Treatment of Comorbidity of ADHD-OCD

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TREATMENT OF COMORBIDITY OF ADHD-OCD

Adults with attention deficit hyperactivity disorder (ADHD) can be considered difficult to diagnose, usually exhibit symptomatology such as impulsivity, restlessness, and other related symptoms, as well as commonly have a comorbidity (Edwin, 2011). Clients with ADHD usually suffer with an anxiety disorder (Sobanski, 2006), such as obsessive compulsive disorder (OCD). Clients with OCD tend to suffer from intrusive and exaggerated thoughts as well as compulsive and ritualistic behavior patterns (Podea, Suciu, Suciu, & Ardelean, 2009). Obsessions related to thoughts and behaviors usually occur with such individuals and cause difficulties with relationships and goals as well as daily life in general.

Clients who exhibit typical behaviors of OCD can suffer from constant intrusive thoughts that are considered as overly important (Podea, Suciu, Suciu, & Ardelean, 2009), which can cause distress. Behaviors can be affected by such obsessive and negative thinking patterns. Despite a growth in awareness of such negative thinking patterns, clients appear to struggle to control such related behaviors, as if having no choice. These behaviors can become compulsions.

If we consider a client who has ADHD as well as OCD, we can consider an intertwining of impulsive and compulsive thinking and behavioral patterns as well as increased difficulty with treatment (Fairfax, Easey, Fletcher, & Barfield, 2014). For example, a client with a comorbidity of ADHD-OCD may feel a compulsive and obsessive desire to constantly seek affirmation from a significant other. This same client may also act with impulsivity and feel a compulsive need to react towards a significant other in order to obtain affirmation. The client can perceive everyday interactions from others or significant other in a general negative manner, such as a perceived rejection and abandonment, which can lead to reactive behaviors. We can see a pattern of dysfunctional thinking and behaviors with such a client.
TREATMENT OF COMORBIDITY OF ADHD-OCD

We may presume that ADHD-OCD has a direct affect on the client’s ability to change certain dysfunctional thinking and behavioral patterns, based in part on a possible obsessive need for affirmation from others, and possibly related feelings of low self-worth brought on from issues of childhood development (Erikson & Erikson, 1998; Newman & Newman, 1991). Clients can find that changing thinking and behavioral patterns can be difficult. More on how a disruption in childhood development can influence development of ADHD-OCD is discussed below.

To further understand treatment it is important for counsellors and therapists to understand some of the nature of the comorbidity of ADHD-OCD, such as how impulsiveness and compulsiveness can interact (Palumbo & Roger Kurlan, 2007). Impulsiveness and compulsiveness may intertwine and influence the behaviors of such clients. Again, a client with ADHD-OCD may exhibit a constant need to act in an obsessive-compulsive manner. Being impulsive may further hinder control of such obsessive-types of behaviors.

This paper also focuses on impulsivity as being a main factor of ADHD and compulsivity associated with OCD (Brem, Grünblatt, Drechsler, Riederer, & Walitza, 2014), and how these factors relate to effective treatment approaches. Again, we may consider that impulsive and compulsive behaviors may intertwine and together cause difficulties with goal oriented behaviors within a social context. Such clients can have difficulty within the social environment that can hinder obtaining desired goals and outcomes. Thus, focusing on treatment towards self-awareness and changing such behaviors is also a main focus of this paper. Impulsiveness of ADHD and compulsiveness of OCD on opposite ends of the same spectrum may actually intertwine, causing an array of difficulties within the social life of such individuals who suffer from a comorbidity of ADHD-OCD.
TREATMENT OF COMORBIDITY OF ADHD-OCD

We will also focus on common symptomatology and comparison of ADHD and OCD to help understand assessment and treatment approaches. Counsellors and therapists can further understand treatment of adult clients who suffer from a comorbidity of ADHD-OCD via cognitive behavioral therapy CBT (Ramsay, 2017) and mindfulness techniques (Fairfax, Easey, Fletcher, & Barfield, 2014), as well as motivational enhancement therapy (Korte & Schmidt, 2015), all of which are discussed below. We will also look briefly at possible medications to help better inform clients.

Lastly, clients with ADHD-OCD may require help with acceptance of having certain thoughts and feelings as not necessarily being negative, as well as accepting certain attitudes and behaviors of others and thus the use of acceptance and commitment therapy (ACT) (Hallis, Cameli, Dionne, & Knäuper, 2016) can possibly benefit such clients. We will now look at the etiology of ADHD-OCD, as part of understanding the background necessary for effective treatment.

