Outside the Box: Rethinking ADD/ADHD in Children and Adults. A Practical Guide


Attention-deficit disorder or attention-deficit/hyperactivity disorder (ADHD) has received a lot of attention (pun unintended) lately, from the media, the public, and the medical profession. As author, Thomas Brown, PhD, notes, “The rate of diagnosis for ADHD and use of medication for this disorder has continued to increase not only in the United States but also internationally” (p 2), despite inadequately informed and negatively biased media coverage. The question is whether this increase is due to careless diagnosing, aggressive promotion by pharmaceutical industry, the public’s (students, parents) demand for performance enhancement medications, or any combination of these.

Dr. Brown cites several factors that may fuel this increase, including (a) escalating pressure for improved literacy and achievement from students as well as adults whose jobs require greater literacy and skills; (b) increased recognition that ADHD affects females as well as males; (c) evidence that, for many individuals, ADHD impairments persist into adulthood; (d) ethnic and racial minorities’ expanded access to care; and (e) increased awareness that some young children may benefit from early treatment of ADHD.

Dr. Brown emphasizes 2 major factors: “ADHD can cause considerable impairment and significant suffering for affected individuals and families,” and “Medication treatments do not cure ADHD, but if appropriately administered, medication often can safely reduce impairment and improve functioning” (p 3). He also promotes a new view of this disorder, suggesting executive function deficit disorder would be a preferable term, as it reflects better what this disorder is about—“a syndrome of impairment of executive functions: clusters of dynamic, interacting cognitive functions of the brain that are critical for most aspects of self-management” (p 12). For many, this disorder appears as a developmental impairment or a delay in development of executive functions. This is certainly an interesting and clearly explained concept. However, Dr. Brown uses the DSM-5 term “ADHD” in this book to avoid confusion.

The book consists of an introduction and 12 chapters. In the Introduction, Dr. Brown lists and comments on “20 assumptions about ADHD that need rethinking in light of recent research” (p. xv), such as ADHD is a simple problem of not listening and not staying focused on a task; everyone has ADHD sometimes; ADHD always starts in childhood, never in adolescence or adulthood; ADHD is always outgrown or always continues for a lifetime; ADHD can be diagnosed objectively with neuropsychological or imaging tests; once adequate executive functioning has developed, it will persist; and ADHD is exclusively an American problem and is not found elsewhere in the world. The 12 chapters that follow address these assumptions, starting with discussing the central mystery of ADHD: “Clinical observations and empirical research have consistently demonstrated that ADHD symptoms are situationally variable and that there is much intra-individual variability in the symptoms of this disorder” (p 7).

Subsequent chapters discuss a new model of ADHD (the above mentioned executive function impairments); the differences among persons with ADHD; ways ADHD can impair function at various age levels; how ADHD impacts “brain Googling” for motivation; how ADHD develops, sometimes worsens, and sometimes improves; how and why other disorders often co-occur with ADHD; assessing children, teenagers, and adults for ADHD; emotional dynamics
in individuals, couples, and families coping with ADHD; practical aspects of medication treatments for ADHD; practical aspects of non-medication interventions for ADHD; and treatment adaptations for ADHD with various complications. Because the book is intended for laypersons as well as clinicians, the chapters are written in an easily understandable language and illustrated by case examples. Some chapters are a bit wordy and repetitive. However, the last 3 chapters, which address treatment issues, are excellent reading, filled with useful information and resources. The medication chapter includes a good table listing all medications approved for ADHD, their duration of action, trade names, available strengths, usual dosage range (in mg), approximate duration of action in hours, and ages approved for ADHD.

