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Adult ADHD vs Obsessive Compulsive Disorder in the DSM-V Era: A Case Report between challenging Differentiation and Comorbidity

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ABSTRACT

ADHD (Attention Deficit Hyperactivity Disorder) is a complex pathological condition analysed mainly in children. In fact, ADHD in adults presents a more heterogeneous pattern of symptoms. Additionally, possible associated comorbidities can contribute to make the correct diagnosis in adults even more difficult. On top of the above-mentioned complexity, coexistence of pathologies like ADHD and Obsessive Compulsive Disorder (OCD) appears to be not thoroughly investigated in adult population.

In this regard, we present a case of a woman with OCD characterized by doubtful obsessions, accumulation compulsions, attention difficulties and deficit in executive functions. In particular, we aim to describe both the peculiarities of each disorder and the overlapping aspects between inattentive ADHD and OCD in adults. A good knowledge of the psychopathology of these two disorders is fundamental for differential diagnosis and exclusion of false comorbidity.

Keywords

Attention-deficit, ADHD, Obsessive-compulsive disorder, OCD, Obsession.

Introduction

ADHD (Attention-Deficit Hyperactivity Disorder) is a complex disorder, which includes a constellation of clinical manifestations based on attentive difficulties, hyperactivity and impulsivity [1]. ADHD characteristics have been studied and analysed, above all, on children, since for a long-time symptoms were believed to decrease with age, eventually disappearing. ADHD global prevalence rates during childhood vary from 5.29% to 7.1%, while in adult population are around 2.8% [2]. Actually, there is an inverse proportionality between age and some symptoms. Nevertheless, these symptoms would not disappear but assume new characteristics no less disabling than the original early-stage ones. In particular, it is known that inattention and organizational difficulties tend to persist in adulthood; on the other hand, hyperactivity and impulsiveness become less visible with aging and tend to express themselves in the form of inner tension [3]. However, it should be emphasized that ADHD in adults can clinically manifest in a way overflowing the diagnostic criteria of DSM-V. As a result, deficits concerning executive functions, work and relational skills constitute a central element in the diagnostic complexity. Additionally, the possibility that comorbidities may be associated with ADHD further complicates the diagnosis. In psychiatric field, the most frequent comorbid conditions include anxiety disorders (47.1%), personality disorders (21.8%), and depressive disorders (from 18.6% to 53.3%) [4], bipolar disorders and substance abuse disorder (between 23% and 30%) [5].

It should be pointed out that most of the studies on comorbidity between ADHD and OCD were carried out in paediatric samples and, currently, available data on comorbidity rates between ADHD and OCD in adult patients report a wide variability, from 0% to 44.4% [6]. Despite the fact that ADHD and OCD are two pathologies with distinct clinical profile, they may present some trait similarities, like attention and concentration span deficit. This can further complicate the differential diagnosis process or lead the clinician to define a false comorbidity condition.

In this regard, we present a case of a woman with OCD characterized by doubtful obsessions, accumulation compulsions, attention difficulties and deficits in executive functions. We aim to define both the overlapping and diverging symptoms of these disorders in adult population, in order to increase the accuracy of clinicians' diagnosis.

Case Report

Fabiola is a 46-year-old Caucasian woman who came for the first time to our Psychiatric Clinic three years ago with thymic deflection, moderate anxiety, difficulties in concentration and in verbal expression. She used to formulate sentences in a verbose and tangential way, with difficulty in answering questions in a concisely way, getting lost in irrelevant details and frequently losing the thread of the speech. Thanks also to her mother's presence during the first interviews, it emerged that F. had accumulated several work failures over the years, significantly contributing to her mood decline. Thus, the described clinical picture was framed as "Major Depressive Episode with anxious characteristics", treated with SSRI (Paroxetine 20mg / day). At subsequent checks, a gradual improvement in mood with attenuation of anxiety levels was observed. Instead, difficulties in attention and concentration persisted, so that doctor often needed to repeat to F. the same questions. Furthermore, bizarre behaviours appeared more clearly, such as the tendency to write down during the interview some words or phrases in her diary. F. justified this behaviour as a need to be sure to remember in the following days her psychiatrist's words. Looking more carefully at her diary, we noticed an interesting element: among the pages, in addition to the sentences of our interviews, there were also fragments of dialogues from television programs, combined with various scheduled appointments (medical visits, cultural events) also temporally overlapping. Furthermore, among the pages of her diary, it was possible to see the disordered accumulation of old bus tickets, candy and snack papers and blister packs of expired drugs used as a bookmark. In the light of the above, we have deepened the psychopathological evaluation in the suspicion of an obsessive compulsive disorder with accumulation conducts. We first administered F. the Structured Clinical Interview for DSM-5- Clinical Version (SCID-V CV) [7] which revealed a Depressive Episode in complete remission and an obsessive compulsive disorder. The latter was then investigated and quantified using the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) [8] from which it was obtained a score of 14 for obsessions and 16 for compulsions; the level of severity was deep and the insight was poor. From the Y-BOCS emerged doubtful obsessions and accumulation compulsions. The latter have been better investigated through the Hoarding Rating Scale (HRS) [9] and the Saving Inventory-Revised (SI-R) [10] which have highlighted not only F'. difficulties in getting rid of old or disused material, but above all the tendency to select everything that could allow her to retain information considered indispensable.

