Addressing the ADHD Symptom Triad:
Focus, Emotional Dysregulation, and Psychiatric Comorbidities

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Attention deficit disorders have been traditionally viewed, and treated, as purely disorders of attention and hyperactivity. Stimulant therapy remains standard of care, first-line treatment. However, when ADHD is viewed correctly as a cluster of symptoms, that manifest to varying degrees, it becomes clear that stimulant therapy addresses only one aspect of the condition. Traditional therapy may even worsen core symptoms, through direct side effects, and interference with nutritional balance.

The following cases demonstrate that addressing the complete condition of ADHD may result in the dramatic resolution of multiple symptoms, not achieved by targeting only behavioral or attentional control.

Case 1: A 17-year-old female presented with a history of ADHD, diagnosed at age seven. She also reported emotional dysregulation, involving bouts of depression, irritability, poor frustration tolerance, and comorbid anxiety. Tearful episodes were independent of menses or social stressors. With stimulant therapy (amphetamine/dextroamphetamine, 20 mg a day) she reported an improved attention span, yet a worsening in mood and anxiety issues, and a marked increase in irritability. EnLyte, one per day was added, with partial success noted at two weeks. Lexapro 10 mg a day was added, and MADRS reduced from 25 to 6 by week 4. Once her stimulant dose was halved, she reported a full resolution in the above symptoms.

Case 2: A 13-year-old female, with ADHD since early childhood, reported emotional dysregulation (inability to control moodiness and irritability), and depression, with dysphoria, social avoidance and academic difficulties. Her dosage of clonidine was continued for ADHD, and daily EnLyte and cognitive therapy were successful at treating the above symptoms. Her MADRS of 21 was reduced to 5 by week seven.

Case 3: A 14-year-old male, with ADHD, emotional dysregulation, and major depression, presented with despondency, dysphoria, avoidance of school, and initial insomnia. Daily EnLyte was added adjunctively to delayed release methylphenidate (20 mg a day). Depression resolved, (MADRS decreased from 24 at presentation to 6 by week eight, as did insomnia, mood swings, and avoidant behaviors). Remission has continued for 2 years.

Case 4: A 10-year-old male, with ADHD, presented on slow release and immediate release methylphenidate therapy (20 mg slow release each morning, and 5 mg immediate release when arriving home from school). "Moodiness, irritability, and feeling down most of the time," were listed as presenting complaints. Past trials of fluoxetine (10 mg a day) and escitalopram (20 mg a day) were perceived by parents a worsening the above symptoms. Enlyte daily was added to his stimulant therapy, resulting in a remission of MDD (MADRS of 21 to 6 by week 8) and overall symptom resolution, which is sustained over one year at present.

Case 5: A 7-year old girl with ADHD had benefited from 27 mg of extended release methylphenidate as far as focus and grade improvement, however, poor frustration tolerance led to anger outbursts, followed by remorse, periods of dysphoria, and guilty ruminations. Parents believed that the stimulant worsened the mood symptoms, and requested a decrease to 18 mg a day, which returned the emotional and mood issues to a baseline that was still problematic. Once daily Enlyte resolved these issues with only "minor flare-ups" within six weeks of therapy, and she has remained on the combination for over two years.

Case 6: A 7-year old boy was depressed following his parent's separation. His baseline status of ADHD was controlled with liquid methylphenidate, 25 mg a day, and usual struggles with difficulty modulating anger, and overall emotional control were exacerbated. Fluoxetine 10 mg a day was successful at reducing anger outbursts, but not for overall stabilization of moods. MADRS remained unchanged after 4 weeks of therapy. EnLyte was added, once daily, with improvement in symptoms, MADRS was reduced from 14 to 6 at the end of 12 weeks.

Case 7: A 5-year-old girl had been in foster care since a young age and had been on a variety of stimulants for the year prior to presentation. She was engaged in individual therapy and was taking low dose lithium with clonidine for behavioral control at the time she presented with dysphoria, emotional outbursts, and crying spells. Lithium levels were low, but dose escalations in the past resulted in nausea and tremors. EnLyte daily was added to her therapy, and she reported marked symptom reduction by week three. There were still anger issues, but less intense, and less frequent according to caregivers.