As a clinician who frequently faces demands for psychological testing and claims that this testing is necessary for evaluation of ADHD, I appreciated Dr. Brown’s emphasis that “There is no single test that provides an adequate assessment for the presence or absence of ADHD. No electroencephalogram, neuropsychological test, or computerized measurement can capture the variety and complexity of functions involved in getting up in the morning and preparing to leave for school or work, riding a bike or driving a car in traffic, reading and comprehending papers or books, participating in social conversations, and prioritizing a variety of tasks and getting started on what is most important while avoiding distractions yet shifting focus when needed” (p 130) and “...the most effective way to determine whether a person may have ADHD is a well-conducted clinical interview with the patient (and, if possible, one or two people who know the patient well) by a clinician who is familiar with ADHD and with other medical and psychological disorders that might produce similar symptoms in a person of comparable age” (p 131).

I also like Dr. Brown’s suggestion on what to teach patients about medication: “… for about 8 of 10 individuals with ADHD, carefully prescribed medication can improve this process. I emphasize that medication for ADHD cures nothing; it is not like antibiotics that may cure infection. This medication is more like eyeglasses that help someone improve his or her vision but only while the individual is wearing those glasses. For some, medication brings huge improvement; for others it is substantial, but not huge; still for others, medication helps a little, but not that much; and for about 2 of 10, medications currently available for ADHD do not improve functioning much at all…” (p 143).

Another clinically important point made is about planning combined use of longer-acting and shorter-acting stimulants. The potency of the long-acting or extended dose at any time over the course of action is only one-half of the face value of the longer-acting formulation. “For example, a 20-mg dose of Adderall XR does not provide 20 mg of coverage throughout its duration of action. It provides 10 mg of coverage for the first few hours and then another 10 mg of coverage for the following few hours. In contrast, the immediate-release version of Adderall 10 mg releases the full 10 mg at the outset” (p 185). This information may seem self-evident to an experienced clinician, but it actually is a priceless tip for beginners. There are many other such tips, eg, about medication rebound; whether a generic version of an ADHD medication is less effective; the risks of drinking alcohol while taking ADHD medications; how using marijuana affects a person who is taking ADHD medications; what risks are involved in using approved stimulant medications for ADHD treatment; and many others.

The discussion of non-medication interventions for ADHD is also useful, emphasizing the role of accurate psychoeducation for patients and their families, and providing very specific guidance for parents and discussion of collaboration with elementary and secondary schools and accommodation in college and postgraduate settings. Similarly useful is the last chapter reviewing the treatment of ADHD comorbid with anxiety, depression, learning problems, emotional regulation and mood problems, sleep and arousal problems, substance abuse, and other conditions.

This is a useful book for anyone involved in the management of ADHD or what is hopefully going to be called executive function deficit disorder. Clinicians, patients, patients’ families, and educators will be able to get comprehensive, understandable, and clinically useful information about this disorder.

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DISCLOSURE: Dr. Balon is a member of the American Psychiatric Association Publishing editorial board.
Psychodynamic Treatment of Depression. Second Edition


With increasing evidence of the efficacy of cognitive-behavioral and interpersonal therapies in treating depression and widespread promotion of their use, many may ask, “Is there any place for psychodynamic psychotherapy in this indication?” The authors of this volume argue that psychodynamic psychotherapy has a definite place in our armamentarium for the treatment of depression because “Psychodynamic psychotherapy explores internal conflicts and unconscious issues that are not often addressed in cognitive-behavioral, interpersonal, or medication treatments” (p4). They also argue that there is a specific dynamism that drives depressive symptoms and syndromes and that “focused psychodynamic psychotherapy can be a valuable adjunct for the treatment of depression, including the vulnerability to recurrence of depression, and that in some cases it may be effective alone” (p 5)—meaning without combining it with medications. The argument for using psychodynamic psychotherapy for depression is strong, although the knowledge and training in this indication is frequently weak or nonexistent. Thus, the authors bring us an introduction and guide to psychodynamic psychotherapy of depression.

The book is divided into 3 parts: I. Introduction and overview; II. Techniques in psychodynamic treatment of depression; and III. Special topics.

