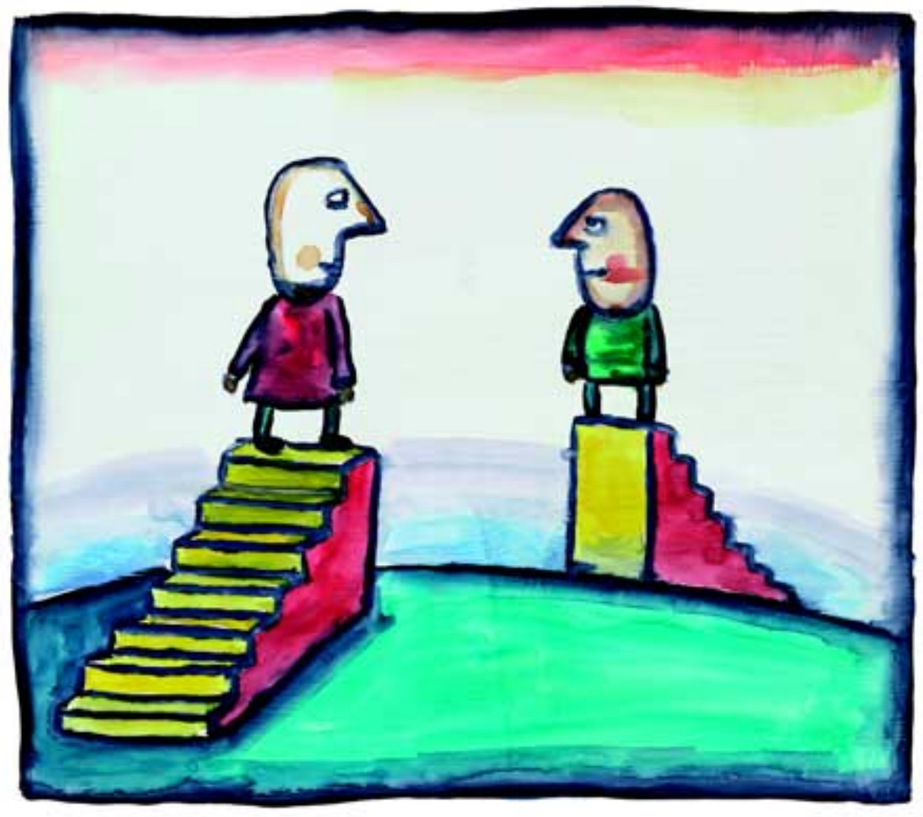
Paying Attention to Adult AD/HD

by Matt McMillen



For the author, an overdue diagnosis was the first step to order.

MY COFFEE TABLE NEARLY BUCKLED beneath mounds of mail and magazines. All around my efficiency apartment, piles of books, papers and clothes grew around the perimeter of the bed, beside the bookshelves and in the closet. I'd been meaning to clean up, but I just hadn't gotten around to it.

Instead, I lay on my couch, picking at a copy of *The American Scholar*, a highbrow journal I had bought on a whim. After flipping through the short subjects, I settled on the lead article.

James Trilling, an art historian, was writing about his father, the literary critic Lionel Trilling. I counted the pages—25. A bit long, I thought; I usually can't make it through a newspaper article without drifting off.

I have had this problem all my life. I often find myself 20 or 30 pages into a book before realizing that my mind has been elsewhere since page 10. With force, I can overcome this briefly, but the effort exhausts me. I usually give up and move on to something else.

Nonetheless, this story held my attention.

James Trilling has attention-deficit hyperactivity disorder (AD/HD). In his article, he argued that his father suffered from AD/HD as well. The lack of a diagnosis and treatment, wrote the younger Trilling, created deep, irreparable fissures in his father's personal and professional life.

"I sensed that large areas of his personality were a facade," Trilling said, "but only with the diagnosis of my own [AD/HD] could I start to understand what might have led him to build it the way he did."

AD/HD is a neurological condition, the most salient features of which are inattentiveness, impulsivity and, above all, hyperactivity. Those with AD/HD suffer impairment of the executive functions of the brain, such as organization, working memory and information assessment. First medically documented in children in 1902, the disorder has been the subject of intense research, and a myriad of theories on its origins have been debated. But only in the past few decades have researchers accepted the idea that AD/HD can persist into adulthood.

Why has this taken so long? Because the hyperactivity so often associated with the disorder diminishes over time. That fact was taken as evidence that the brain somehow corrected itself, that it became "normal," with age.

Scientists "used to believe that the brain caught up in adolescence," explains Stephen Faraone, associate professor of psychology at Harvard Medical School. "That's wrong. With the passage of time, symptoms tend to change. [There is] a diminution of hyperactivity and impulsivity, [but] not a diminution of inattentiveness." Hyperactivity, in fact, is no longer an essential symptom for a diagnosis of AD/HD, in children or adults.

Seeing Myself

As Trilling graphically catalogued the symptoms of the disorder, I had a building sense of recognition. The intense impulses, the restless movements from task to task, the thoughts that switched from one to the other like stations on a radio whose dial I could

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not control. I experienced all of these all of the time and had done so for as long as I could remember.