In fact, in retracing her story, F. told us about the fascination that the cultural world had given her since childhood, with particular reference to everything related to art (especially dance and music) and psychology. In relation to these cultural dimensions, F. expressed a sense of inferiority and inadequacy that correlated with the difficulty of "retain" the learned information. As a consequence, she tended to accumulate books, newspapers and videotapes, especially on the mentioned subjects. Experiences of devaluation and insecurity have progressively strengthened and overwhelmed F.'s other areas of life and interest, such as school, relationships and work, described as a tiring run-up. F. has a negative psychiatric history and has no internal pathologies. She is an only child; she lost her father at the age of 6 for cancer disease and has since lived with her mother. For about 15 years she has been engaged to the same man who has been living with F. and her mother for a long time. Further social network remains scarce. Considering the results of the administered tests, we increased the dosage of Paroxetine up to 60 mg/day and set up a cognitive-behavioural psychotherapy program to reduce intrusive thoughts and accumulation conducts that gradually decreased. However, we realized that some unresolved clinical aspects inherent the macro-area of executive functions remained. As a consequence, F. underwent the Adult-ADHD Self-Report Scale (ASRS) [11], namely the first step of ADHD assessment in adults. The self-screening by ASRS was positive and therefore F. was referred to an ADHD specialist center for second level assessment which is still ongoing.

Discussion

Due to the gradual attenuation of obsessive-compulsive spectrum symptoms, further clinical elements, probably attributable to an ADHD core, became clearer and compromised F. psychophysical well-being.

First of all, inattention emerged. This element has to be considered not as an overall absence of attention and concentration, but as a peculiar way of paying attention in relation to the required task, which in F. has taken the form of inability to distribute concentration in an adaptive way [12]. The current job as a data entry employee has become tiring for F. She described this activity as boring and repetitive, even if undertaken for just over a year. In her work, F. remains insecure, making lists and writing down the data entered to confirm the task has been carried out correctly. Instead, she appears capable of maintaining adequate levels of attention when engaged in activities considered interesting and enjoyable, such as participating in a theater-dance course and in a Thai-chi course. F.'s sustained attention also appeared to be reduced in other activities that tend to be an adult prerogative, such as meeting deadlines, fulfilling family duties or filling out forms. Due to concentration skills fluctuations, ADHD people are often judged in different life contexts - even from school age as reported on F.'s school report cards- as indolent, lazy or unmotivated, thus considerably contributing to increase personal suffering [13].

In F., as typically in an ADHD adult, we found a lack of decision-making skills and working memory, with planning deficits, difficulties in starting or completing a task, delaying commitments

[14]. In F.' case, these shortcomings seemed evident especially in the domestic environment, within which F. does not carry out any kind of activity- not even the basic house duties (she does not cook, clean, go grocery shopping or tidy up)- letting her mother take care of it.

Mind-wandering, common in ADHD adults [15], is another trait emerged in F. This phenomenon consists in the tendency to shift attention from an activity in progress to the mental contents of the individual. F. has often reported getting lost in her own thoughts. This would seem to go beyond the classic obsessive rumination and crosses over into an excessive mental wandering. Mind-wandering is mentioned in the DSM-V as "the presence of incongruous thoughts" [16]: it is different from obsessions and it appears that ADHD adults are unable to interrupt their own flow [17]. Therefore, in these people the coerciveness concerns mental wandering and not obsessions as it happens, instead, in the OCD.

