

## CO-MORBID NEURO-BIOLOGICAL CONDITIONS: What's Really going On?

This is the fourth in a series of articles on child and adolescent mental health and the implications for special education. This article focuses on an overview of the various conditions, formally referred to as Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence according to the DSM-IV TR, the psychiatric bible. For those of you unfamiliar with this publication, it is the Diagnostic & Statistical Manual of Mental Disorders, 4<sup>th</sup> edition, Text Revision, 2000 (i.e. some updates after the initial version of DSM-IV was released in 1994). The release date of a hoped for 5<sup>th</sup> edition is unknown. The DSM is published by the American Psychiatric Association. An excellent internet resource for the material contained within the DSM-IV TR is <http://www.behavenet.com> (DSM links are on the right).

The following conditions are those covered under the above heading regarding child and adolescent conditions:

- Mental Retardation
- Learning Disorders in math, reading and written expression.
- Motor Skills Disorders
- Communication Disorders such as stuttering.
- Pervasive Developmental Disorders which include Asperger and Autism among others.
- Attention-Deficit and Disruptive Behavior Disorders which include Attention-Deficit/Hyperactivity Disorder, Conduct Disorder and Oppositional Defiant Disorder.
- Feeding and Eating Disorders of Infancy or Early Childhood that include anorexia and bulimia.
- Tic Disorders such as Tourette Syndrome.
- Elimination Disorders: Encopresis, Enuresis
- Other Disorders of Infancy, Childhood, or Adolescence such as Separation Anxiety Disorder and Reactive Attachment Disorder.

This list of conditions is overwhelming. And, it does not mention other conditions such as Early Onset (or Pediatric) Bi-Polar disorder, other mood disorders such as depression, anxiety states and substance abuse issues. There is, seemingly, no end to the mental health/behavior/personality challenges faced by children and adolescents.

I do not intend, in this article, to cover each and every condition. With some, such as learning disorders and pervasive developmental delay concerns (which I refer to as the traditional special education camp – see previous articles about this), I do not have expertise. This article provides an overview of co-morbidity among these various conditions. Subsequent articles will address specific disorders.

In my clinical thinking I refer to co-morbid conditions as “First Cousins.” In my seminars I tell attendees, “These are the family members that all show up and gather around the table for say, Thanksgiving Dinner. They are there because they are all part of the family, whether you like them or not.”

Clinically, co-morbidity means that the person has more than one condition wherein the conditions and their symptoms and manifestations overlap and blend together to create a

unique clinical picture for that individual. For instance, Obsessive-Compulsive Disorder (OCD) is highly co-morbid **with** Attention Deficit Hyperactivity Disorder (ADHD). That means that if a kid has ADHD, it is highly likely that s/he will also have OCD along with it. Tourette Syndrome (TS) **with** ADHD is another example. Bear in mind though that just because ADHD is highly co-morbid with TS does not mean that TS is highly co-morbid with ADHD. Co-morbidity does not go in both directions. Look at it as a one-way street. One must start with a specific condition and determine what is co-morbid with it. And, once that's done, it does not go in reverse. Or, to put it another way, just because you have ADHD as a co-morbid condition to the primary diagnosis of TS does not mean that if you have ADHD that you also have a good shot at having TS. Each situation is unique and must be deciphered individually. What is clear is that the more co-morbid conditions one has, the more severe and challenging is that person's situation.

Studies on co-morbidity indicate no less than double-digit probabilities that 2 or more neuro-biological conditions, along with the traditional educational matters such as learning disabilities and processing disorders, will exist simultaneously. Such combined co-morbidity (i.e. mental health and educational conditions) wrecks havoc emotionally and behaviorally and clearly impacts educational pursuits. It all adds up to present severe challenges for all involved.

At any given time, any one neuro-biological condition can predominate. Sometimes, for instance, with TS and ADHD and OCD all co-mingling in one individual, it's difficult to determine what condition is actually generating a specific behavior. Could it be that a specific physical tic is not really coming from the Tourette piece, but is rather some sort of OCD manifestation as the person attempts to get all the pieces lined up so everything feels "just right," which also sounds a bit like a sensory integration issue. Deciphering situations such as that can be quite challenging. It is imperative **NOT** to pigeon-hole these kids by trying to assign certain manifestations to specific conditions. That defeats the whole notion of co-morbidity which is to see that the individual has enough observable criteria to support more than one clinical condition, yet the melding/blending/overlapping of them presents a picture unique to that individual. It's the multi-function system of the mind, analogous to the kind Hewlett-Packard makes for office use. When you go to Staples and look at those devices, what do you see? The scanner? The copier? The printer. The fax machine? Depending on what's going on, you use that specific function, yet you realize that it's an AIO (i.e. all-in-one) device, a complete package. No one piece is necessarily better or stronger or more useful than any other or in our case, more challenging. It's integrated. The machine/person as-a-whole is what's important.

In my therapeutic approach, I tend not to focus on the specific conditions. Rather, I work with the individual to ascertain conceptually what's bothering them, realizing that the concern(s) will change over time. For instance, in working with a teenage girl with TS, ADHD, OCD and ODD, her main "problem" seemed to be that she got stuck cognitively and emotionally. That "stuckness" generated severe frustration which in turn led to meltdowns. My main focus became trying to "loosen her up," so she could become more flexible and, in my words, get out of her own way. (See Ross Greene's book about frustration, listed in the resource section at the end of the article).