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"We think about what we know about," says Faraone. "[People] tend to attribute symptoms to depression or anxiety because they don't know enough about AD/HD."

Sadly, both are often present in addition to AD/HD. The disorder, according to Timothy Wilens, an associate professor of psychiatry at Harvard, "doubles your risk for . . . disorders like anxiety, conduct disorders, depression and substance abuse."

Until I came across the Trilling article, all I had read about AD/HD was that it affected children and caused them to misbehave in the extreme.

That didn't describe me. I merely couldn't concentrate, couldn't keep my mind on my work, so I didn't bother with it. All I needed to do, as my teachers told me time and time again, was "apply myself."

But I couldn't. In eighth grade, I failed every class except Latin. I idled for a year at a Jesuit high school before transferring to a public high school. There I watched my friends breeze through with A's while I barely graduated. It took me 6 1/2 years and four colleges (one of them twice) to get my BA. I dropped out of graduate school.

My lack of hyperactivity, perhaps, was a detriment. Teachers wrote on my report card that I wasn't living up to my potential. I stared out the window, the slightest movement caught by my peripheral vision, pulling my attention away from the teacher and the chalkboard. But my behavior was rarely an issue. If I had been hyperactive, that might have sounded a few alarms. In a structured setting like school, after all, abnormal behavior stands out.

"When you have a set environment," says Alan Zametkin, senior staff physician at the National Institute of Mental Health (NIMH), "it is easier to identify difference." If the disorder goes undiagnosed, it is often simply because it goes unnoticed.

And it goes unnoticed more frequently in girls than in boys. While both sexes are equally prone to the disorder, "what you tend to find," says Wilens, "is that girls are less...disruptive or oppositional."

The fact that girls tend not to act out helps explain the 5–1 ratio of boys to girls who are referred for AD/HD, Wilens says. But hyperactivity diminishes over time—by adulthood, the symptoms men and women experience will be very much the same.

Working with It

When I read James Trilling's piece, I was 28. Two years and three jobs after dropping out of graduate school, I had taken a temp job in a busy downtown office. Hardly what I wanted to do, which changed from week to week. Anyway it was a job I merely settled for, feeling I had few marketable skills beyond an ability to type.

As a newly minted administrative assistant, this was the first time that I had had to face my utter inability to organize on a daily basis. From 9 to 5:30 I answered phones, sorted mail, filed documents, prepared expense reports, handled travel arrangements, typed correspondence, all with epic inefficiency. Around me, piles of papers grew, scribbled phone messages disappeared and handwritten dictation I had taken left me baffled when I troubled myself to transcribe it. Once, a $10,000 check disappeared on my watch.

Before taking this job, I had coped, however poorly, with my problems with organizing, concentration and motivation. Here, it became clear how bad those problems were.

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Tracking the Source

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"[AD/HD] is the accumulation of many small things," says Faraone.

Genetic irregularities, below-normal rates of glucose metabolism in the brain, structural abnormalities in the frontal cortex, aberrations in the noradrenergic and dopaminergic neurotransmitter systems, prenatal exposure to alcohol and nicotine—all have been implicated in the development of AD/HD.

There is strong evidence as well—20 to 30 studies, says Zametkin—that AD/HD is, in many cases, an inherited disorder. Of particular interest to researchers studying the heritability of the disorder are the D-4 dopamine receptor and dopamine transporter genes. Both play a role in the functioning of the frontal lobe, or what Wilens calls "the secretary of the brain." Genetic and neuroimaging studies recently have shown that both function abnormally in some AD/HD cases.

Identifying the disorder's causes clearly is complicated. Compounding that, though, is increasing evidence that those causes combine differently in different individuals. So while some cases may be linked primarily to genetic abnormalities, others may be a result of complications during pregnancy. AD/HD,

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simply put, is no cookie-cutter disorder.

Getting Help

I saw a psychiatrist for the first time a few weeks before I turned 29.

During my initial appointment, I told the doctor I had recently learned about AD/HD and that I thought I should be evaluated. He didn't agree.

Instead, he prescribed Wellbutrin, an antidepressant. Poor concentration, he told me, is a hallmark of depression. The medication didn't work. After a while I lost interest in our monthly appointments and didn't go back.

Like many people with AD/HD, novelty-seeking has been a significant part of my profile. No matter how initially focused I can be on a job, hobby, book or relationship, when it becomes routine, I move on. Even the possibility that I had AD/HD and that I could (and should) get help lost its appeal. It would be almost two years before I saw a therapist again.

In the meantime, I quit my office job. I went to cooking school and then worked as a pastry cook in a busy hotel kitchen. The ceaseless rush of activity rarely allowed my mind to wander. All my tasks were assigned at the beginning of each day. I had problems keeping things in order, as always, and frequently fell behind. But the kitchen staff worked as a team, and I could count on help when I needed it. The job was ideal.

But after seven months, I quit. It had gotten old.

Freelance writing was next. What was I thinking? After all, I knew from my office-job debacle that basic tasks, like scheduling my time and organizing my notes, were immovable roadblocks. How could I expect to accomplish anything when all my energy was spent getting started?

