ADd

ATTENTION DEFICIT DIGEST

ADHD AROUND THE WORLD

How common is attention deficit disorder globally?

COMORBIDITIES

How they change your ADHD brain and can complicate diagnosis and treatment

ADHD & RSD

Do you know what it is?

ISSUE #1 SPRING 2020

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LETTER FROM THE EDITOR

BY ALICE LONGTIN

APRIL 27 2020

The goal of this magazine was to create an ADHD information hub in a digestible format. Its for, made and by Adults with ADHD. It was an absolute pleasure to work so hard towards something for it to turn out perfectly. A challenging blend of form and function.

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YOU'RE A CRYBABY!

BY WILLIAM DODSON, M.D. & ANDREA BONIOR PH.D.

MODIFIED BY ALICE LONGTIN

Rejection Sensitive Dysphoria can mean extreme emotional sensitivity and emotional pain — and it may imitate mood disorders with suicidal ideation and manifest as instantaneous rage at the person responsible for causing the pain.

"I'M NOT A CRYBABY!"

Rejection sensitive dysphoria (RSD) is extreme emotional sensitivity and pain triggered by the perception that a person has been rejected or criticized by important people in their life. It may also be triggered by a sense of falling short—failing to meet their own high standards or others' expectations.

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Dysphoria is Greek for "difficult to bear." It's not that people with attention deficit disorder (ADHD or ADD) are wimps, or weak; it's that the emotional response hurts them much more than it does people without the condition.

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No one likes to be rejected, criticized or fail. For people with RSD, these universal life experiences are much more severe than for neurotypical individuals. They are unbearable, and highly impairing.

Rejection Sensitivity Dysphoria, in fact, is a common ADHD symptom, particularly in adults.

When this emotional response is externalized, it looks like an impressive, instantaneous rage at the person or situation responsible for causing the pain. 50% of people who are assigned court-mandated anger-management treatment have previously unrecognized ADHD.

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RSD can make adults with ADHD anticipate rejection — even when it is anything but certain. This can make them vigilant about avoiding it, which can be misdiagnosed as social anxiety disorder (formally known as social phobia).

Often, people can't find the words to describe its pain. They say it's intense, awful, terrible, overwhelming.

When this emotional response is internalized, it can imitate a full, major mood disorder complete with suicidal ideation. The sudden change from feeling perfectly fine to feeling intensely sad that results from RSD is often misdiagnosed as rapid cycling mood disorder.

Social Anxiety Disorder, which is an official disorder within the DSM-5, is one of the most prevalent psychological disorders in the U.S. At its core, it involves preoccupation or distress related to the fear and worry of being judged negatively by others.

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Rejection Sensitive Dysphoria naturally has some overlap with Social Anxiety Disorder, and the two constellations of symptoms may occur in the same person and even contribute to each other. That said, Rejection Sensitive Dysphoria does have some distinctions from Social Anxiety Disorder.

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People with Social Anxiety Disorder may feel worst around people they are not yet comfortable with, becoming preoccupied with potential embarrassment when among strangers, for instance.

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Someone with RSD, however, does not necessarily feel any less distress around those who are closest to them when it comes to feeling rejected, their main concern. In fact, feeling rejected by a loved one will likely hurt even more.

It can take a long time for physicians to recognize that these symptoms are caused by the sudden emotional changes associated with ADHD and rejection sensitivity, while all other object relations are totally normal. RSD is, in fact, a common ADHD symptom, particularly in adults.

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Rejection sensitivity is hard to tease apart. Often, people can't find the words to describe its pain. They say it's intense, awful, terrible, overwhelming. It is always triggered by the perceived or real loss of approval, love, or respect.

After hearing this diagnosis, they know it's not their fault, that they are not damaged.

People with ADHD cope with this huge emotional elephant in two main ways, which are not mutually exclusive.

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1. They become people pleasers.
They scan every person they meet to figure out what that person admires and praises. Then, that's the false self they present. Often this becomes such a dominating goal that they forget what they actually wanted from their own lives. They are too busy making sure other people aren't displeased with them.

