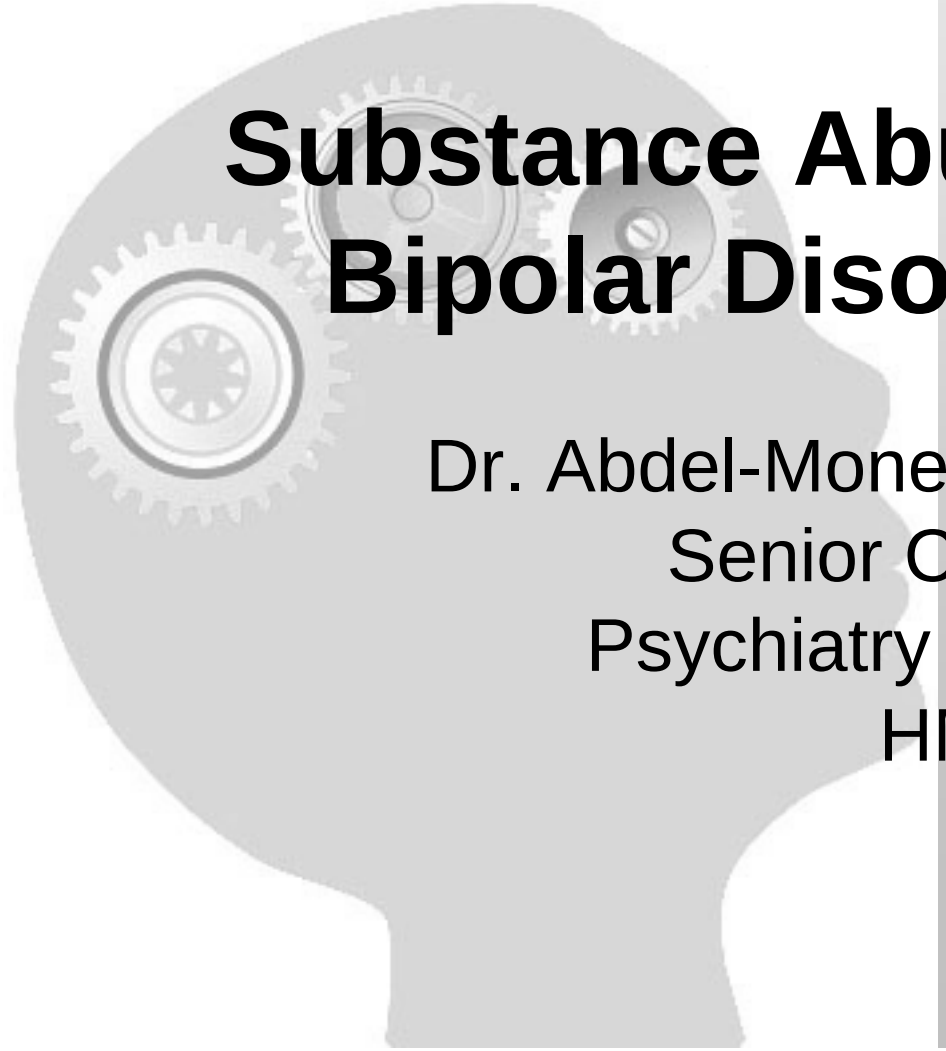

Substance Abusing Man with Bipolar Disorder & ADHD

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Introduction

Adam is a 25 year old, single, white, man who is referred after dropping out of college subsequent to being arrested for making fake college IDs.

In addition to this, his parents report that he has taken money from them for college when, in fact, he was not attending classes.

Introduction

Adam moved back home with his parents 1 year ago, since then, he has had angry outbursts and has destroyed some household property. His parents report that he has written bad checks, has a history of chronic lying, has years of substance abuse, and has severe mood swings with violent outbursts.

The psychiatrist interviews Adam privately, and then speaks with Adam's mother for historical confirmation. His father is interviewed at a later session for corroborating information.

