescribed for ADHD, all those cases involved immediate-release formulations rather than sustained release.

Beyond the risks of substance abuse, Dr. Wilens addressed other issues unique to older adolescents and adults with ADHD. He cited his own recent paper in the Journal of Clinical Psychiatry (2009;70:1557-62) showing that the most common presenting symptom in adult ADHD, present in more than 90% of cases, is being easily distracted.

The impulsivity component of the disorder can have serious consequences in adulthood, he said. The hyperactivity component typically seen in children, however, often changes into inner restlessness, resulting in fidgeting, excessive talking, and self-selection of an active job.

"You have to set expectations," he said, emphasizing that most younger people today will be quick to search online. "Direct them to sites that are balanced and have good information," he urged.

While noting that pharmacotherapy is considered a first-line treatment option and more effective than behavioral treatment alone, Dr. Wilens warned against agents that have yet to gain a Food and Drug Administration indication for adult ADHD. Studies are continuing to investigate nicotinic agents, modafinil, and fish oils, he said, but most published trials so far have been negative. "I want you to focus on what's approved in adolescents and adults," he said.

Dr. Wilens receives or has received research support, served as a consultant, and/or served on speakers bureaus for several companies that make drugs used to treat ADHD. ■

Relationship Seen Between Falls, Depression in Preschoolers

BY BETSY BATES

LOS ANGELES — Serious falls were strongly associated with childhood depression in a study of preschoolers aged 2-5 years.

A series of longitudinal studies conducted at Duke University has found associations between high-stress events and cumulative stressors in the lives of young children and DSM-IV diagnoses, with serious falls emerging as a uniquely important contributor, Dr. Helen Link Egger said at an international conference on pediatric psychological trauma.

In the current study, a weighted representative sample of 666 preschoolers was statistically reflective of a larger community sample of more than 3,000 children of the same age. The children who suffered a serious fall were 5.8 times more likely than others to meet criteria for childhood depression, Dr. Egger said.

The rate of depression in children who fell was 18%, compared with 3.6% in the other children enrolled in the study.

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Major Findings: Children aged 2-5 who had a fall serious enough to require medical attention were 5.8 times more likely than other preschoolers to meet diagnostic criteria for depression. In more than half of these children, the first depression symptom occurred only after a major fall.

Data Source: Longitudinal study of 666 children representing a larger community sample of more than 3,000 children of the same age.

Disclosures: Dr. Egger reported no relevant financial conflicts of interest.

No association was detected between depression and the age at which children fell.

Because the study captured baseline data, the researchers were able to show that 58% of children who fell during the time period of the study developed their first depressive symptom only after the injury.

The findings do not prove causality, but they do raise numerous questions, said Dr. Egger of the center for developmental epidemiology, department of psychiatry and behavioral sciences, Duke University, Durham, N.C.

Of particular interest is whether maternal depression or household environmental factors may set the stage for some childhood falls, as well as for the depression that some of the same children develop, she said.

Beyond physical safety hazards, children who fall may be "living in a household where nobody is watching out for them," she suggested. If so, the trauma associated with the fall itself and the resulting trip to the emergency room may not be a causal factor in depression, but rather a reflection of caregiving that is not attentive or deeply attached. Factors significantly more common in children who fell included a recent change in day care (41.2% of children who fell, compared with 13.5% of those who did not); death of a loved one (30.4% of children who fell, 13.7% of those who did not); death of a sibling or peer (4.4% of children who fell, 0.5% of those who did not); and removal from the home because of physical abuse (1.7% of children who fell, 0.1% of those who did not).

Children with any injury requiring medical attention, including falls, were 2.7 times more likely than other preschoolers to meet criteria for separation anxiety disorder, with a quarter of the injured children meeting criteria for that DSM-IV diagnosis. Serious injuries occurred in more than 12% of children studied, with serious falls accounting for almost half.

Falls are a major cause of early childhood injury nationally as well, according to the Centers for Disease Control and Prevention. Between the years 2000 and 2006, more than half of all injuries to infants were falls, and falls accounted for 43% of injuries to children aged 1-4 years.

Dr. Egger noted that links between traumatic events in early childhood and psychological sequelae are likely very complex and might depend on the child's pre-existing emotional, developmental, and behavioral characteristics; parental and socioeconomic risk factors; and the event's direct impact on neurocognition. ■

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