In addition to the introduction, Part I includes a chapter on the development of a psychodynamic model of depression and an overview of psychodynamic psychotherapy of depression. The introduction discusses the value and limitations of current treatment approaches to depression; the evidence for psychodynamic approaches to depressive disorder; indications for psychodynamic treatment of depression (mild to moderate major depression; chronic persistent depressive disorder; depression with comorbid personality disorder); discussion of initial evaluation and determination of the appropriateness of psychodynamic psychotherapy; length of treatment, and a brief overview of the entire book. I found the discussion of determining the appropriateness of psychodynamic psychotherapy especially useful. The authors list patient characteristics conducive to psychodynamics psychotherapy, such as a motivation to understand the sources of symptoms; the ability to think psychologically; the capacity to have and think about meaningful and complex relationships with others; the capacity for control over impulses; the ability to understand metaphors; the capacity to acknowledge emotional states; and good reality testing. They also include relative contraindications, such as marked difficulty observing the self or reflecting on others’ motivations; significant inability to tolerate frustration; globally impaired relationships; marked difficulty forming an alliance with the therapist; low intelligence; and severe depression that disrupts the patient’s ability to work effectively in psychotherapy. The listed characteristics and contraindications are quite important, yet not always spelled out, especially for novices in psychodynamic psychotherapy.

The chapter on the development of psychodynamic models of depression first reviews the early psychoanalytic models and their focus on disappointment, loss and anger, and then discusses the later models, which focus on problems with self-esteem regulation and aggression. Part of this chapter also reviews the attachment theory. The table on central dynamics of depression seems especially useful. The last part of this chapter focuses on core dynamic formulation for depression. The authors emphasize that narcissistic vulnerability and low self-esteem are fundamental to the susceptibility to depression. This vulnerability
could result “in sensitivity to disappointment and rejection and thus to easily trigger rage, which leads to feelings of guilt and worthlessness” (p 31). Another core dynamic of depression could be the “individual’s attempt to deal with low self-esteem by idealization and devaluation” (p 31). The overview of psychodynamic psychotherapy of depression briefly reviews 3 phases of treatment: (1) forming a therapeutic alliance and a frame for treatment; (2) treatment of vulnerability to depression; and (3) termination.

Part II consists of 8 chapters that discuss issues such as getting started with psychodynamic treatment of depression; the middle phase of treatment; addressing narcissistic vulnerability; addressing angry reactions to narcissistic injury; the severe super-ego and guilt; defense mechanisms in depressed patients; and the termination phase. The chapters are well written, well organized, and include a lot of vignettes and tables.

I found the inclusion of a discussion of the role of psychoeducation in the early treatment phase useful and novel, because its role is not often emphasized. The authors write that “Although the psychoeducation is not formal or didactic, the psychodynamic therapist helps patients to recognize that symptoms have meaning, that developmental factors affect current mental life and relationships, that feelings and fantasies that may be out of awareness can create conflict, and that feelings about the therapist can play a valuable role in learning about these conflicts. The therapist indirectly educates the patient about how these factors contribute to depressive symptoms” (p 63). The chapter on the middle phase of treatment contains a useful discussion of the use of countertransference. The 2 chapters on narcissistic injury are educational in the way of putting the narcissistic injury and the reaction to it into the context of depression. As the authors point out, “narcissistic vulnerability has been viewed as central to the development of depression and is thought to arise in early experiences of helplessness, loss, or rejection, and temperamental factors also may play a role” (p 87). The authors skillfully outline the areas of exploration—addressing a lack of awareness of anger, identifying specific angry fantasies, identifying guilty reactions to anger, identifying expectations of punishment, exploring the link between competitiveness and aggression, becoming more comfortable with assertiveness, and recognizing anger directed toward the self. They also cover the anticipated responses to exploration such as increased comfort with aggressiveness and diminished self-directed anger. These 2 chapters would probably be the most educational reading for any novice in psychotherapy of depression.