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2. They stop trying.
If there is the slightest possibility that a person might try something new and fail or fall short in front of anyone else, it's just too painful and too risky to even consider.
So, these people just don't. These are the very bright, capable people who become the slackers of the world and do absolutely nothing with their lives because making any effort is so anxiety-provoking. They give up going on dates, applying for jobs, or speaking in meetings.

Some people use the pain of RSD to find adaptations and overachieve.
They constantly work to be the best at what they do. Or, they are driven to be above criticism/reproach. They lead admirable lives, but at what cost? They strive for perfection, which is never attainable, and are constantly driven to achieve more.

How do I get over RSD?
Rejection sensitivity is part of ADHD. It's neurologic and genetic. Early childhood trauma makes anything worse, but it does not cause RSD. Often, patients are comforted just to know there is a name for this feeling. It makes a difference knowing what it is, that they are not alone, and that almost 100% of people with ADHD experience rejection sensitivity. After hearing this diagnosis, they know it's not their fault, that they are not damaged.

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Psychotherapy does not particularly help patients with RSD because the emotions hit suddenly and completely overwhelm the mind and senses. It takes a while for someone with RSD to get back on his feet after an episode.

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When talking about treatment options, there are two possible medication solutions for RSD. *

***Note:** Please talk to your doctor. This isn't advice or a diagnostic manual, this is just information so you can be informed on the possible options available to you.

The simplest solution is to prescribe an alpha agonist like guanfacineor clonidine. These were originally designed as blood pressure medications. The optimal dose varies from half a milligram up to seven milligrams for guanfacine, and from a tenth of a milligram to five tenths of a milligram for clonidine.

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Within that dosage range, about one in three people feel relief from RSD. When that happens, the change is life altering. The treatment can make an even greater difference than a stimulant does to treat ADHD.

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These two medications seem to work equally well, but for different groups of people. If the first medication does not work, it should be stopped, and the other one tried. They should not be used at the same time, just one or the other.

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The second treatment is prescribing monoamine oxidase inhibitors (MAOI) off-label. This has traditionally been the treatment of choice for RSD among experienced clinicians. It can be dramatically effective for both the attention/ impulsive component of ADHD and the emotional component.

This has traditionally been the treatment of choice for RSD among experienced clinicians.

Parnate (tranylcypromine) often works best, with the fewest side effects. Common side effects are low blood pressure, agitation, sedation, and confusion.

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MAOIs were found to be as effective for ADHD as methylphenidate in one head-to-head trial conducted in the 1960s. They also produce very few side effects with true once-a-day dosing, are not a controlled substance (no abuse potential), come in inexpensive, high-quality generic versions, and are FDA-approved for both mood and anxiety disorders.

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The disadvantage is that patients must avoid foods that are aged instead of cooked, as well as first-line ADHD stimulant medications, all antidepressant medications, OTC cold, sinus, and hay fever medications, OTC cough remedies. Some forms of anesthesia can't be administered.

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Please remember that this is to help you be better informed and not to self diagnose or self medicate. Please talk with a trained health care professional in regards to your personal journey with managing RSD and ADHD.

When It's Not Just ADHD

Symptoms of Co-morbid Conditions

BY LARRY SILVER, M.D.

MODIFIED BY ALICE LONGTIN

Roughly half of all people with ADHD also have a second condition — like learning disabilities, depression, or anxiety — that requires separate treatment. Learn about the most common conditions that come along with ADHD and how to distinguish symptoms.

Some individuals with ADHD continue to experience significant symptoms after starting treatment — deep sadness, anxiety, defiance, learning and organization problems — long after their most pressing ADHD symptoms are brought under control.

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Doctors once considered ADHD a standalone disorder. They were wrong. We now know that 50 percent of people with ADHD also suffer from one or more additional condition.

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Half of All People with ADHD / ADD Also Have Another Condition

In some cases, these problems are "secondary" to ADHD — that is, they are triggered by the frustration of coping with symptoms of ADHD. When secondary problems don't resolve with effective ADHD treatment, they are likely symptoms of a "co-morbid" condition.

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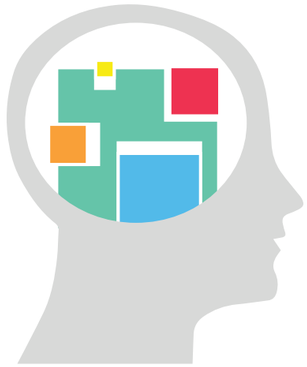
What Is a Co-morbid Condition?