Etiology

In order to better treat adults with a comorbidity of ADHD-OCD effectively, we can consider the effects of a disruption in childhood development caused from emotional or other forms of abuse during childhood upbringing, or simply a child not having certain needs met with during development. Environmental stressors such as childhood trauma may be part of the development of ADHD (Szymanski, Sapanski, & Conway, 2011). ADHD and OCD both appear to be related to stress as well as possible dysfunction (Abramovitch, Dar, Mittelman, & Wilhelm, 2015), such as the development of dysfunctional thinking and behavioral patterns.

As a child moves through the stages of development, certain behavioral and social challenges that are not met with successfully can cause issues with being unable to function at a
A developing child must meet social challenges in order to function healthy within the surrounding social environment, and a disruption in such development can cause issues of healthy functioning such as difficulty with trust and feelings of being unworthy of love and affection (Erikson & Erikson, 1998; Newman & Newman, 1991).

Dysfunctional core beliefs can also result from such disruption of development. The core belief of low self-worth seems to contribute to obsessive thinking in the form of a constant need for affirmation. Children can develop feelings of extreme low self-worth that can likely transcend into adulthood and can cause difficulty functioning on a healthy level within the social environment and within relationships in general.

We can see a possible connection with childhood trauma related to development of both ADHD and OCD (Abramovitch, Dar, Mittelman, & Wilhelm, 2015). A child may also feel abandonment and have difficulty developing a healthy level of attachment (Erikson & Erikson, 1998; Newman & Newman, 1991). Insecurity within intimate and other types of relationships can development and lead to obsessive or reactive types of behaviors associated with OCD and possibly ADHD.

We can also consider that impulsivity can develop as a result of such childhood trauma that may also hinder a client’s ability to change dysfunctional patterns of thinking and behaviors. Impulsivity is part of the diagnosis of ADHD. “According to the DSM-IV-TR, central criteria for diagnosing attention deficit/hyperactivity disorder (ADHD) are the presence of symptoms of inattention, impulsivity, and hyperactivity” (Szymanski, Sapanski, & Conway, 2011, p. 52). If impulsivity is an issue with certain clients who are diagnosed with ADHD and possibly OCD,
TREATMENT OF COMORBIDITY OF ADHD-OCD

and who have suffered from trauma, then treatment with use of CBT can be considered effective (Ramsay, 2017).

Clients may suffer from avoidance behaviors and blaming of self as well as have possible distorted thinking patterns that contribute to maintenance cycles. Such clients may also be impulsive. CBT can help target thoughts and feelings that can contribute towards impulsivity, by targeting and questioning impulsive behaviors. The result is to help clients not only change distorted thinking patterns and cognitions but impulsive behaviors associated with such patterns.

We can also consider a main causation of ADHD as being genetic (Abramovitch, Dar, Mittelman, & Wilhelm, 2015; Beaver, Nedelec, Rowland, & Schwartz, 2012), as well as OCD also being possibly inherited (Abramovitch, Dar, Mittelman, & Wilhelm, 2015). This may lead us to believe that comorbidity of ADHD-OCD is largely part of the genetic makeup of certain clients.

However, as mentioned, we can also consider stressors within childhood upbringing as a possible causation of ADHD (Szymanski, Sapanski, & Conway, 2011), as well as similarly for the development of OCD (Abramovitch, Dar, Mittelman, & Wilhelm, 2015). Therefore, individuals who develop a comorbidity of ADHD-OCD appear to be prone to this development due to a combination of genetics and trauma experienced during childhood upbringing. Trauma in this case may be perhaps even considered as a lack of needs met during childhood development.

Comparison of environmental stressors versus inherited genes that can influence development of ADHD-OCD goes beyond the scope of this paper. What is important to understand in order to aim for effective treatment, are the differences and similarities between symptoms of ADHD and OCD, as well as possible misinterpretations.
TREATMENT OF COMORBIDITY OF ADHD-OCD

Comparison of ADHD and OCD

In order for counsellors and therapists to treat a comorbidity of ADHD-OCD effectively, understanding of the similarities and differences of ADHD and OCD symptomatology is important. This can help to avoid possible misunderstandings and therefore aim for effective treatment. This and the next section attempt to show an adequate comparison of symptoms, as well as touch on the nature of the comorbidity of ADHD-OCD at the level of impulsiveness and compulsiveness. Before delving into a comparison we will look at the diagnosis and assessment of ADHD-OCD and the importance of accuracy. Discussion of diagnosis and assessment helps to offer a clearer understanding of differences between ADHD and OCD in general.

