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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Helping Adult Patients Find the Right Treatment for ADHD Symptoms

Ashley Baker:
Welcome to NeuroFrontiers on ReachMD. I'm your host, Psychiatric Nurse Practitioner Ashley Baker, and here with me today to discuss the diagnosis of ADHD post the COVID-19 pandemic is Dr. Margaret Sibley. She's a Professor of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine and a Licensed Clinical Psychologist who specializes in ADHD.

Dr. Sibley, thanks for joining me today.

Dr. Sibley:
Thanks for having me, Ashley.

Ashley Baker:
Let's dive right in, Dr. Sibley. How has the COVID-19 pandemic shifted the paradigm of ADHD?

Dr. Sibley:
Well, one of the things that we saw first from the Center for Disease Control and Prevention's data that was released last year was that there was an increased amount of help-seeking for ADHD, specifically in adults, from essentially the late pandemic immediately post-pandemic. And then when we zoomed in a little bit to understand those trends, we saw that the demographics that were contributing most to that increase were women versus men and also people who come in at 25 and older, people in their 30s, people in their 40s. And it was the biggest uptick in help-seeking that we've seen in a single year in history. So a lot of people aren't surprised to hear that because they see that in their own patient settings, and I think a lot of us have been spending the last year or so trying to unravel a little bit about where those trends came from. And so we're trying to understand a little bit about why suddenly are people coming in for ADHD help after the pandemic.

Ashley Baker:
So it sounds like people seeking care and treatment for ADHD and other similar disorders increased, but have actual diagnoses increased? And if so, what reasons might explain this?

Dr. Sibley:
It depends how you look at the question. So in children and in adolescents, the diagnoses have not increased. In fact, they've maybe gone down a little bit. But in that age range that I talked about, in adults, that's where we're seeing the increases. But what we're seeing is that the bigger piece of this isn't necessarily new diagnoses, but we're seeing people who are disproportionately seeking and obtaining stimulant medications during that time. So the question is are people having more problems, and that's why they are in greater need of these medications? Are people more aware of ADHD as a possible diagnosis if they're struggling with cognition, and so now they're connecting those dots and going in and saying, "Hey, I think I have this. I need care." Are providers more prone to give stimulants nationally than they used to be a few years ago? So there's a bit of a mystery there to disentangle. I think your listeners

probably can draw some of their own conclusions based on what they've seen as well, but around the time that the pandemic was sort of mid-swing, we saw people I think experiencing increased burden, cognitive load—if you think about it that way—from having to juggle a lot of things all at once. And so some people say, "Well, maybe it's the case that just more going on for a person is leading them to exacerbated ADHD symptoms." So if you had mild symptoms that didn't really cause a big problem in your life and then all of the chaos of the pandemic hits, suddenly, those symptoms feel worse for you, and you feel like they're at the point where you need help. So that's one hypothesis.

We also saw some interesting things happen in the landscape of care around this time as well. Because when the RyanHaightAct was lifted for a while, we saw a lot of ADHD care go to telehealth. We saw traditional providers pivoting to telehealth, but we also saw startup companies who their sole purpose was to generate profit based on a telehealth industry for mostly prescribing ADHD medications. Some of them are no longer operating because of investigations against them federally.

But a lot of advertisements from those companies were hitting people on social media. I show them in presentations, and you can actually see they're very suggestive—like, "Stressed and tired at work? You may have ADHD." So if that's hitting a lot of people online at once, they're thinking to themselves, "Huh, I wonder if that's what's going on for me." And so we think that may also be contributing to people arriving in the office.

But at the same time, another hypothesis, The New York Times published something on this in the fall. There's also a group of people out here saying this might be long COVID. Maybe there's just more people literally with biological symptoms impairing their cognition, and because of that, we're seeing this uptick. There's some census data that a larger proportion of Americans are reporting in the same time frame as all this ADHD help-seeking is increasing cognitive problems that are impairing their ability to work on census data. So they're not saying that's ADHD in that questionnaire, but it's certainly interesting to see those two upticks. Both the medication prescribing patterns and the census data have curves that match each other in time.

Ashley Baker:
It's interesting that you mentioned those different examples because I'm actually across the country from you in Boston, but I'm seeing the same things coming to my practice, and on one hand, it's so wonderful that our nation is really acknowledging mental health issues and we have such access to content and other people's stories, but on the other hand, you're absolutely right. It could also be people that are identifying with symptoms and maybe don't fit the diagnostic criteria, and then there becomes that gray area.

Dr. Sibley:
Yeah. So something that's interesting is I think there might be two things that are really struggles for practitioners right now. One is I think we have a greater proportion of milder people coming in looking for help than we used to. ADHD is a disorder that is trait-based on a continuum. It's generally thought of as polygenic, which means that there's a lot of genetic contributors, and as they add up, people may have higher genetic loads, but people with the more moderate genetic load, they may not look like a person with ADHD every day, but sometimes when things get really rough for them in their life those symptoms can flare up for them. So are there more people who are generally milder walking in? And that's a harder clinical picture to decide whether they're severe enough to diagnose and treat.

The other thing is people are coming in with diagnoses from these telehealth startups maybe a year or two ago that they got, and then practitioners aren't sure whether to honor those diagnoses or not because they don't all trust them.

So I think this is what a lot of people are struggling with right now. It's not to say that there haven't been a lot of really important new diagnoses made among people who've struggled for their lifetime and are finally understanding what's going on for them and getting care. There's a lot of people like that, so that's the good part. But then are there other people who really should be getting a different care or a different intervention? They're attributing what's going on for them to ADHD, but actually, it might be something else.

Ashley Baker:
For those just tuning in, you're listening to NeuroFrontiers on ReachMD. I'm Psychiatric Nurse Practitioner Ashley Baker, and I'm speaking with Dr. Maggie Sibley about the diagnosis of ADHD following the COVID-19 pandemic.