Co-morbid conditions are distinct diagnoses that exist simultaneously with ADHD / ADD. They do not go away once the primary condition – in this case, ADHD – is treated. Co-morbid conditions exist in parallel with ADHD and require their own specific treatment plan.

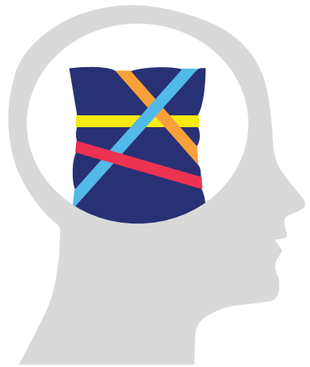
OPPOSITIONAL DEFIANT DISORDER (ODD)

"I was always just so angry inside that sometimes I felt I would burst if I didn't get it out. I would also lash at at those I presumed to be talking down to me or treating me as though I was stupid. It was so much hurt, much of it I didn't know the cause of, and a lot of remorse."
- O. F.



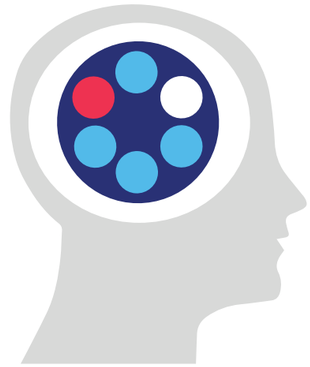
BORDERLINE PERSONALITY DISORDER (BPD)

"Imagine the most intense feeling you have ever had in your life. The intensity with which you felt those emotions is probably equivalent to what a person with BPD feels on a regular basis."
- Anon.



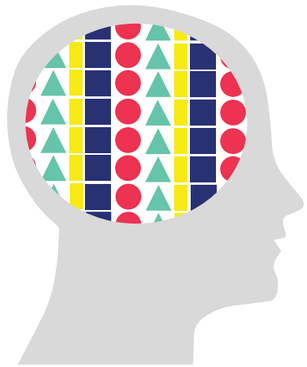
GENERALIZED ANXIETY DISORDER

"My whole body is tense and my hands and feet tingle. This feeling can last all day and can make me exceptionally irritated. It makes focusing on tasks difficult and often makes me seem like my head is in the clouds. On these days I also tend to be very edgy."
- Marisa Lancione



POST-TRAUMATIC STRESS DISORDER (PTSD)

"It's like no matter how happy you appear on the outside or try to convince yourself that you are, there's something really sad and negative hiding just below the surface."
- Jessica T

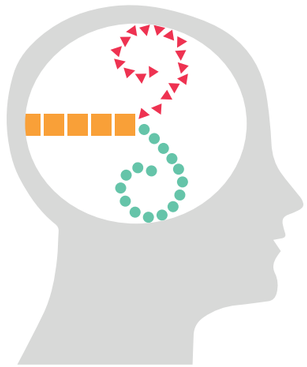


OBSESSIVE-COMPULSIVE DISORDER (OCD)

"It feels like you're not in control of your brain. Intrusive thoughts – vivid, visual images of the most horrendous things – plague me on a daily basis. I pick up a knife to chop an onion and see myself stabbing someone."
- Alice Franklin

CIRCADIAN RHYTHM SLEEP DISORDERS (CRSD)

This disorder is a catch-all for 6 other things. Some are external factors (ex: Shift work, Jet lag) and others are internal (ex: Delayed/advanced/ irregular/non-24-hour sleep-wake phase)



LEARNING DISABILITIES

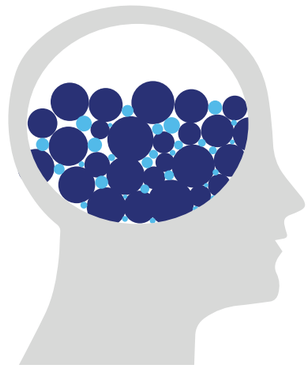
"It takes me twice as long as my peers to complete assignments if not longer. This is true especially in a rigorous, writing-intensive curriculum. It would take me hours to write a single page."
- Brennan

SUBSTANCE USE DISORDER (DRUG ADDICTION)

"I began taking opioid painkillers for a legitimate injury, despite clear instructions to take one pill every six hours, I realized that increasing my dosage made me feel like a million dollars. I went from taking two at a time to ten at a time."
- Nikki Seay

BIPOLAR DISORDER

"The best part of mania is that I'm so optimistic about everything. It makes me feel invincible. When I'm depressed, I want to be left alone. It's not that I want to be by myself; I want everyone to disappear."
- Anon.