Diagnosis and Assessment

Counsellors and therapists can discuss with clients the possible formal diagnosis of a comorbidity of ADHD-OCD by a psychiatrist. Counsellors and therapists who are trained to use formal assessment tools can also assess for possible ADHD-OCD. Certain criteria must be met with in order to diagnose and or assess for ADHD-OCD.

According to the DSM-IV, a key aspect of diagnosis of OCD for adults is a certain level of insight into personal symptoms so as to rule out psychosis (Brem, Grünblatt, Drechsler, Riederer, & Walitza, 2014). Also, clients who exhibit some realization of the pointlessness of repetitive obsessive-compulsions in the form of thinking and behaviors are also more prone to positive counselling outcomes through effective treatment approaches (Brem, Grünblatt, Drechsler, Riederer, & Walitza, 2014). Counsellors and therapists can help the client discover insight through the client’s story but also help clients gain insight and self-awareness. Adult clients with OCD should be able to grow in understanding of related symptoms.
TREATMENT OF COMORBIDITY OF ADHD-OCD

and awareness of the kind of senseless behaviors exhibited, and thus start to work towards possible growth and change.

ADHD has a different formal diagnosis. The DSM-IV includes ADHD related to a certain level of inattention, hyperactivity, and impulsivity, as well as being exhibited across several settings such as home and work (Brem, Grünblatt, Drechsler, Riederer, & Walitza, 2014). Clients with ADHD can manifest behaviors that are considered impulsive, acting in a sense with little thought behind such impulsive behaviors. Thus, we can begin to see a combination of impulsiveness and compulsiveness with clients who have a comorbidity of ADHD-OCD. More on impulsiveness and compulsive is discussed below. For now it is important to understand that impulsivity is a key factor of ADHD. Also, compulsiveness is a main symptom of OCD (Spengler & Jacobi, 1998), which further helps to understand the nature of OCD alongside ADHD as well as accurate assessment and diagnosis.

One such method to help conclude that a client truly has ADHD-OCD is to start with the assumption of the client having OCD (Geller et al., 2004). We can refer to studies of youth who have ADHD-OCD and presume the results can apply to adults as well. If a youth client has OCD and exhibits ADHD-type symptomatology, then a comorbidity of ADHD-OCD most likely exists (Geller et al., 2004). Also, assessment tools can be used by counsellors and therapists who are trained in such tools, such as the Child Behavior Checklist (CBCL) (Geller et al., 2004, p. 83), and adapted for use with adults.

Finally, taking into account the level of impulsivity a client may exhibit is important, as well as if the client reveals high compulsivity associated with OCD (Brem, Grünblatt, Drechsler, Riederer, & Walitza, 2014). Listening to the client’s story can help to determine if impulsive and compulsive behaviors exist as a form of informal assessment (Young, 2013). We can consider
that impulsive and compulsive behaviors may intertwine and together cause difficulties with goal oriented behaviors within a social context.

Also, as mentioned above, treatment will largely focus on helping the client to grow in self-awareness and change of such impulsive and compulsive behaviors. Thus, the client can learn to better function in a healthy manner within the social environment and better work towards achieving desired goals. Now, let us consider a comparison of ADHD and OCD, so as to further understand possible effective treatment approaches.

**Differences and Similarities**

Both ADHD and OCD affect different parts of the brain, such as over-activation in the mesial frontal cortex and basal ganglia that can lead to inappropriate reactions in relevance to pursuing goals and cause issues with relationships (Brem, Grünblatt, Drechsler, Riederer, & Walitza, 2014). Whether these parts of the brain are from trauma or genetic influences goes beyond the scope of this paper.

Clients with OCD tend to exhibit obsessive behaviors and thoughts. With ADHD we tend to see a lack of control with responses to others such as impulsiveness. Thus, we can see that a client who has a comorbidity of ADHD-OCD may suffer from an intertwining of obsessive thoughts as well as impulsive and or compulsive reactions to such thoughts. Treatment can focus around helping clients to not only grow in awareness and change possible dysfunctional patterns of behaviors and thinking with use of CBT (Westbrook, Kennerly, & Kirk, 2011), but also to help clients to better learn to react towards others, especially in relation to pursuing goals and relationships in general. Behaviors can be stressed again as a desired focus of change.