Another interesting discussion evolves in the areas on severe super-ego and guilt, as well as on idealization and devaluation. The chapters emphasize that “...depressed patients can have scrupulously held moral standards. Additionally, their personal expectations of themselves in other realms of endeavor can be unrealistic. These attitudes are rooted in an excessively perfectionistic ego ideal.... Failures to meet excessive expectations give rise to depressive effects of shame, humiliation, or unworthiness, as distinct from the guilt stimulated by a failure to meet moral standards” (p 137). Similarly interesting is the review of the defense mechanisms employed by depressed patients, which usually include denial, projection, idealization and devaluation, passive aggression, identification with the aggressor, and reaction formation.

Lastly, the chapter on termination outlines the criteria for termination, provides suggestions on how to handle premature requests for termination, and discusses countertransference reactions during the termination phase.

Part III of the book focuses on 4 special areas: (1) psychodynamic approaches to depression with comorbid personality disorder (namely dependent, avoidant, obsessive-compulsive, narcissistic, and borderline); (2) managing impasses and negative reactions to treatment; (3) psychodynamic aspects of suicidality; and (4) the use of psychodynamic psychotherapy with other treatment approaches. The chapter on suicidality reviews concepts such as suicide as revenge, suicide as pathological mourning and wish for reunion, suicide as a reaction to experiencing the other as torturer, suicide as self-punishment and protection of the other against aggression, and suicide as a function of impaired reality testing and ego integration.

The last chapter emphasizes that medication always should be considered for patients with major depression. This chapter further discusses issues such as determining whether to use medication with psychodynamic psychotherapy, shame about psychotherapeutic or psychopharma-
cological interventions, medication as an aid to psychotherapy, psychotherapy as an aid to taking medication, coordination of split treatments, and combining psychodynamic psychotherapy with other therapies such as cognitive-behavioral or couples therapy. This chapter will certainly surprise those trained years ago, when combining psychodynamic psychotherapy with any other treatment was almost unthinkable.

This is a useful, well-conceptualized, well-organized, highly readable book. I believe it could be of use to any clinician who treats depressed patients, not just those implementing psychodynamic psychotherapy. It is also a text that could be recommended for residents and beginning clinicians.

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DSM-5 Pocket Guide for Elder Mental Health


The population of the United States and other developed countries is clearly getting older. It is estimated that the number of Americans age ≥65 will more than double from 46 million today to approximately 98 million in 2060, and that the share of this segment of the population will rise to approximately 24% of the total. The demands for general geriatric and geriatric psychiatry services will increase similarly. However, we do not have enough specialists to take care of all elderly patients, and we will not be able to train sufficient numbers of geriatricians and geriatric psychiatrists to handle all in need. Our education system is producing enough specialists for the current numbers, and is not prepared for the future growth in demand. Thus, we all, specialists and generalists alike, have to educate and train ourselves in how to approach and treat elderly patients.

The DSM-5 Pocket Guide for Elder Mental Health is a small volume that will hopefully help us improve our skills and ability to more effectively take care of elderly adults with mental illness. As the authors write in the Preface, the hotly debated question during the creation of DSM-5 was “whether an older adult’s experience is best described as depression or grieving opens a broader debate about the boundaries between mental illness and normal age-related changes” (p vii). This distinction has to be made during a thorough evaluation. The authors of this volume believe that DSM-5 is a way to begin this kind of evaluation. However, they recognize that this way is not straightforward. The use of DSM-5 with older adults, “whose health is inevitably bound up in their communities and families, requires an act of translation. Similarly, this book is a translation of DSM-5” (p vii), but not a replacement for it or many textbooks now available. Rather, it “presents a way to employ DSM-5 criteria as a part of a person-centered interview and an evidence-based treatment plan” (p viii).