Background

Starting with a childhood history, relevant developmental and social history for this patient includes no pregnancy drug exposure or delivery complications. Adam was born by C-Section and reached normal developmental milestones, according to his parents.

The mother has a master's degree and is employed as a supervisor of middle school teachers.

The father, who also has a master's degree, is a retired middle school principal. Thus, the patient grew up in a highly educated, middle-class, stable household with no history of physical abuse.

Signs & Sympotms

Adam recalls that as a child he was restless in class but not disruptive. He was a daydreamer, taking longer to finish assignments in class; he procrastinated with homework, typically handing it late, and was moved to the front of the class by teachers because he was inattentive and impulsive.

His mother reports that as a child, he was also inattentive at home and required oversight much of the time; he was fidgety, distractible during conversations or tasks, and disorganized, which meant that he took more time to finish tasks. He was impulsive but not reckless, often lying about attending school when he hadn't. his teachers also noted his inattention and the need to place him in the front of the classroom.

Drug Abuse History

Adam's substance abuse started at age 15 with alcohol on weekends, and by age 22 had gradually increased to drinking 5 days/week and smoking marijuana 4 times a day.

When in his mid-teens, he was taken to an emergency department for alcohol intoxication. He reports having "experience with all the drugs" except intravenous abuse. He acknowledges obtaining drugs of abuse from the internet.

Psychiatric History

At age 18, Adam was seen by a psychologist while in a clinically depressed mood, and for 2 years, he was treated for depression with sertraline.

He reports that his mood swings were less intense, but he was left in a chronic dysthymic mood, feeling “just blah all the time”

Psychiatric History

When he was 19 and still in college, Adam resumed psychiatric treatment with a psychologist whose expertise in ADHD, but he refused to take psychotropic dedications treatment consisted of psychotherapy. The patient admits that he continued to abuse alcohol and drugs without accurately conveying this fact to the psychologist.

Adam has been arrested 3 times for marijuana possession; driving on suspended license; and manufacturing/selling false college IDs. For which he was suspended from the last college.

Psychiatric History

At age 20, Adam was seen by a second psychologist who suggested that he had bipolar disorder, presumably because of episodes consisting of depressed mood, quiet and withdrawn disposition, amotivation, apathy, hopelessness, passive suicide ideation, inclination to stay in bed, listlessness, anhedonia, sensitivity to remarks, tearfulness, self-critical outlook, more easily reactive temperament, irritability, agitation, and angry outbursts.

He has no history of suicide or self-injury attempts. These mood symptoms lasted days to weeks.

Psychiatric History

Adam also reported episodes during which his mood was expansive, overconfident, and more impulsive, with clarity of thought or accelerated mentation rate, hyper talkativity, and more spending. He experiences this mood as qualitatively different from being happy. These episodes occurred less frequently and lasted a shorter duration of time (days) than the depressed state.

Family members and friends also noticed both mood states. Adam recalls that theses mood episodes started after puberty and not before. He was treated with valproate for 1 year, which helped appreciably reduce his mood swings and also the migraine headaches that he had had for years.