DEPRESSION

"There is a heavy, leaden feeling in your chest, rather as when someone you love dearly has died; but no one has – except, perhaps, you. You feel acutely alone."
- Tim Lott

MAIN ADHD CO-MORBIDITIES

IMPULSE CONTROL / PERSONALITY DISORDERS

An impulse control disorder is a condition in which a person has trouble controlling emotions or behaviors. Often, the behaviors violate the rights of others or conflict with societal norms and the law.

- Oppositional Defiant Disorder
- Conduct Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Intermittent Explosive Disorder

ANXIETY DISORDERS

Anxiety Disorders are a group of mental illnesses, and the distress they cause can keep you from carrying on with your life.

- Generalized Anxiety Disorders
- Social Phobia / Specific Phobia
- Post-Traumatic Stress Disorder
- Obsessive-Complusive Disorder
- Panic Disorder
- Agoraphobia

ANXIETY DISORDERS

A sleep disorder can affect your overall health, safety and quality of life. Sleep deprivation can affect your ability to drive safely and increase your risk of other health problems.

- Circadian Rhythm Disturbances
- Obstructive Sleep Apnoea
- Excessive Daytime Sleepiness
- Restless Legs / Periodic Limb Movement Disorder

NOTE:
If you believe you have an undiagnosed co-morbidity, please talk to a certified healthcare professional. Therapy, medication, support and self-care can help manage these co-morbidities.

LEARNING DISABILITIES

People with learning disabilities see, hear, and understand things differently. This can lead to trouble with learning new information and skills, and putting them to use.

- Reading
- Mathematics
- Written Expression

SUBSTANCE USE DISORDERS

Substance Use disorder, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug and/or medication.

- Alcohol abuse / dependence
- Drug abuse / dependence

MOOD DISORDERS

A mood disorder is a mental health class that health professionals use to broadly describe all types of depression and bipolar disorders.

- Major Depressive Disorder (esp. Seasonal Affective Disorder)
- Bipolar Disorder
- Dysthymic Disorder
- Cyclothymic Disorder

Hyperactive Around the World?

The History of ADHD in Global Perspective

BY MATTHEW SMITH

MODIFIED BY ALICE LONGTIN

Summary. A recent study has claimed that the global rate of Attention Deficit Hyperactivity Disorder (ADHD) is 5.29%.

Such reports strengthen the flawed notion that ADHD is a universal and essential disorder, found in all human populations across time and place. In this paper, Andrew compares ADHD's emergence in Canada, the UK, Scandinavia, China and India, arguing that, while ADHD can be considered a global phenomenon, behavioral and educational imperfections remain very much a product of local historical, cultural and political factors.

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CANADA & THE USA

Many aspects of the Canadian–American relationship have ambiguity when it comes to health. On the one hand, the proximity of the *'Darwinian US health care system'*, has compelled Canadians to place a high value on their own public health care system. The medical profession in Canada, has long been influenced by American medicine.

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Given the contrast between a Canadian public and Canadian medical profession that has looked to their American colleagues, the history of Canadian health care has been the need to find a balance between these views.

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It is also characteristic of Canada's approach to ADHD, particularly given the enormous influence of the USA. The first American medical articles described it as hyperkinetic impulse disorder from 1957, Canadian medical journals began to discuss it less than a decade later.

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Those who assume that ADHD is of purely American origin is that many of the features that allowed it to become a globally-diagnosed condition that was treated with stimulants and could be identified in girls and adults were first recognized by a team at McGill University in Montreal.