Symptomatology of both ADHD and OCD can include: hyperactivity within the orbitofrontal cortex and other areas of the brain, difficulties with executive functioning such as
poor planning and suppression of inappropriate responses in relation to goal oriented behaviors, as well as difficulties with attention span (Abramovitch, Dar, Hermesh, & Schweiger, 2012). For the purpose of this paper and in regards to treatment of a comorbidity of ADHD-OCD, we will also focus on the effects of ADHD-OCD on the ability to have healthy relationships in general and on achieving desired goals. Being able to interact with others within the social environment on a daily basis requires being able to respond in a socially acceptable and appropriate manner within social situations, across time and cultural settings. ADHD and OCD can hinder a client from being able to act and respond towards others in a considered healthy manner, thus harming the chances of achieving desired goals and having healthy intimate and other types of relationships.

We can deduce that adult clients with a comorbidity of ADHD-OCD tend to have difficulty maintaining healthy intimate relationships, as well as relationships with others in general such as in regards to work or educational related settings or other. Skills involved in achieving goals in relation to healthy relationships can involve understanding how to respond to others within a certain social context, planning, and being able to maintain a certain level of attention. Thus, focus of treatment of clients who suffer from both ADHD and OCD should involve ways to plan goal oriented tasks, and how to achieve and maintain healthy relationships in general.

Again, with adult clients having ADHD we can see Symptomatology related to impulsive behaviors, and who may have difficulty understanding social cues and consequences related to social behaviors; whereas with OCD we can see clients who can suffer from having compulsive behaviors, avoiding risks, and as having an obsessive type of concern with exaggerated consequences of social behaviors (Abramovitch, Dar, Hermesh, & Schweiger, 2012). As
TREATMENT OF COMORBIDITY OF ADHD-OCD

mentioned, a comorbidity of ADHD-OCD can cause intertwining effects of both impulsive and compulsive behaviors that can overlap and impact the client’s ability to live a healthy life.

Overall, a client with both ADHD and OCD can exhibit behaviors that can be considered to have negative affects within social settings, causing difficulties obtaining desired goals and having healthy relationships in general. These factors and other factors may also contribute to difficulty with treatment of a client who suffers from both ADHD and OCD. More on possible difficulties with treatment are discussed below. For now, we will look more closely at the nature of a comorbidity of ADHD-OCD.

Nature of a Comorbidity of ADHD and OCD

In this section we will focus on the main difference of impulsiveness being associated with ADHD and compulsiveness being associated with OCD. We will look closer at how impulsive and compulsive behaviors can interact and cause difficulties within the social environment.

Impulsivity and Compulsivity

We can consider studies on the relationship between impulsivity and compulsivity related to clients who suffer from Tourette’s syndrome (Palumbo & Kurlan, 2007), in order to better understand how ADHD and OCD can affect behaviors. We can therefore improve upon treatment. Clients with ADHD-OCD can be burdened with impulsive behaviors but within a certain ritualistic or compulsive manner. For example, clients may exhibit pleasure seeking behaviors combined with high levels of anxiety as well as avoidance type behaviors. Such clients may exhibit difficulties with “impulse control but also [manifest behavioral problems as] part of the obsessive compulsive spectrum, characterized by the inability to inhibit or delay repetitive behaviors” (Palumbo & Kurlan, 2007, p.688). We can see an intertwining affect of impulsive and
compulsive types of behaviors with such clients. Obsession-type thoughts and behaviors can be considered uncontrollable by a client who suffers from a comorbidity of ADHD-OCD.

We can also consider a client with ADHD-OCD who suffers from feelings of low self-worth who constantly seeks affirmation from a significant other, in which such a client can feel a compulsion to respond negatively to a perceived lack of affirmation. Despite a growth in self-awareness of compulsive behaviors, such a client will most likely find it difficult to change negative or dysfunctional behavioral patterns. Thus, we can further see an interaction between impulsive and compulsive types of thinking and behaviors. Again, treatment approaches such as the use of CBT can aim at helping the client deal with both impulsiveness and compulsiveness by targeting dysfunctional patterns of thinking and behaviors (Westbrook, Kennerly, & Kirk, 2011) associated with impulsivity and compulsivity.

