Appendix 3: Comorbidity

Attention-deficit hyperactivity disorder (ADHD) in adults and differentiating comorbid conditions			
Disorder	Comorbid rate	Shared symptoms	Differentiating symptoms
Specific intellectual difficulty	33%	Problems with concentration, poorly organised work, forgetfulness, poor time management	Presence of academic skills deficits (dyscalculia, dyslexia)
Emotionally unstable personality disorder	13%	Problems with concentration, poorly organised work, forgetfulness, poor time management	Chronic feelings of emptiness Presence of identity disturbance Suicide threats or acts of self-harm Fear of abandonment Quasi-psychotic symptoms
Dissocial personality disorder (DSPD)	24%	Enduring pervasive pattern of behaviour that causes impairment in multiple domains Low tolerance to frustration Problems maintaining relationships Conduct disorder can coexist with ADHD and has been invariably present in DSPD History of hyperactivity in childhood in ADHD and DSPD	Callous unconcern for feelings of others Incapacity to experience guilt Persistent attitude of irresponsibility and disregard for social norms, rules and obligations
Anxiety disorder	Inconsistent findings, some studies report elevated rates up to 33%	Poor concentration Motor tension Inability to switch thoughts off Checking may be employed in ADHD as a means of managing forgetfulness/disorganisation	Autonomic overactivity Presence of somatic symptoms Persistent anxiety symptoms of an episodic nature (periods where symptoms not present) Evidence of clear triggers to anxiety (presence of avoidance) Specific focus to thought content, e.g. fear of negative appraisal, contamination, threat Implications for treatment Treat clear anxiety disorder first Re-evaluate severity of ADHD once anxiety disorder treated Consider atomoxetine if stimulant treatment exacerbates anxiety symptoms
Moderate to severe depressive disorder	63%	Poor self-esteem Affective instability Irritability Poor concentration Sleep problems	Episodic history of pervasive low mood and/or anhedonia (different to usual mental state), presence of somatic syndrome Treatment implications: treat depression first
Dysthymia	23%	Poor concentration Problems making decisions Irritability Sleep problems Low self-esteem Feeling incapable	Chronically depressed mood present for minimum of 2 years Treatment implications: treat ADHD first

ADHD in adults and differentiating comorbid conditions (continued)			
Disorder	Comorbid rate	Shared symptoms	Differentiating symptoms
Bipolar affective disorder (BPAD)	20%	Mania/ADHD Affective instability Hyperactivity/impulsivity Sleep problems Depression (see p. 41)	BPAD has an episodic presentation with distinct periods of abnormal moods (hypomanic/manic, depressed) with a return to baseline level of functioning in between episodes; psychotic symptoms may be present Implications for treatment: treat mood disorder first
Autism spectrum disorder (ASD)	No adult studies; now recognised that conditions frequently co-occur	Severe hyperactivity in childhood, social impairment, poor concentration. Developmental coordination disorder often coexists with either ADHD or ASD	Attentional problems centred around not listening and problems shifting focus (attentional problems in ADHD due to short attention span and excessive distractibility) Impairment of reciprocal social interactions All-absorbing narrow interest Imposition of routines and interest Non-verbal communication problems Speech and language problems (formal, pedantic, odd prosody, staccato speech)
Substance use disorders	25% (earlier onset of substance misuse)	Impulsivity Overactivity Poor concentration	Use of one or more psychoactive drugs causing damage to health with or without dependence syndrome Treatment implications: stabilise substance misuse first Make ADHD diagnosis when patient in recovery Consider drug interactions and risk of diversion. If risk of diversion, non-stimulant treatment should be used
Neurological disorders, tic disorder, epilepsy			*Implications for treatment* Tic disorder: if severe, use non-stimulant Epilepsy: optimise seizure control. Liaise with neurology. Some anticonvulsant medications have a negative impact on attention. Monitor for deterioration in seizure control with stimulant
Developmental coordination disorder	40% in children (75% persist into adulthood)	Problems with planning, working memory Restlessness Poor concentration	Presence of motor coordination difficulties, hypo/hypertonia

Further reading

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