Antisocial or Impulsive ? A case report on Adult ADHD and Antisocial Personality Disorder Comorbidity

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Background

Antisocial personality disorder (APD) is characterized by a disregard for social and moral norms and others, impulsiveness, recklessness and unlawful behavior, leading to interpersonal and social difficulties. Specific Diagnostic criteria for APD are still under debate.

Adult Attention Deficit Hyperactivity Disorder (ADHD) affects up to 7.6% of adult patients, being present in about 60% of kids reaching adulthood. It is defined as inappropriate levels of inattention, hyperactivity or impulsivity causing impairment. The DSM 5 diagnostic criteria are divided between inattention criteria and hyperactivity and impulsivity symptoms (table 1). At least six or more criteria of one category must be present to make the diagnosis of predominantly inattentive or predominantly hyperactive presentation, or combined presentation if at least six criteria from both groups are met simultaneously. Symptoms must also be **present prior to age 12 and in two or more settings, having functional impact and not being better accounted for by other mental disorders**.

There is established association between ADHD and Personality Disorders with comorbidity ranging from 10 to 75% depending on samples, the most common being Antisocial Personality Disorder and Borderline Personality Disorder. ADHD significantly increases risk of personality disorder, with a 5.8 hazard ratio.

We present a case report of an adult male patient who attended an appointment concerned about his violent and erratic behavior which had put him various times at odds with the judicial system. He complained about anxiety, inability to control his impulses and difficulties in maintaining relationships

Identification, sociodemographics

Male, 27 y/o, 2 children (7 and 9 y/o) from 2 different past relationships.
9th grade at 18 y/o (normal age for completion is 14)
Currently unemployed. Earns money via illegal drug related activity.
Living alone in social housing

Psychiatric/Medical History

No psychiatric history
13 ER episodes related to traumatic episodes inflicted in skirmishes and physically aggressive contexts
No ongoing Medications
Familial Psychiatric History :

- Mother and father: alcohol and drug abuse.
- Younger brother: ADHD at 8 y/o, treated with metilphenidate with good clinical response.

Substance Abuse :

- 40 cigarettes daily.
- No alcohol or drug consumption

Clinical Course

Main Complaints
Persistent Anxious Mood, **Difficulty controlling his impulses** (“too short fused” and “unable to control myself when I get nervous”), **Erratic and hetero-aggressive behavior** which the patient struggles to suppress, **Worry about his tobacco consumption**, which increases mainly during periods of more anxiety, **Difficulty maintaining interpersonal relationships**, **Inability to focus and easy distractibility** (“unworthy of trust, professionally”). Denies complaints of depressed mood or other depressive symptoms, obsessive thoughts or compulsive behavior
Psychiatric and biographical history :
Pattern of disruptive behavior starting around age 16, mainly through small skirmishes with school colleagues, which progressed to criminal behavior starting at 20y/o related to drug activity (help with storing and protecting drug stashes) and a pattern of problem solving centered mainly around violence and detachment from others.
School period: Persistent difficulty in sustaining attention, staying still, following orders, as well as a constant fidgeting and feet tapping and a tendency to excessive talking (observed during the interview) and interrupting others. These complaints are present, according to the patient “since he can remember himself”, and are described as **impactful during childhood (mainly concerning learning) and adulthood (in previous works and interpersonal relationships)**.
Mental State Examination: Restless behavior, anxious mood and affect, fast paced speech, but easily interrupted, No delusions, hallucinations or behavior suggestive of such. No suicidal thoughts. No other alterations on MSE

Workup/Diagnosis, Treatment and Follow-Up

Workup:
Psychiatric interview, clinical, biographic and psychiatric history.
Complete blood and urine analysis, including drug test and thyroid function – **All results Normal**
Adult ADHD Self-Report Scale (ASRS v1.1) (table 2) – Scored 3 “often” and 3 “very often” in Part A and 7 “often” and 5 “very often” in Part B. Results suggest, in addition to and biographic history, high likelihood of ADHD.
Diagnostic : Adult Attention Deficit Hiperactivity Disorder
Treatment:
– Atomoxetine 20mg 2id, adjusted to 40mg 2id a week after initial dose.
Follow-up:
Patient observed on a weekly basis for three weeks and then monthly. Shown **clinical improvement** in anxiety and restlessness, attention deficits, focus capacity, mood, relational and impulsive behavior. Started job as a hotel clerk, reporting good adaptation and performance.

Conclusion

ADHD is still underdiagnosed in the adult population. It is an impactful clinical entity, starting during childhood, influencing development and life of an individual. It requires an early diagnosis and steady treatment in childhood putting poorer patients in risk of underdiagnosis or misdiagnosis. As several of ADHD symptoms can present themselves with behavioral features, such as restlessness, misbehavior in school and severe difficulty in learning, children can be put in a path of marginalization and delinquency from early on. Adding to that the increased drug consumption observed in ADHD patients (looking for the drug’s “therapeutic effect”) patients may present biographical history suggestive of APD, justifying the observed diagnostic overlap.

Differential Diagnosis requires attention to patient’s history, chronological symptom appearance and evolution, and attention to behavior pattern and empathy. ADHD symptoms should be present since early on and show predictable evolution over time. Behavior stemming from APD is undertaken with a lack of empathy and a sense of instrumentalisation of others

Of the therapeutic options available, stimulants are by far the most commonly used, but pose abuse potential, so when there is a substance abuse risk, atomoxetine is safer.

This case report highlights the importance of considering adult ADHD in patients presenting with a history of misbehavior, delinquency and symptoms of relational instability, anxiety, substance abuse, in order to allow for a partial and life-improving treatment.

ADHD HYPERACTIVE, IMPULSIVE SYMPTOMS	ADHD INATTENTION SYMPTOMS
<ul style="list-style-type: none">• Fidgets with hands or feet• Leaves seat in classroom or situations where sitting is expected• Runs about or climbs excessively inappropriately• Has difficulty playing quietly• Often on the go “as if driven by a motor”• Talks excessively• Blurts out answers even before question is completed• Difficulty awaiting turn• often interrupts others	<ul style="list-style-type: none">• Has difficulty sustaining attention &makes careless mistakes• Doesnot give close attention to details• Doesnot seem to listen• Doesnot follow through• Has difficulty organizing tasks• Avoids engaging in tasks requiring sustained mental effort (eg homework)• Often loses necessary things (toys, pencil, books etc)• Easily distracted• Forgetful in daily activities

Table 1. ADHD Hoyoeractive and Innatention Symptoms

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist					
Patient Name	Today's Date				
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an 'X' in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.					
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	Never	Rarely	Sometimes	Often	Very Often
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
Part A					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
Part B					

Table 2 . ASRS v1.1

References

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