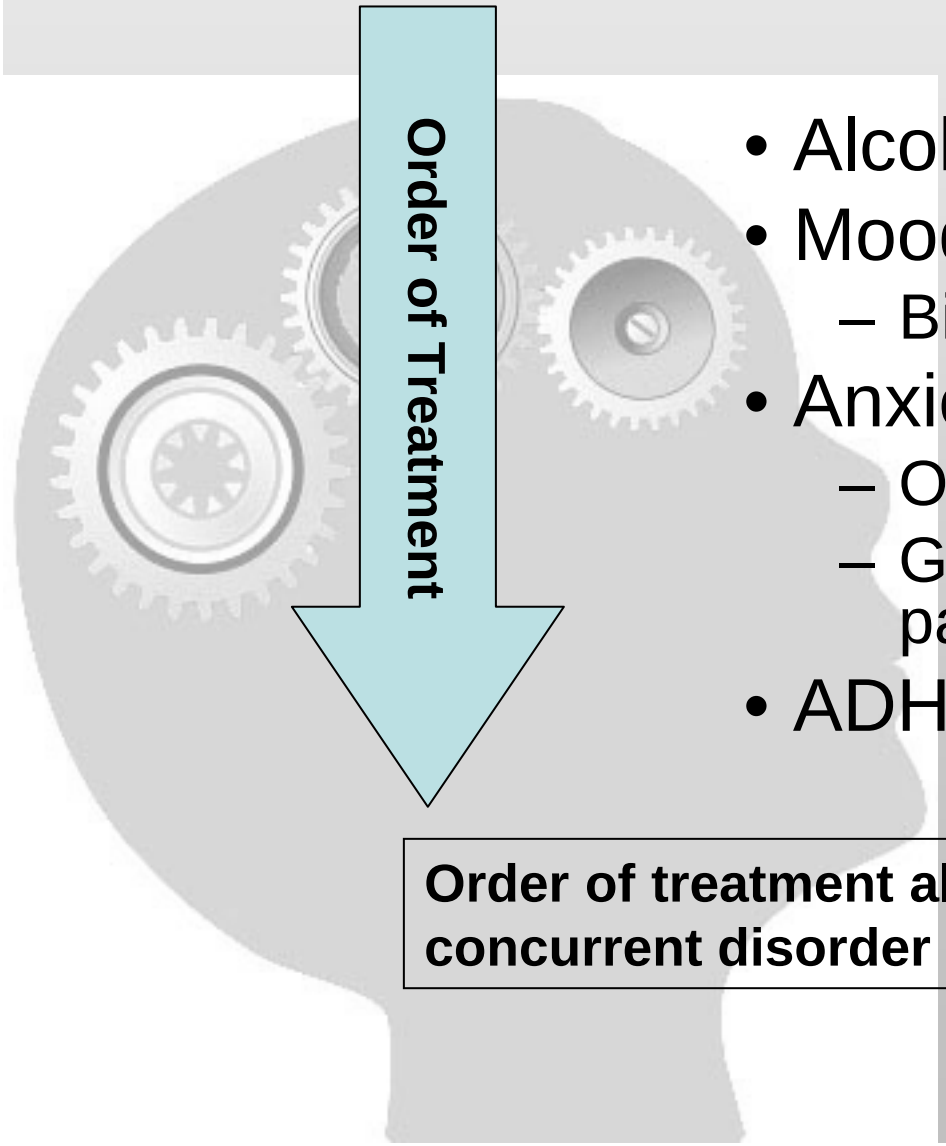
Other History

Family psychiatric history is significant for mother with depression treated with antidepressants; maternal grandmother described as alcoholic and depressed; 4 maternal cousins who are recovering alcoholics, and a maternal aunt with alcoholism/SUC, mood swings, and a psychiatric admission – diagnosis unknown.

Adam's medical history is significant for migraine headaches. He denies thyroid disease, stroke, loss of consciousness, myocardial infraction, fainting, chest pain, cardiac murmur, seizure, major surgery, or hospitalization. At the time of the evaluation, he had been taking fluoxetine 20mg once daily in the morning for the past 8 months. Adam denies taking over-the-counter medications or supplements. He was in alcohol recovery for 3 months before this evaluation but admitted to still using marijuana "a few times a week".

The patient has been employed full time as a waiter at a restaurant for 9 moths before this evaluation.