Clients with a comorbidity of ADHD-OCD can undergo difficulty in understanding important social cues and thus prone to act on impulsiveness, yet at the same time exhibit avoidance behaviors or feel the need to act within a certain ritualistic style of behavior, as well as becoming overly concerned with consequences of social behaviors (Abramovitch, Dar, Hermesh, & Schweiger, 2012). One could suggest that such clients are prone to perceiving situations as conflicting such as within the client’s perceived meaning of social situations. Thus, helping such clients to change negative thoughts, thinking and behavioral patterns (Westbrook, Kennerly, & Kirk, 2011) can be considered an effective treatment approach, as well as helping such clients to better understand how to navigate the social environment. Such clients can require help to change personal perspectives in regards to relationships.

Clients with either ADHD or OCD can manifest behaviors leading to consequences that can be considered undesirable. Again, acting within an inappropriate manner within social
TREATMENT OF COMORBIDITY OF ADHD-OCD

situations appears to be a key aspect of both ADHD and OCD. “Both disorders appear to display response inhibition deficit” (Abramovitch, Dar, Hermesh, & Schweiger, 2012). As mentioned, symptomatology of both ADHD and OCD can lead to inappropriate behaviors in relevance to achieving goals and maintaining healthy relationships (Brem, Grünblatt, Drechsler, Riederer, & Walitza, 2014), in which we may consider as part of both impulsivity and compulsivity. Perhaps we can deduce that a client who exhibits both impulsive and compulsive thinking and behaviors can have great difficulty with understanding how to relate to others at healthy levels within the social environment. We can also conclude that these difficulties within the social environment are due to genetic and childhood upbringing influences.

Our continued discovery of the nature of a comorbidity of ADHD-OCD brings us back to the need to look more closely at how to help clients improve upon self-awareness of and change such “response inhibition deficit” (Abramovitch, Dar, Hermesh, & Schweiger, 2012). As appropriate and acceptable behaviors are deemed necessary for healthy social interaction across time and differing cultural social settings, clients who have difficulty with such behavioral navigation require help to reformulate cognitions and behaviors (Westbrook, Kennerly, & Kirk, 2011). Treatment of such a comorbidity can also be considered difficult. Before we look at the difficulty with treatment let’s take a closer look at what constitutes healthy relationships and social functioning.

**Healthy Relationships and Social Functioning**

So far we have discussed some of the issues surrounding healthy social functioning for clients who suffer from a comorbidity of ADHD-OCD. However, what does it truly mean to function at a healthy level within the social environment and relationships in general? In therapy, we can consider that clients work on self-awareness and positive growth in order to achieve
TREATMENT OF COMORBIDITY OF ADHD-OCD

certain goals related to mental health and wellbeing. Such goals can perhaps often relate to how a client feels about oneself and how the client relates to others. Thus, we may deduce that social functioning at a healthy level can begin with looking inwards.

We can consider the popular work of Peck (1978), in regards to clients who suffer from neurosis and take too much personal responsibility for problems, as well as clients who suffer from a character disorder who take too little responsibility, blaming the outside world for personal problems. Helping clients who suffer from impulsive and compulsive behaviors to discover where personal responsibility lies can be considered difficult but perhaps important. A client who suffers from uncontrollable compulsive thinking and behavioral patterns may have great difficulty looking inwards and taking personal responsibility for behaviors and reactions towards others, seeing others as the problem. The client who is constantly seeking affirmation from a significant other, and who suffers from feelings of extreme low self-worth, may likely find it difficult to see inner underlined issues as a cause of exhibiting dysfunctional reactive behaviors. Thus, part of healthy social functioning appears to be taking personal responsibility for behaviors, as well as how to behave towards others within social situations.

Peck (1978) also discusses the need for a caring upbringing in order to develop feelings of self-worth and be able to obtain healthy functioning within the social environment. As mentioned above, the dysfunctional core belief of low self-worth can be detrimental for mental health and wellbeing. Such beliefs can be carried into adulthood, causing issues with trust and abandonment and become quite difficult to change (Peck, 1978).

One of Peck’s main ideas regarding feeling of value is that one can also take the time necessary for adequate self-care and to do the tasks needed to achieve desired goals. If a client does not feel of value the chances of that client performing related work to counselling outcomes
TREATMENT OF COMORBIDITY OF ADHD-OCD

may be hindered as well as work related to desired goals in general within the client’s life. Thus again, we can see how detrimental trauma related to childhood abuse, often associated with development of ADHD and OCD (Abramovitch, Dar, Mittelman, & Wilhelm, 2015), can be towards being able to function socially at a healthy level.

