

## Make ADHD treatment as effective as possible

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**“What bothers you the most about your ADHD, and what do you want to get fixed today?”**

Clinical practice guidelines (CPGs) for the diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD) in children and adults represent a consensus on the minimal standards and most reasonable, evidence-based practices.<sup>1-3</sup> ADHD is too complex for any set of guidelines to address every situation, but CPGs are an excellent starting point for the conscientious practitioner who wants to make ADHD treatment as effective as possible.

**Obtain a copy** of the CPG that best fits your patients. Several are available for free at [www.pediatrics.org/cgi/content/full/105/5/1158](http://www.pediatrics.org/cgi/content/full/105/5/1158) (children) and [www.aacap.org/galleries/PracticeParameters/New\\_ADHD\\_Parameter.pdf](http://www.aacap.org/galleries/PracticeParameters/New_ADHD_Parameter.pdf) (children, adolescents, and adults).

**Use a validated rating scale** to confirm your clinical judgment and monitor treatment progress. Several rating scales for childhood psychiatric conditions are available at [www.massgeneral.org/schoolpsychiatry/screeningtools\\_table.asp](http://www.massgeneral.org/schoolpsychiatry/screeningtools_table.asp).

For adults with suspected ADHD, consider asking those who knew the patient as a child to fill out the Adult ADHD Self-Report Scale—available at [www.med.nyu.edu/psych/assets/adhd\\_screen18.pdf](http://www.med.nyu.edu/psych/assets/adhd_screen18.pdf)—and corroborate the patient’s memory of childhood symptoms. This step is not always necessary, however, because adults with ADHD have been shown to adequately report childhood impairment.<sup>4</sup>

**Start treatment** with stimulant medications unless there are clinical reasons

to avoid them, such as active substance abuse, glaucoma, or unstabilized bipolar disorder. CPGs note that many FDA contraindications for stimulants have little basis in practice or research. These drugs therefore can be used as first-line treatment of ADHD in patients with comorbid tics, anxiety disorders, seizures, stabilized bipolar disorder, carefully monitored substance abuse, and during pregnancy.

Nineteen medications are FDA-approved for ADHD, and 18 are delivery systems of amphetamine or methylphenidate. In large groups, both chemicals have:

- similar effect size (about 0.95)
- the same side effects
- a response rate of 70% to 75%, which increases to 80% to 90% when both are tried.<sup>5</sup>

Although studies do not show either molecule to be more effective, individuals usually have a clear preference based on how well the medication manages their target symptoms.

**Adjust medication** according to the patient’s target symptoms. This process educates the patient about why he or she should take the medication. Remember that the patient with ADHD rarely seeks treatment; the primary motivation usually comes from parents or significant others.

Asking “What bothers you the most about your ADHD, and what do you want to get fixed today?” speaks to how the patient can benefit from therapy and indicates what symptoms he or she should look for. Remember, these patients always

have had ADHD; they do not know what is possible with treatment.

This answer also tells you what the patient—as opposed to the family—defines as success and reveals his or her motivation to adhere to the medication. Particularly when treating adolescents, get a list of target symptoms from them and their parents because the lists may be different. Unless both the parents and adolescent are satisfied, one might sabotage therapy.

**Fine-tune** the medication for optimal relief of target symptoms. Although this seems obvious, the prevailing practice pattern is to increase the dosage until the first sign of improvement and then stop. This practice forfeits many potential benefits of medication. Instead, increase the dosage by the lowest increment available as long as the patient:

- reports clear improvement of his or her target symptoms with each dosage increase
- experiences no side effects other than a mild loss of appetite.

When the patient no longer sees improvement, the lowest dose that resolved the target symptoms will be that individual's optimal dose.

#### References

1. Committee on Quality Improvement, Subcommittee on Attention-Deficit/Hyperactivity Disorder. Clinical practice guideline: diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. *Pediatrics* 2000;105:1158-70.
2. Dulcan M, Dunne JE, Ayres W, et al. Practice parameters for the assessment and treatment of children, adolescents, and adults with attention-deficit/hyperactivity disorder. *J Am Acad Child Adolesc Psychiatry* 1997;(suppl 10):S85-S121.
3. Greenhill LL, Pliszka S, Dulcan MK, et al. Practice parameter for the use of stimulant medications in the treatment of children, adolescents, and adults. *J Am Acad Child Adolesc Psychiatry* 2002;(suppl 2):S26-S49.
4. Murphy P, Schachar R. Uses of self-ratings in the assessment of symptoms of attention deficit hyperactivity disorder in adults. *Am J Psychiatry* 2000;157:1156-9.
5. Greenhill LL, Abikoff HB, Arnold LE, et al. Medication treatment strategies in the MTA study: relevance to clinicians and researchers. *J Am Acad Child Adolesc Psychiatry* 1996;35:1304-13.

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