The Montreal group established of the first long-term follow-up study of ADHD. Comparing how hyperactive children fared academically, vocationally, cognitively, emotionally and socially with a control group, Gabrielle Weiss observed that, though both groups experienced difficulties, the ADHD group struggled more to cope with them.

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Moreover, these difficulties often persisted into adulthood and developed into more serious problems. Such findings demonstrated that **children with ADHD did not grow out of it.**

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Virginia Douglas would challenge ideas about what lay behind the disruptive behavior of children. She had been involved in researching the effects stimulant drugs had on hyperactive children during the 1960s, but by the early 1970s she had also begun to wonder about the core symptoms of the disorder.

What actually drove such behaviors? Douglas suspected and then confirmed that attention-deficits were actually the underlying explanation and the key feature.

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The obvious result was that what had variously been described as hyperkinesis, simply hyperactivity, was now termed Attention Deficit Disorder (ADD) in DSMIII (1980) and later Attention-Deficit Hyperactivity Disorder (ADHD).

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Through the various contributions of the McGill team, the Canadian understandings of ADHD shaped how Americans would see the disorder even more than the reverse.

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THE UK

When compared to their Canadian counterparts, British psychiatrists took longer to embrace ADHD.

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Most articles in British medical journals prior to the 1980s tended to discuss hyperactivity as a symptom of underlying conditions instead of as a disorder unto itself.

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British media stories about hyperactivity were similarly rare, and those that did appear tended to depict the disorder as a North American, rather than a British, problem. The situation did not change until the 1990s.

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American ideas about the mental health of children had previously been influential in the UK.
The American medical model, dominated by psychiatrists, rather than psychologists, was not fully adopted in the UK. After the Second World War, British psychiatrists were less keen to embrace the biomedical model of mental illness than their colleagues across the Atlantic.

There was 'a strong anti-drug therapy feeling among British child psychiatric experts'. Put more bluntly by a consultant child psychiatrist in 1981: 'I don't practice chemical warfare against children'.

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The very terminology used to describe such troublesome children was also a factor. While British schoolchildren were often described by educators as 'maladjusted' or 'medium educational subnormal', British psychiatrists might diagnose them with 'conduct disorder', 'school phobia', 'emotional disorder' or even 'autism'.

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British children with such problems were still seen in psychosocial rather than biological terms and drugs were rarely prescribed, highlighting fundamental conceptual differences.

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Nevertheless, there was little indication of a hyperactivity epidemic in Britain during the 1980s.
Attitudes, however, were changing.

Atomoxetine (Strattera) look alike

As the 1990s dawned, British psychiatrists argued that the differential rates of diagnoses were not a question of cultural difference but were due to the diagnostic criteria they were using. The DSM criteria used by North American physicians was less strict than that of the preferred WHO's International Classification of Disease.

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All of this led to the UK adopting a less rigid and more open-ended approach to ADHD. "There is no single solution to mental disorder, nor single approach to helping patients" said Anthony Clare.

NORDIC COUNTRIES

Dextroamphetamine-Amphetamine (Adderall)

When the history of ADHD in non-Anglo countries is examined, the picture becomes even more complex. The Nordic countries bear plenty of historical, cultural, linguistic and political similarities. But in terms of ADHD, their approaches have varied enormously.

The use of ADHD drugs provides a compelling example of this, where children in **Iceland** are over ten times more likely to be prescribed drugs than those in **Finland**, where ADHD is seen as an 'everyday learning challenge', instead of pathology.

Sweden's ADHD history: During the late 1960s, the concept of the disorder and the drugs prescribed to treat it would have been unwelcome in Sweden, due largely to fears about amphetamine abuse. The Swedish government banned Ritalin in 1968. The general approach to psychiatry in Sweden starting in 1945 was initially psycho-analytical, then more psycho-dynamic during the 1970s.

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By the 1980s, however, Swedish physicians and the Swedish National Board of Health began to warm to the concept of hyperactivity and biological psychiatry. During the 1970s, Swedish interest was limited, but once Christopher Gillberg began to lead the charge in the early 1980s, awareness of the disorder in Sweden bloomed in parallel to his career.

A recent study on the remarkable variation in the use of ADHD drugs in Nordic countries suggested that the availability of ADHD drugs and non-pharmacological treatments, training of mental health practitioners, and clinical practices all contributed to these differences with varied rates in countries.