Another emblematic element found in F., and transversal manifestation in ADHD adults with preeminent inattention [18], is slowness. It manifests as a low level of activity, conceptually linked to dysfunctional syndromes which usually involve working memory deficits and which cause ADHD people to appear passive, withdrawn or detached [19]. F. seemed slow in thinking, making decisions, formulating sentences and answering questions in a timely manner. This element, however, could also be the result of the doubtful quality of her obsessions.

The current evidence available on adult patient samples is scarce and does not allow to accurately quantify the rates of comorbidity between ADHD and OCD. Therefore, a good psychopathology knowledge of these two disorders represents the main tool for differential diagnosis and exclusion of false comorbidity conditions. The attention/concentration difficulties, typical of these two pathologies, can represent symptomatic epiphenomena of different psychopathological nucleus [20]. In the OCD, inattention is a consequence of the persistence, intrusiveness and egodistonia of obsessions and, together with the need to implement compulsions, leads to a consequent impairment of executive functions, with greater slowness in the execution of daily activities and a tendency to procrastination [21]. In this respect, some authors speak of ADHD-like symptoms [22]. In the case of F., however, inattention seems to be a separate and antecedent dimension to the structuring of the OCD, which we phenomenologically understand as an attempt to stem the suspected attention deficit. Regarding the comorbidity between ADHD and OCD, few authors in the literature have studied how the coexistence of these disorders can affect the clinical manifestations of both. Recent evidence suggests that coexistence of these pathologies determines a synergistic effect on the impairment of the individual's functioning, especially in the workplace, greater than the one determined by the disorders individually [23]. It has also been hypothesized that ADHD/OCD condition is characterized by a greater prevalence of predominant inattention ADHD form [24]. However, in regards to obsessive-compulsive symptoms, some authors have highlighted a relationship between ADHD/OCD and the dimension of "accumulation" [25] precisely found in F.

Conclusion

This case-report wants to highlight how a clinician should carefully explore not only symptoms present today but also those experienced in the past. In addition, a clinician shouldn't focus only on the most evident problematic aspects, but should also grasp those subtle signs of difficulty which otherwise might get undetected. Their recognition would offer a deeper assessment and an adequate subsequent treatment setting [26]. For the purposes of an adequate diagnostic evaluation, it is also essential to remember that DSM-V works as a compass in the diagnostic orientation of ADHD in adults, but at the same time has limitations. On the one hand, we point out the categorical approach, which would not be adequate to describe a dimensional disorder such as ADHD, which develops along a continuum. On the other hand, we report the lack of thoroughness of the symptoms chosen as diagnostic criteria, from which some specific problems of the disorder have been excluded, such as: the difficulty of managing time, tendency to procrastinate, low frustration tolerance, emotional dysregulation and a scarce attention to the changes in the disease symptomatic presentation between the various ages of life (the criteria of adults are similar to those of children).

We also want to emphasize the need for further studies relating to ADHD and its comorbidities. More specifically, with regard to the coexistence of ADHD/OCD, further data are need to accurately estimate the rates of this comorbidity in adult patient populations in order to better understand how the coexistence of these two pathologies can affect the clinical and prognostic profile.

References

1. Asherson P, Buitelaar J, Faraone SV, et al. Adult attention-deficit hyperactivity disorder: key conceptual issues. The Lancet Psychiatry. 2016; 3: 568-578.
2. Adler LA, Spencer T, Stein, et al. Best practices in adult ADHD: Epidemiology impairments and differential diagnosis. CNS Spectr. 2008; 13: 4.
3. Asherson P, Manor I, Huss M. Attention deficit/hyperactivity disorder in adults: update on clinical presentation and care. Neuropsychiatry. 2014; 4: 1-20.
4. Kessler RC, JG, Adler LA, et al. Structure and diagnosis of adult attention-deficit/hyperactivity disorder: analysis of expanded symptom criteria from the Adult ADAD Clinical Diagnostic Scale. Archives of general psychiatry. 2010; 67: 1168-1178.
5. Faraone SV, Biederman J, Mick E. The age-dependent declineof attention deficit hyperactivity disorder: a meta-analysis of follow-up studies. Psychological medicine. 2006; 36: 159-165.
6. Mersin Kilic S, Dondu A, Memis CO, et al. The Clinical Characteristics of ADHD and Obsessive-Compulsive Disorder Comorbidity. Journal of of Attention Disorders. 2020; 24: 1757-1763.
7. First M, Williams J, Karg R, et al. Structured Clinical Interview for DSM-5- Clinician Version. American Psychiatric Publishing. 2016.