Co-morbidity also presents challenging situations medically in the use of psychiatric medications. There are questions about which disorder to treat first and about the

implications that one medication may have on other, co-morbid, conditions. Historically, for instance, with TS & ADHD, accepted thinking has been that if there was a need to treat ADHD with stimulant medication because of the severity of the ADHD, that in doing so it might exacerbate the Tourette tics. Also, at times, conditions are prioritized. Bi-Polar Disorder, for example, requires attention to mood stability before, let's say, any accompanying co-morbid ADHD or OCD considerations. Note that I am in no way making any medical claims here regarding the use of any medication. Further, I am not here to debate the use of psychotropic drugs in any way. I am merely raising the nature of the issues concerning this type of intervention.

When it comes to the educational setting, intertwining conditions present complicated challenges to those charged with educating that child. A major classroom issue with kids is that of motivation. Again, not being clinicians, school personnel are often in a quandary as to how to "interpret" a child's apparent lack of motivation. Let's say a child has been diagnosed with various co-morbid conditions. The questions then become, "Is the child's seeming or assumed lack of motivation due to outside environmental factors such as family dysfunction? Is it due to a clinical depression or is it the distractibility/lack of attention engendered by ADHD? Or, is the child merely being a child (as even an 8 year old with these conditions is still an 8 year old)?" If the child was diagnosed with ADHD, a learning disability and depression, any and all of those conditions can be playing on the situation. Understanding the different specific conditions let alone the interplay between them poses difficult hurdles for school personnel to surmount.

In working with anyone challenged by any condition mentioned in this article or a combination of them, it is imperative that we view the individual as a complete person. We should not make any assumptions about a child or adolescent which results in labeling them as lazy or stupid or just a bad apple. Such "moralizing" labels are often applied to these kids, a process which only serves to engrain a stigmatizing and prejudicial attitude. Above all, we need to change the way we think about people with these conditions and how we interact with them, clinically and educationally. Acknowledging the individual-as-a-whole and treating them as a legitimate person are the initial keys to successful intervention.

In this fast paced culture it's inevitable that those in charge want these conditions fixed and they want them fixed quickly. The imperative to correct or eliminate "bad behaviors" in the classroom is debilitating to all involved. A strict behavioral approach fails to see, understand and appreciate the complexities of these brain-based conditions.

These kids are different. That they are does not make them "less than," or second class citizens. We have to realize that the "normals" have to make efforts to work with the "abnormals" in ways that are outside the box. Trying to make them respond in the usual fashion for the sake of order and acceptable behavior will only frustrate everyone. Realize that they did not choose to have these conditions, that the act of having them is, for them, consequence enough. They are not the way they are on purpose.

Next in the series will be information/discussion on the various child and adolescent mental health conditions previously mentioned in this series of articles. They will, as does this article, appear on The Greenfield Optimist. Please check back regularly for this continuing series.

## RESOURCES

### Books:

Blakemore, Sarah-Jayne & Uta Firth. *The Learning Brain: Lessons for Education*. Blackwell Publishing, Malden, MA. 2005.

Crist, James J., Ph.D. *ADHD: A Teenager's Guide*. Childswork/Childsplay, LLC. Plainview, NY. 1997.

Greene, Ross, Ph.D. *The Explosive Child: A New Approach for Understanding an Parenting Easily Frustrated, Chronically Inflexible Children*. Harper-Collins Publishers, Quill Edition. 2001.

Hallowell, Edward M., M.D. *Crazy Busy: Overstretched, Overbooked and About to Snap!. Strategies for Coping in a World Gone ADD*. Ballantine Books, NY. 2006.

Kutscher, Martin, M.D. *Kids in the Syndrome Mix of ADHD, LD, Aperger's, Tourette;s, Bipolar and More! The one stop guide for parents, teachers and other professionals*. Jessica Kingsley, Philadelphia. 2005.

Ornstein, Robert & Charles Swencionis, eds. *The Healing Brain, A Scientific Reader*. Guilford Press, New York. 1990.

Silver, Larry, M.D. *The Misunderstood Child, Fourth Edition: Understanding and Coping with Your Child's Learning Disabilities* (Paperback). Three Rivers Press, 2006.

Tohen, Mauricio, ed. *Comorbidity in Affective Disorders*. Marcel Decker, Inc., New York. 1999.

### Internet:

*Neuroscience for Kids: Explore the Brain and Spinal Cord*. See the section on neurological and mental disorders. <http://faculty.washington.edu/chudler/introb.html>

ADDitudeMag.com - Common Comorbid Conditions Associated with ADHD  
<http://www.additudemag.com/adhd/article/1476.html>

The following are the links to the previous articles in this series on T.G.O.:

Article #1 – Massachusetts Legislation re: Child & Adolescent Mental Health:  
[http://www.greenfieldoptimist.com/index.php?option=com\\_content&task=view&id=220&Itemid=29](http://www.greenfieldoptimist.com/index.php?option=com_content&task=view&id=220&Itemid=29)

Article #2 – One Crisis in SpEd: Child & Adolescent Mental Health:  
[http://www.greenfieldoptimist.com/index.php?option=com\\_content&task=view&id=248&Itemid=29](http://www.greenfieldoptimist.com/index.php?option=com_content&task=view&id=248&Itemid=29)

Article #3 – SpEd & Mental Health: What the Numbers Really Say:  
[http://www.greenfieldoptimist.com/index.php?option=com\\_content&task=view&id=253&Itemid=29](http://www.greenfieldoptimist.com/index.php?option=com_content&task=view&id=253&Itemid=29)

Garry L. Earles, L.I.C.S.W. is a Licensed Independent Clinical Social Worker in Franklin County. With a national reputation as a seminar presenter on child & adolescent mental health disorders such as ADHD, Obsessive Compulsive Disorder, Early Onset Bi-Polar Disorder, Tourette Syndrome, etc., he has trained thousands of mental health professionals and educational personnel. He also provides direct therapeutic services to clients as well as phone consultations. He is available for public speaking engagements. For more information, please visit: <http://www.garryearles.com>.

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