Case Presentation: Diagnostic Prioritization for Pharmacotherapy



- Alcohol & substance abuse
- Mood disorders
  - Bipolar and MDD
- Anxiety disorders
  - Obsessive-Compulsive disorder
  - Generalized anxiety disorder, panic
- ADHD

Order of treatment also considers the severity of the concurrent disorder

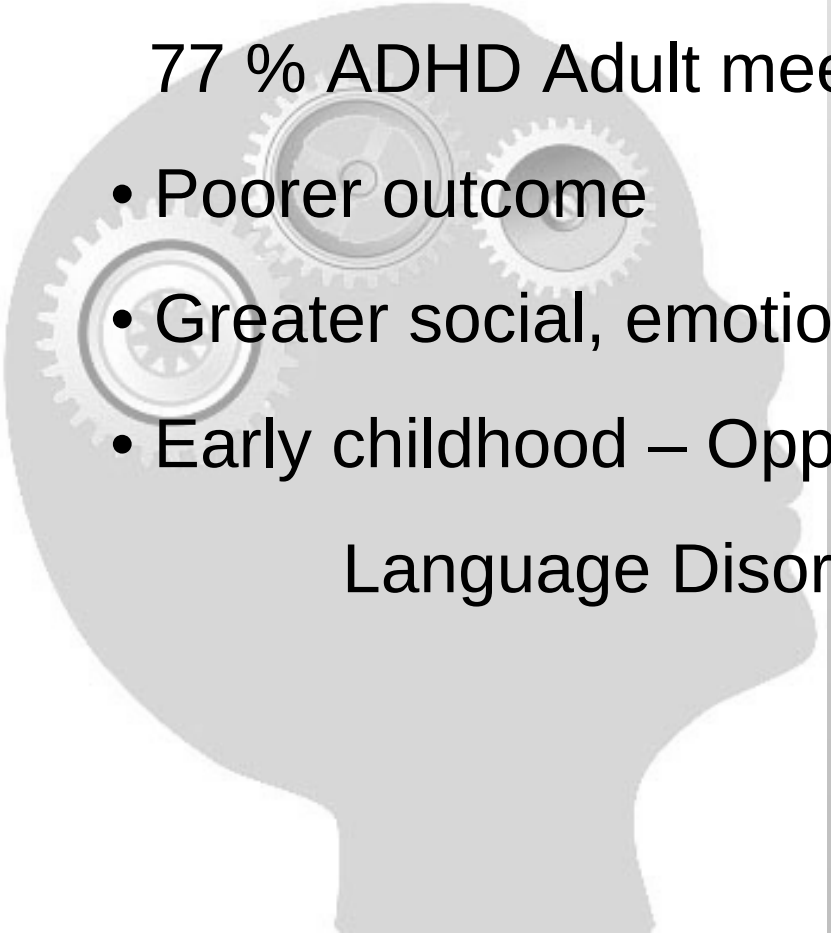
Comorbities

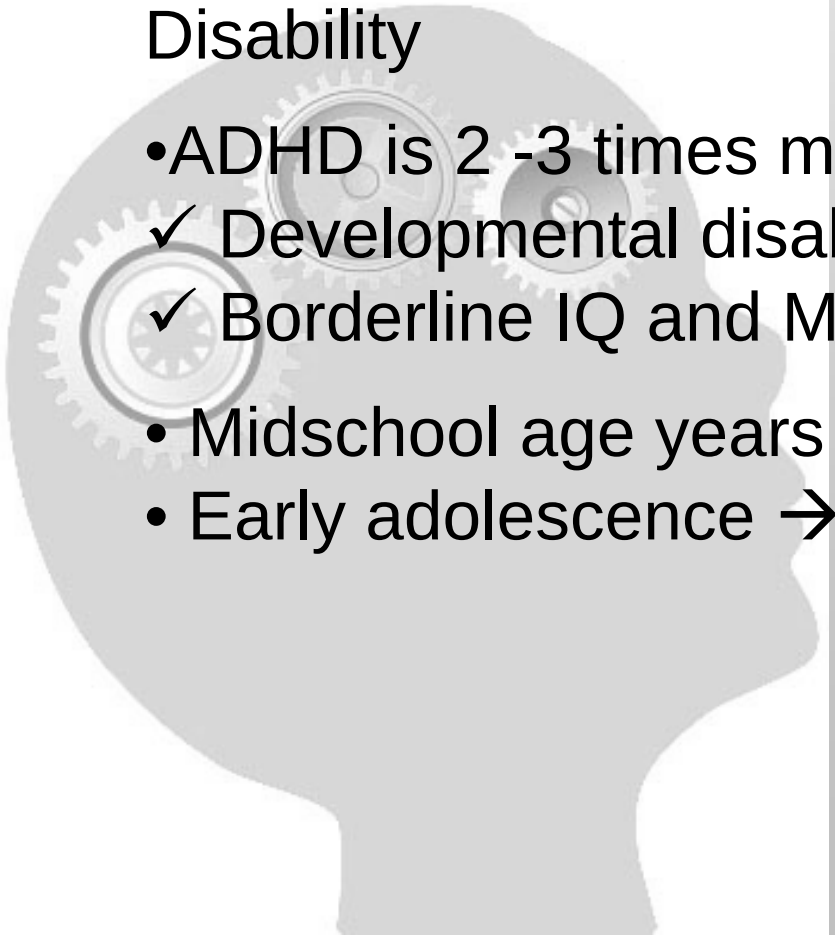
- 87 % have at least ONE comorbidity

  67 % have at least TWO comorbidities

  77 % ADHD Adult meet criteria of comorbid conditions
- Poorer outcome
- Greater social, emotional and Psychological difficulties
- Early childhood – Oppositional Defiant Disorder (ODD)

  Language Disorders and Enuresis





•70 % of children with ADHD there are either General Learning Disability or Specific Learning Disability

•ADHD is 2 -3 times more common in children:

✓ Developmental disabilities

✓ Borderline IQ and Mental Retardation

• Midschool age years → Anxiety or Tic disorders

• Early adolescence → Mood disorders

ADHD and oppositional defiant disorder (ODD)

- Behavioural problems including ODD, aggression and delinquency, account for the most of comorbidity in children with ADHD.
- → Substancial impairment →↑ referral for treatment
- 25 – 75 % ADD + ODD
- ? Paternal vulnerability → insecurity → a need to control → active confrontation of authority
- re-establish the generational boundaries
- optimization of pharmacotherapy

Distinguish ODD with CD

ODD – recurring, negativistic, defiant, hostile and disobedient behaviour towards authority figure.

CD – repeatedly violate the basic rights of others or age-appropriate societal norms.

- pattern of repeated aggression lying – stealing – truancy

• ODD is prodromal to CD in some case

• ADHD and CD in adolescence is often a precursor of Antisocial behaviours, nicotine use, substance abuse, anxiety or depression and Antisocial DD as adults.

ADHD and Anxiety

- Internalization of symptoms
- Inattentive subtype
- Negative situations

  Compensation for environmental insults anxiety → attention severely compromised → significant damage to self-esteem → lack of academic success, etc.
- Cognitive massage “what if..”
- Hold on beliefs, thoughts and emotions
- ↑Nor adrenaline activity
- Behavior → impairment in functioning