A client who feels abandonment and low self-worth will most likely development poor attachment styles and have difficulty maintaining healthy relationships, in which personal responsibility as well as being able to read into and understand social cues can be hindered.

We may also consider works by Ruiz (2000), in which emphasis is placed on the need to find one’s inner truth and discovery of one’s personal story. Earlier works by Ruiz (1997) emphasize personal agreements or truths that individuals live by, such as related to clients underlined and possible dysfunctional core beliefs. Clients who are taught to be unlovable can find great difficulty in finding personal truth to her or his story. Such clients may hold several dysfunctional agreements or beliefs regarding self that can be damaging to self-worth and thus cause issues with feeling of value. As mentioned, feeling of low value can lead one to disregard the need for certain required work towards obtaining desired goals (Peck, 1978). One such goal can include being able to maintain a healthy and caring intimate relationship, which requires work and feeling of some value (Peck, 1978). We may also consider what it means to be human as well.

We can consider what it means for humans to have a healthy level of social functioning across time and cultural settings. For this purpose we may consider communalities across time and cultures. It can be most likely agreed upon that humans require a caring and nurturing upbringing in order to function at a socially healthy level (Peck, 1978), and that this type of upbringing can be considered important universally. We may therefore conclude that humans
TREATMENT OF COMORBIDITY OF ADHD-OCD

require love and affection on a universal level and that interactions with others usually require some level of warmth and affection in order to be considered fundamentally healthy. We can deduce that humans require feelings of self-worth and to feel of value in order to have mental health and wellbeing, no matter which cultural background. Thus, development and treatment of ADHD-OCD can take on commonalities across time and cultures.

However, we can also consider gender, as well as views and perspectives on a cultural and personal level. Counsellors and therapists should be understanding of the client’s personal values, beliefs, and cultural background (Spangenberg, 2003), as well as take into account the meaning behind the client’s story (Young, 2013).

Counsellors and therapists can view the client individually, from a holistic view such as taking into account the biological, sociological, and psychological background. Listening to the individual client with use of an ethnographic inquiry can further help to better understand how client’s cultural norms can apply to assessment and treatment (Seeley, 2004) of ADHD-OCD. Treatment of a comorbidity of ADHD-OCD can therefore be difficult for numerous reasons.

**Difficulty with Treatment**

Clients who suffer from OCD will tend to resist treatment and thus further understanding of the nature of a comorbidity of ADHD-OCD can help determine effective treatment approaches (Anholt, et al., 2010). We can see that clients with either ADHD or OCD can suffer from similar symptomatology. Clients with a comorbidity of ADHD-OCD will tend to exhibit both impulsive and compulsive types of behaviors (Abramovitch, Dar, Hermesh, & Schweiger, 2012), which may be considered a key aspect of understanding how such a comorbidity can affect treatment in general and possible resistance to treatment.
As mentioned, both ADHD and OCD can cause issues with goal oriented behaviors (Brem, Grünblatt, Drechsler, Riederer, & Walitza, 2014) that can play a role in resistance to treatment. The very act of performing tasks related to behavior oriented therapy for example, may be hindered with an inability to perceive certain tasks as beneficial, and thus we can see a need for motivational interviewing (Ryan, Lynch, Vansteenkiste, & Deci, 2011) and motivational enhancement therapy (MET) (Korte & Schmidt, 2015). Such clients can require help with motivation towards tasks related to therapeutic goals. Performing tasks and relating to others in order to achieve desired goals can be affected by the impulsive and compulsive types of behaviors of a client with ADHD-OCD, and resistance to change can perhaps be considered deeply ingrained.

Again, clients of ADHD-OCD may have feelings of low self-worth and low value of self as well as not value work related to desired goals. Part of helping such clients with motivation can mean helping to challenge dysfunctional ingrained beliefs. Helping a client who can feel an uncontrollable need to be reactive within social situations caused by feelings of low self-worth, can most likely be considered difficult to treat in general via talk therapy.

Challenging dysfunctional core beliefs of self can be considered difficult with perhaps any client (Westbrook, Kennerly, & Kirk, 2011). Again, clients who have ADHD-OCD most likely have experienced some form of stress during childhood upbringing (Abramovitch, Dar, Mittelman, & Wilhelm, 2015) such as trauma. Such clients may likely have had negative beliefs regarding self ingrained since childhood upbringing.