8. Goodman WK, Price LH, Rasmussen SA, et al. Yale-Brown Obsessive Compulsive Scale (Y-BOCS). Development, use, and reliability. Archives of General Psychiatry. 1989; 46: 1006-1011.
9. Tolin DF, Frost RO, Steketee G. A brief interview for assessing compulsive hoarding: the hoarding rating scale-interview (HRS). Psychiatry Res. 2010; 178: 147-152.
10. Frost RO, Steketee G, Grisham J. Measurement of compulsive hoarding: Saving inventory-revised (SIR). Behav Res Ther. 2004; 42: 1163-1182.
11. Kessler RC, Adler L, Ames M, et al. The World Health Organization Adult ADHD Self-Report Scale (ASRS): a short screening scale for use in the general population. Psychol Med. 2005; 35: 245-256.
12. Mostert JC, Onnink AMH, Klein M. et al. Cognitive heterogeneity in adult attention deficit/hyperactivity disorder: a systematic analysis of neuropsychological measurements. European Neuropsychopharmacology. 2015; 25: 2062-2074.
13. Surman CBH, Biederman J, Spencer T, et al. Understanding deficent emoziona self-regulation in adults with attention deficit hyperactivity disorder: a controller study. Attention deficit and hyperactivity disorders. 2013; 5: 273-281.
14. Skodzik T, Holling H, Pedersen. Long-term memory performance in adult ADHD. Journal of attention disorders. 2017; 21: 267-283.
15. Seli P, Smallwood J, Cheyne JA, et al. On the relation of mind wandering and ADHD symptomatology. Psychonomic bulletin & review. 2015; 22: 629-636.
16. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-V) 5th ed. APA, Washington DC. 2013.
17. Lanier J, Noyes E, Biederman J. Mind wandering (internal distractibility) in ADHD: a literature review. Journal of attention disorders. 2021; 25: 885-890.
18. Stern A, Pollak Y, Bonne O, et al. The relationship between executive functions and quality of life in adults with ADHD. Journal of Attention Disorders. 2017; 21: 323-330.
19. Tucha L, Fuermaier ABM, Koerts J, et al. Sustained attention in adult ADHD: time-on-task effects of various measures of attention. Journal of neural transmission. 2017; 124: 39-53.
20. Abramovitch A, Dar R, Mittelman A, et al. Comorbidity between Attention Deficit/Hyperactivity Disorder and Obsessive-Compulsive Disorder Across the lifespan: a systematic and critical review. Harvard Review of Psychiatry. 2015; 23: 245-262.
21. Tan O, Metin B, Metin S. Obsessive-compulsive adults with and without childhood ADHD symptoms. Attention Deficit Hyperactivity Disorders. 2016; 8: 131-138.
22. Adler LA, Faraone SV, Spencer TJ, et al. The structure of adult ADHD. International journal of methods in psychiatric research. 2017; 26: e1555.
23. Blanco-Viera T, Santos M, Ferrao A, et al. The impact of attention deficit hyperactivity disorder in obsessive-compulsive disorder subjects. Depress Anxiety. 2019; 36: 533-542.
24. Wilens TE, Biederman J, Faraone SV, et al. Presenting ADHD symptoms, subtypes, and comorbid disorders in clinically referred adults with ADHD. The Journal of Clinical Psychiatry. 2009; 70: 1557-1562.
25. Sheppard B, Chavira D, Azzam A, et al. ADHD prevalence and association with hoarding behaviors in childhood-onset OCD. Depression and Anxiety. 2010; 27: 667-674.
26. Kooij JJS, Bejerot S, Blackwell A, et al. European consensus statement on diagnosis and treatment of adult ADHD: The European Network Adult ADHD. BMC Psychiatry. 2010; 10: 67.