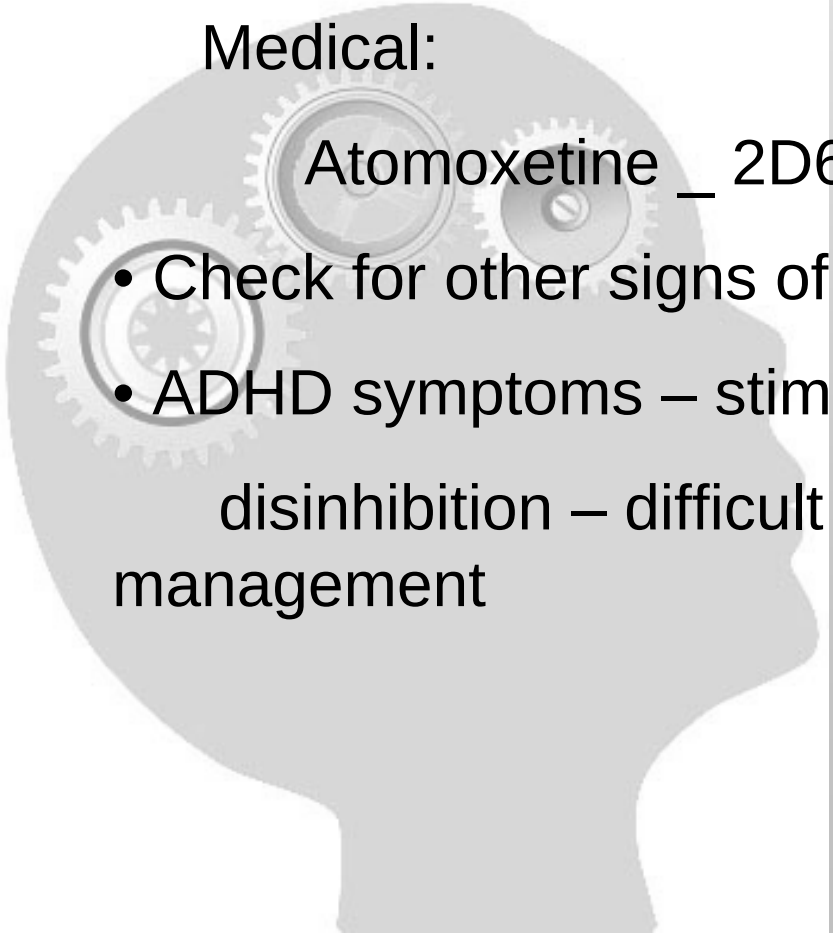
Treatment

Behavioural

Psychological - CBT, individual

Medical:

Atomoxetine _ 2D6 inhibition



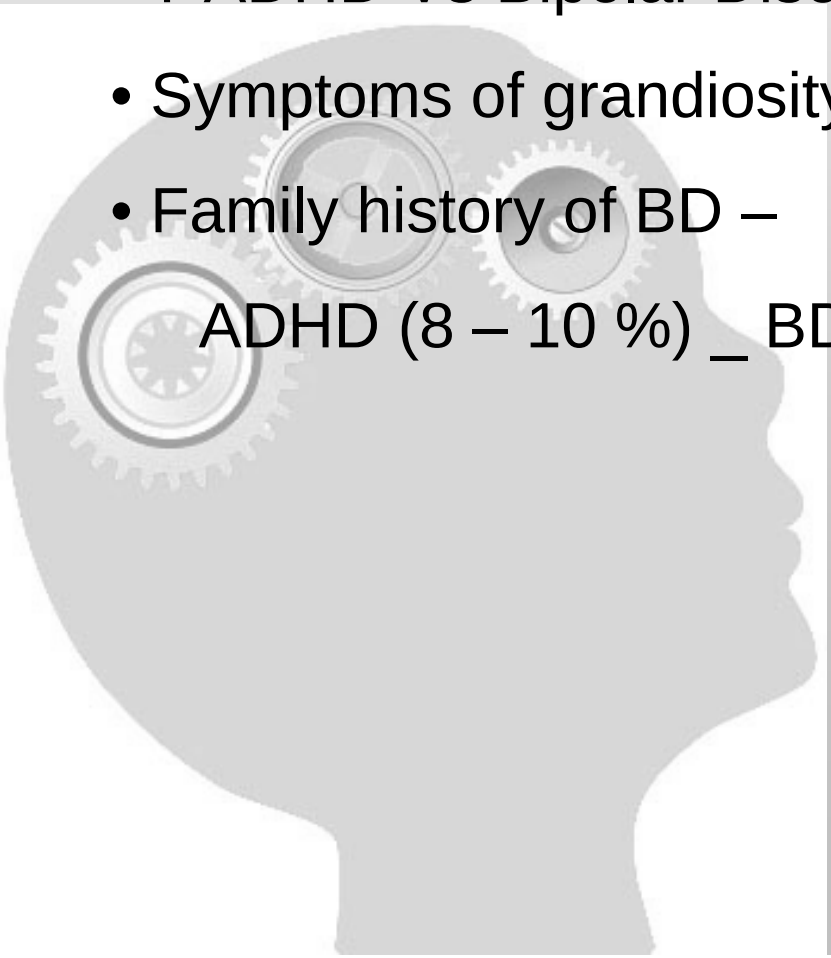
- Check for other signs of anxiety and family history
- ADHD symptoms – stimulus-seeking behaviour