Still, my first article was accepted by a major newspaper. Then another. Success.

Nevertheless, I put off interviews, I avoided research, every passerby outside my window pulled my attention from the computer screen. Writing a 1,200-word article took me three months. The disorder was busily working and wouldn't let me ignore it. Picking up a part-time job at a book store, I got on their health plan and saw a psychiatrist.

Medication Again

When I took my first dose of Ritalin, the brand name for the stimulant methylphenidate, the effect was immediate. An hour or so into the dose, the frustration and irritation that I constantly felt were gone. Without hesitation, I started writing a proposal for my next article. The procrastination that had always plagued me had vanished, too.

But, when I stood in the shower, where there are no distractions, and tried to control the rush of thoughts that always dart in and out of my head, I couldn't do it. A mental outline of my next article lost its place when a stray thought jumped the line, followed by another, and another. In an instant, all was disarray—in other words, normal. After a few weeks and a few different dosing schedules, my concentration had yet to improve.

This experience is not uncommon. While Ritalin is still the most frequently prescribed drug for reducing the symptoms of AD/HD ("It's been 50 years now," says Zametkin, "and we know that stimulants are safe and effective."), it doesn't work for everyone.

"Why do we have a variable response? Because the brain is a highly complex organ," Zametkin says. "It is safe to say that the disorder affects different people in different parts of the brain."

Fortunately, there are other drugs, and I began trying them. The stimulant Adderall, a long-acting mixture of dextroamphetamine and amphetamine, was first. My concentration improved momentarily.

Then, in an about-face, my mind became muddied, confused. When the drug wore off, the comedown left me tired and depressed. I went back on Ritalin, pairing it with desipramine, an antidepressant that has proven effective for some with AD/HD. Instead of helping, the new drug made me want to sleep all the time, so my doctor switched me to Dexedrine (dextroamphetamin), a stimulant. With a different chemical makeup than either Adderall or Ritalin, it was worth a try. Taking it three times a day, my mood shifted constantly as the drug's effectiveness seemed to turn on and off like a toggle switch. It was intolerable. With some hesitation, I agreed to try Dexedrine Spansules, a time-release version of the previous drug.

And it worked. Concentration, to a greater degree than I have ever experienced it, is there. My mind wanders still, though now I feel like I have a leash on my thoughts and can pull them in when I need to. On the downside, I have been sleeping less than usual, so the drug occasionally has to compete with sleep deficits. Still, it works better, much better, than any other medication I have tried.

Why? My particular brain chemistry must just like it.

No Easy Fix

As effective as drugs can be, those diagnosed with AD/HD in adulthood have more problems than medication alone can solve. Taking Ritalin won't get you organized—a lifetime of disarray needs to be unlearned and replaced with more effective and efficient habits. As Zametkin says, "one area that we need research in is non-pharmacological approaches."

A two-year study underway at Massachusetts General Hospital in Boston seeks to measure the effectiveness of cognitive behavioral therapy on adults with AD/HD who have been stabilized by medication. Researchers hope to find methods to curb some of the disorder's most disruptive symptoms. Novelty-seeking and distractibility, for example, are "modules" of the study. Both prevent those with AD/HD from sticking with basic routines such as balancing a checkbook, keeping a calendar and paying bills.

"What we've found," says Stephen Safren, a researcher with the project as well as an assistant professor of psychology at Harvard Medical School, "is people who have adult [AD/HD] often have started these [routines,] but because of the [AD/HD] they have moved on to something else."

The challenge of the study is to develop and teach long-term strategies that will counteract a lifetime of impulsivity and disorganization.

Even therapy and taking the medication becomes routine, though. I have yet to forget a dose or an appointment, but I often feel that my excitement over finally getting diagnosed and over my success so far with treatment is wearing thin. I want to try different medications, a different kind of therapy, anything that's new. My current routine is often dull and difficult. But as Safren points out, "You have to realize there is no perfect system, that you have to practice—if you can get past the hard part, you will realize that you can do it."

I hope he's right. ■

Matt McMillen is a Washington freelance writer. Reprinted with the author's permission. This article first appeared in the Health Section of The Washington Post on July 30, 2002.

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Starting Points

Attention-deficit hyperactivity disorder (AD/HD) is a chronic disorder that begins in childhood and is marked by symptoms such as inattentiveness, distractibility and impulsivity. Because psychologists and psychiatrists who ordinarily treat adults are not often presented with symptoms of AD/HD, Alan Zametkin, senior staff physician at the NIMH, recommends that adults who think they may have the disorder seek help from someone with training in child and adolescent psychiatry.

There is no cure for AD/HD, but psychostimulant medications, such as Ritalin, and behavior therapy can be highly effective in alleviating symptoms and addressing conditions that sometimes accompany the disorder, such as depression and anxiety. Because of the high success rate for therapy, Wilens calls working with adults with AD/HD "the most rewarding thing I've done in my life."

For more information on the disorder, contact Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD), a nonprofit education, advocacy and support group. Call them at 301-306-7070 , or visit their website at www.chadd.org. Or, contact the National Institute of Mental Health at 301-443-4513, or visit their website at www.nimh.nih.gov. —Matt McMillen