The book consists of 3 sections: I. Diagnosing and treating older adults; II. Using DSM-5 with older adults; and III. Additional tools and initial treatments. The 6 chapters of the first section represent a good introduction to the evaluation and diagnosis in the elderly population. These chapters also introduce many interesting and useful concepts. For instance, in the introductory chapter, the authors outline 4 concepts that define geriatric psychiatry: (1) Everyone has a story; (2) Treatment must have functional benefit; (3) Practitioners care for both the patient and the caregiver; and (4) Simple works best. This chapter also discusses issues such as the dif-
ferences between mental distress and mental illness (an important distinction in this population), use of a diagnostic interview to distinguish between mental distress and mental illness, the fact that therapeutic alliance is the key to an accurate diagnosis and successful treatment, and quick tips on how to build a therapeutic alliance with older adults and their caregivers. The following chapter on addressing behavioral and mental health problems in community settings starts with a discussion of screening and early detection, then quickly moves into clarifying the diagnosis in 3 stages: I. Characterization of a behavioral or mental health problem identified by a screening tool; II. Confirming a diagnosis using DSM-5 criteria; and III. Expansion of the differential diagnosis to include medical and neurological problems. I liked 2 caveats here. First, the authors warn us that “Psychiatric diagnosis teaches you humility and patience, as first impressions are often incorrect and best impressions develop along with the therapeutic relationship” (p 23). Then they remind us that, “Just as hypertension, hypercholesterolemia, diabetes, and obesity cluster in patients with metabolic syndrome, certain mental health disorders are frequently comorbid with other mental health disorders... Clusters can, unfortunately, mask redundant diagnoses” (p 23). Chapter 3, “The Diagnostic Ds: the building blocks for diagnosing mental health disorders in older adults,” demonstrates on 3 cases 6 common disorders among older adults: delirium, drugs, diseases of medical or neurological origin, disrupted sleep, depressive disorders, and dementia and other neurocognitive disorders. These 6 issues are discussed in a practical way. The review of disrupted sleep reminds us that older adults, especially the recently retired ones, frequently complain of insomnia because they lack stimulating daily activities. “Many spend hours in front of a TV or computer and frequently nap during the day. The combination of daytime napping and decreased exposure to natural light disrupts or degrades nighttime sleep” (p 47). The management of insomnia should always start with sleep hygiene! The following chapter, “Beyond the Diagnostic Ds: other common clinical challenges,” focuses on other mental health problems in older persons, such as irritability and labile mood; unusual experiences such as hallucinations and delusions; agitation and aggression; sexual dysfunction; and suicide and end-of-life concerns. This chapter includes a good table outlining a workup for new-onset manic or psychiatric symptoms in older adults.

The next 2 chapters, chapter 5: “The 15-minute older adult diagnostic interview,” and chapter 6: “The 30-minute older adult diagnostic interview,” outline 2 types of interviews minute-by-minute including the challenges during those interviews, exploration why patients reject help, talking about the forbidden 3 Ss (sex, substance use, and suicide), and some useful tips. The chapter on the 30-minute interview includes example questions. This chapter again brings some important caveats. First, any psychiatric examination in which all the information comes from a single source is incomplete. Second, a successful psychiatric examination ultimately provides access to the internal world of a person. Lastly, a skilled psychiatric examination always includes an account of the relationships that constitute a person’s existence.

The 2 chapters of Section II present “The DSM-5 older adult diagnostic interview” and “A brief version of DSM-5.” In the diagnostic interview chapter, each section presenting a DSM-5 diagnostic category starts with one or more screening questions and continues with follow-up questions. These questions are followed by the diagnostic criteria. The diagnostic interview chapter presents a bulk of the book and would be most useful for a nonpsychiatric physician to navigate through the DSM-5 criteria.

The third section of the book consists of 11 chapters covering issues such as a stepwise approach to differential diagnosis; the mental status examination; selected DSM-5 assessment measures; rating scales and alternate diagnostic systems; psychoeducational interventions; psychosocial interventions; psychopharmacological interventions; brain stimulation therapies; and mental health treatment planning. The chapters are brief, informative, and straight to the point. The stepwise approach to differential diagnosis describes 6 steps to consider: (1) The extent to which the signs and symptoms are related to a stressor or functional change; (2) The extent to which the signs and symptoms are related to a caregiver conflict; (3) The extent to which the signs and symptoms are related to substances; (4) The extent to which the signs and symptoms are related to another medical condition; (5) The extent to which the signs and symp-
BOOK REVIEWS

BOOKS RECEIVED

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