disinhibition – difficult with organization and time management

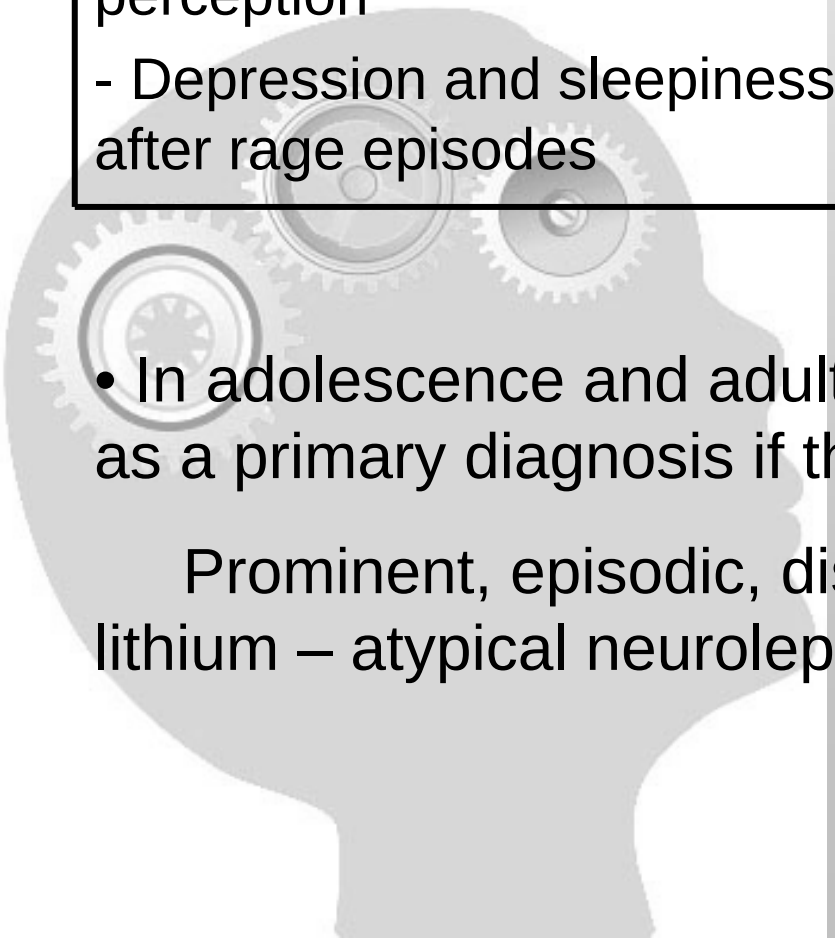
ADHD and Bipolar Spectrum Disorder (BD)

- ? ADHD Vs Bipolar Disorder
- Symptoms of grandiosity, euphoria and periodicity
- Family history of BD –

  ADHD (8 – 10 %) _ BD (5 %)



Bipolar Disoder	ADHD
-Discrete cyclical symptoms of emotional ability - Psychosis, grandiose perception - Depression and sleepiness after rage episodes	-Continuous symptoms - Base-line recovery - Non episodic severe mood dysregulation developmental - severe impairment



• In adolescence and adulthood BD should be considered as a primary diagnosis if there are:

Prominent, episodic, discrete, cycling mood symptoms, lithium – atypical neuroleptics

Thank you! ☺