We can also consider part of the nature of OCD such as the obsession-type thinking and behavioral patterns (Palumbo & Kurlan, 2007), as well as related dysfunctional belief system (Westbrook, Kennerly, & Kirk, 2011) that can lead to resistance to treatment. It is apparent that
TREATMENT OF COMORBIDITY OF ADHD-OCD

treatment should focus on possible negative thoughts before core beliefs, since beliefs can be too difficult to change at first (Westbrook, Kennerly, & Kirk, 2011). Challenging such beliefs may cause resistance to treatment in the form of negative reactions towards the counsellor or therapist. The client could possibly be offended or take such challenges as a personal attack. This leads us into the final section on treatment of a comorbidity of ADHD-OCD.

Treatment

Treatment of a comorbidity of ADHD-OCD can be broken down into stages. Treatment starts with the development of the therapeutic relationship and listening to the client’s story to assess (Young, 2013) for possible childhood trauma, as well as related symptomatology. If the client has suffered from a disruption in childhood development it is important to help the client to become aware of how such as disruption can affect ability to maintain current relationships at a healthy level and achieve desired goals (Newman & Newman, 1991). The client may require help to process traumatic memories. Trauma focused cognitive behavioral therapy (Kira, Ashby, Omidy, & Lewandowski, 2015) can be an effective treatment approach.

Most likely due to a disruption in childhood development (Erikson & Erikson, 1998), treatment of ADHD-OCD appears to revolve around helping clients to develop the ability to increase trust, and to better form adult attachment styles. Thus, clients may learn to better function within the social environment.

Counsellors and therapists should also be aware of how the client’s levels of trust and attachment can affect treatment, such as possibly modifying treatment approaches (Berry & Danquah, 2016). Cognitive processing therapy can be one such approach to treatment, to help clients increase awareness and process intrusive thoughts (Lenz, Bruijn, Serman, & Bailey, 2014). Clients with low levels of trust and dysfunctional attachment styles may need extra care
when being helped to address possible intrusive or exaggerated thoughts that the client may feel are real.

Helping the client with acceptance of certain thoughts may help to reduce possible high levels of anxiety and or depression. Combining cognitive therapy with acceptance and commitment therapy can be considered an effective treatment approach (Hallis, Cameli, Dionne, & Knäuper, 2016) to help reduce symptoms. Such clients can require help with acceptance of certain thoughts. This can also include helping the client to discover possible dysfunctional patterns of thinking and behaviors in order to work towards further awareness and positive change. The client should work towards recognition of possible exaggerated thoughts and patterns of negative reactions towards others.

Clients should be helped with navigating the social environment such as help in awareness of what constitutes healthy relationships. This can include helping the client to understand and set boundaries within personal relationships, and again, learning acceptance of other’s interactions. However, clients with ADHD-OCD may also exhibit feelings of low self-worth and require help with motivation. Motivation may also be hindered by the impulsive and compulsive thinking and behavioral patterns exhibited by the client.

Motivation enhancement therapy (MET) (Korte & Schmidt, 2015) can be considered an effective treatment approach to help increase the client’s internal motivation. Clients with ADHD-OCD tend to have difficulties with motivation towards doing the work necessary for positive growth and change, in part due to related symptoms of impulsiveness and compulsiveness and the client’s difficulty with changing repetitive behaviors Palumbo & Kurlan, 2007), as well as the likelihood of not feeling of value (Peck, 1978). Clients who are stuck within negative repetitive patterns may require extra focus on motivation for change. Feeling of value is
TREATMENT OF COMORBIDITY OF ADHD-OCD

needed in order to love one’s self and therefore do the work necessary for achieving desired goals such as positive growth and change (Peck, 1978). Helping the client to discover personal strengths and reinforce such strengths may help increase the client’s feelings of self-worth.

The client may learn to better value self and to increase feelings of self-worth. Impulsive and compulsive behaviors should become more manageable. The client should be able to development and maintain relationships at a healthy level. Overall, treatment can seem daunting and perhaps a long process in order to see some positive results. Let’s now take a closer look at the therapeutic relationship as the starting point for effective treatment of ADHD-OCD and achieving positive counselling outcomes.

Therapeutic Relationship

Establishing a therapeutic bond with the client can be considered an important common factor across most or all treatment approaches (Leibert & Dunne-Bryant, 2015; McAleavey & Castonguay, 2014; Miciak, 2012). Effective counselling skills can increase the use of treatment approaches and help to create a strong bond with the client. Helping the client feel safe and welcomed, as well as held in a positive regard and showing empathy (Young, 2013) can help strengthen the bond with the client. This can help increase the client’s levels of trust and comfort enough to open up and allow for better use of treatment approaches. The client should open up with honesty and reveal certain aspects of the story that will allow counsellors and therapists to assess accurately. Thus, the client’s underlined issues can be revealed at deeper levels through a strong therapeutic alliance.