Let's talk more about the treatment of ADHD in adults. Dr. Sibley, what do the guidelines say about diagnosing and treating ADHD in this population?

Dr. Sibley:
Well, first, let's be clear. In the US, there are no guidelines right now for the diagnosis and treatment of ADHD. There are some forthcoming from APSARD that it should be out later this year, but right now folks don't have that good information. We can look at what the research says though. And so as far as it goes for treatment, there are two main categories of treatments that show repeated efficacy in randomized controlled trials for ADHD in adults versus medication. Pharmacologically, you have stimulant medications and non-stimulant medications. And then we also have the nonpharmacological treatments, the cognitive behavioral therapies.

Underneath that, you have some sort of sub-therapies. Some people are integrating aspects of mindfulness, for example, dialectical behavioral therapy. There's some little studies that also address the efficacy of that class, but they're all under this cognitive behavioral treatment category of therapies that people go into short term with a therapist, a mental health practitioner, and can get help there.

And we think of them as complementary to each other. Generally, across the lifespan, you see bigger impact of the medications on your day-to-day ADHD symptoms, but the cognitive behavioral therapies, they teach coping skills that help people manage their life. So if you have both the medication, what patients will say it takes the edge off or just helps them feel like the volume of their ADHD is turned down a little bit, and then you help give them the skills to increase their self-awareness, to increase their motivation, and help them with executive functions, and then folks are really able to feel their best.

Ashley Baker:
Based on your practice, what needs to be done to close the gaps and unmet needs in this area?

Dr. Sibley:
So first of all, we have to think about how to support providers. Obviously, an increase in help-seeking means that we need more than just the traditional ADHD providers to come on board and help with this patient need, which means we need people who maybe haven't historically done ADHD diagnosis and treatment to consider getting trained in those methods so that they can be part of the army of clinicians that are essentially needed now to help handle this wave of people coming in and looking for help for ADHD.

So the guidelines I mentioned a second ago are going to be one important part of that effort because, first of all, in order for people to know how to help, they need to know what to do, and there is a lack of clarity I think right now in the field about what is best practices for the diagnosis of ADHD, the treatment of ADHD. Yes, we have the DSM-5. The criteria in the DSM-5 are not being questioned here, but how do you make the diagnosis is more than just what do you see in that book. We need to know who do you talk too? Do you just do a quick questionnaire with a patient? Best practices tend to suggest, no, you should actually sit down and do an interview with them. That might take an hour or even 90 minutes for a complex case. You need to get information from other people in the person's life, like a spouse or a parent who can fill out some forms and tell you what they're like from the outsider's perspective as well. Differential diagnosis. So people need to know what the steps are in the diagnostic process so they can think about how to fit those into the workflow of their practices.

Aside from that, I think need to think about how to get good information out there to patients because there are a lot of folks who are getting misinformation off the internet about ADHD. There was a great study done by a Canadian team where they rated all of the videos on TikTok and found that the majority of them are actually pretty misleading when it comes to ADHD, so we need to combat that misinformation with good information that's engaging for people so they actually will look at it and listen to it and hopefully, get a better sense of what's going on for them. But I do think it's healthy for people if they're questioning if they have ADHD to seek help, so I think on the provider side, we just have to be ready to meet those folks who are questioning.

Ashley Baker:
In practice, I've seen a lot of providers require neuropsychological testing before providing treatment. What are your thoughts around that, if any? What is your take?

Dr. Sibley:
Well, if you look at the research literature, it's really important to remember that ADHD is a clinical diagnosis. It's not a neuropsychiatric diagnosis, and it's really important that we are aware that a neuro-psych evaluation, it also includes the psychological evaluation, and that part of it is valid for diagnosing ADHD. But when it comes to the cognitive tasks, we see very low correlations between those cognitive tasks and ADHD, and so it can be burdensome to patients to send them off to get a neuro-psych evaluation that is expensive,

that can have very long wait lists, and that extra level of information, it does not add anything to the diagnosis of ADHD. And so it really is problematic to think about those tests as somehow like the gold standard of an ADHD diagnosis.

Ashley Baker:
I really appreciate your feedback on that. Thank you so much. Before we end our discussion, Dr. Sibley, are there any other final thoughts you'd like to leave our audience with today?

Dr. Sibley:
I think the main thing we need to remember is that we're at a time where a lot of people who were not diagnosed as children are recognizing ADHD possibly in themselves and coming forward for help, and we especially see this in a few groups of patients that are classically underdiagnosed. So one of them is women because ADHD in girls is a quieter phenomenon, and it is often missed. It doesn't annoy other people as much often, and that's part of why the teachers don't send them in to get help. So listen carefully when you're meeting a middle-aged woman who is questioning because there is a good chance that she could have been missed.

When you think about people of color, minorities, people who have faced a lot of adversity in their life, and everyone seems to attribute the problems that they're having now to that adversity, "Well, they went through so much it must be trauma," but it could have also been ADHD. We know people with ADHD are more likely to experience trauma because of the situations that either they get themselves into because of their struggles or that their family who, since it's a genetic disorder, is experiencing because of their parents' struggles, their siblings' struggles that then gives them experiences of trauma. So just don't forget that ADHD can be relevant in some of the places that we make these automatic assumptions that maybe it wasn't.

Ashley Baker:
And with those final thoughts on the diagnosis, management, and treatment landscape for ADHD, I'd like to thank my guest, Dr. Maggie Sibley, for sharing these important updates.

Dr. Sibley, it was great speaking with you.

Dr. Sibley:
You too. Thank you.

Ashley Baker:
For ReachMD, I'm Ashley Baker. To access this and other episodes in our series, visit NeuroFrontiers on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.