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Strangely, the counties with the lowest and highest rates for ADHD diagnosis respectively were Vest Agder and Aust Agder, which border one another in southern **Norway**; in contrast, these two counties had the lowest diagnostic levels for autism spectrum disorders.

A recent **Danish** research indicates considerable variation of ADHD diagnoses despite the provision of free health care. The authors theorized that the lower rates of diagnosis in rural areas may have been due to inaccessibility of diagnostic services, it is also possible that various aspects of rural life make ADHD behaviors less problematic.

INDIA

The history of psychiatry in the colonies of the British Empire provides a useful comparison for the spread of mental disorder of American origin today.

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India provides an intriguing example of how the concept of ADHD—and the drugs associated with it—has both been readily adopted, not only by physicians and educators, but also by parents. The case of ADHD in India provides further proof that understandings and acceptance of ADHD have been shaped by social factors, in particular, by issues of class and socioeconomics.

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One article from the late 1960s on the effectiveness of jatamansone in treating hyperactive behaviors serves as an intriguing outlier to the sluggish rest of the ADHD model.

When studies did begin to emerge, charting the rates of the disorder in small school, hospital or outpatient populations, researchers were keen to explore whether other factors, including perinatal difficulties, family breakdown and socioeconomic status were correlated with it.

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It is no surprise that ADHD would come to India. But there has been an unappreciated factor, the willingness of some parents to accept an ADHD diagnosis in the hopes that it will help their child to live up to their full potential. The stigma of mental disorders in Indian society is supplanted by middle-class parents' desire to see their children do well in school and attain career success.

Methylphenidate (Concerta)

Drug treatments have been viewed suspiciously though. In one study, 20/24 Indian subjects refused to adhere to their prescriptions for one month. The reasons included side effects, inefficacy, fears of addiction, cost, the opposition of other family members/physicians, the 'careless attitudes'.

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Such findings were not unique. Many of the explanations cited for non-adherence centered on concerns about the drug itself or lack of understanding about the disorder. Instead of opting for drugs, these parents tended to rely on educational or religious interventions.

Dextroamphetamine Sulfate (Dexedrine) look alike

CHINA

Chinese psychiatry, much like psychiatry in communist Europe, has been shaped by deep-rooted cultural and historical factors, as well as the prevailing political climate but this appears to be changing.

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Unlike in India, Chinese psychiatrists have recognized hyperactivity as being prevalent in the childhood population for decades. Children were 'revered' in China, with the one child policy strengthening their 'special place in Chinese society'.

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Chinese children were also 'well disciplined as a result of the traditional Chinese authoritarian family structure.' This is an explanation for why Chinese-American children rate lower for hyperactivity than their peers. The existence of strong, multi-generational family units also meant that emotional problems were solved by elders in the family.

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Hyperactivity was found to be present in children at roughly the same rates as in the USA. Charting Chinese hyperactivity rates was something fairly unusual in China. Although amphetamines were used to treat such children, traditional herbal stimulants and behavioral therapy were also used.

Why were Chinese families willing to accept the ADHD diagnosis?
Because of the 'over concern of parents' regarding their 'only child' and their academic performance. Recognizing that behaviors threaten education and were socially unacceptable, many parents chose Ritalin, the 'be wise drug'.

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China provides an interesting case for the take up of ADHD, one that bears the hallmarks of a complex society that has been shaped by ancient traditions, 65 years of communism and selective flirtations with the west.

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In contrast, Chinese parents' distrust of ADHD drugs and their preference for traditional remedies reflects attitudes about western and Chinese medicine more generally.

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Parental willingness to accept blame for their children's behavior also makes some sense in an authoritarian society where basic family decisions, such as how many children a couple should have, have been taken out of the hands of parents.

Conclusion. Worldwide interest in ADHD goes on.

While there is a great deal of homogeneity in this vast body of research, the histories of ADHD in individual nations reveals a very different picture. Perhaps, instead of expecting all children to conform to DSM determined criteria of behavior, learning and development, we should do the opposite, and encourage creativity, courage and flexibility in everyone.

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WINTER 2020

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