Again, clients with ADHD-OCD can require help in growth of awareness and understanding that childhood experiences or memories can be an influential factor in current levels of social functioning. If the client holds back on certain details of possible trauma,
TREATMENT OF COMORBIDITY OF ADHD-OCD

treatment will most likely not be as effective. Being open and honest with others in general can be considered a difficult task. Again, creating an effective therapeutic relationship with the client will help to increase openness and honesty. Otherwise the client may keep back secrets that could be important for treatment and use of treatment approaches in general.

Establishing a strong therapeutic relationship with the client will help with more effective assessment, co-operation with the client, ongoing treatment using various treatment approaches, as well as positive counselling outcomes (Young, 2013). Counsellors and therapists can help the client to feel at ease but also to instill a level of confidence.

The client should feel that the helper is competent in being able to effectively help and deliver treatment in order to help increase client disclosure (Young, 2013). No matter which treatment approach is used, the client should feel confident that the helper can use such treatment approaches well. If the client feels the opposite then levels of trust may decrease and disclosure may be limited.

Thus, establishing a therapeutic bond requires several influencing factors or counselling skills in order to help the client grow and change in a positive manner. It is important for counsellors and therapists to show warmth, empathy, be non-judgmental, be authentic, be careful to use moderate and effective self-disclosure, and be an active listener (Young, 2013). These skills can be considered as part of the essential counsellor skills for achieving a therapeutic relationship with the client and working towards positive counselling outcomes. We will now look at helping the client to increase awareness of the effects of childhood trauma and a disruption in childhood development.
Increased Awareness of Childhood Development

Childhood development is an important factor to consider for affective treatment approaches of ADHD-OCD. Clients may not be aware of possible childhood trauma being related to current dysfunctional patterns (Erikson & Erikson, 1998). As mentioned, early childhood environmental stressors can influence the development of ADHD-OCD (Abramovitch, Dar, Mittelman, & Wilhelm, 2015). Again, it is important for clients to disclose such possible details. Clients can explore personal stories with the helper to discover possible connections of a disruption in childhood development to current possible dysfunctional patterns, negative thoughts, and difficulties with maintaining current relationships in general.

Counsellors and therapists can also help clients to realize how current issues with trust and attachment can cause the client to constantly refer back to a mental state of childhood. The client may be repeating feelings and memories from childhood due to not having personal needs met (Newman & Newman, 1991). Therefore, current social situations can evoke feelings of mistrust and abandonment.

According to psychosocial theory, growth during childhood developmental stages involves some growing pains (Newman & Newman, 1991). However, challenges during development should be met with and overcome in order to progress at a healthy level of social functioning. If a child suffers from abuse and needs are not met with, healthy growth at such stages of development is not achieved at a healthy level and an individual can become stuck in a kind of perpetual state of unhealthy functioning (Erikson & Erikson, 1998; Newman & Newman, 1991). Thus, the adult with ADHD-OCD can constantly resort back to a state of childhood mentality. The client can be experiencing feelings of abandonment and lack of trust.
TREATMENT OF COMORBIDITY OF ADHD- OCD

As we know that a comorbidity of ADHD-OCD can develop in part by environmental stressors (Abramovitch, Dar, Mittelman, & Wilhelm, 2015) such as childhood abuse and trauma, it is most likely that such clients are reliving a state of childhood related dysfunctional patterns. Thus, the client can repeat old patterns of related dysfunctional thinking and behaviors, as well as negative and exaggerated thoughts. Current dysfunctional core beliefs of low self-worth also play a major role in these patterns.

For example, the client who is suffering from a constant need for affirmation from a significant other may not realize the nature of internal dysfunctional patterns. The client may be reacting negatively as well as exhibiting impulsive and compulsive behaviors towards a partner across several social situations. The client would most likely feel as if there is no control over such behaviors, even if a growth in awareness is achieved. The client will require help realizing that such reactive behaviors are merely a regression into childhood, to a state when development was disrupted and certain needs during childhood upbringing were not met with (Newman & Newman, 1991). The client will most likely be reliving times of feeling abandoned which can also mean not being able to trust a significant other as well as experiencing unhealthy levels of adult attachment. Thus, clients of ADHD-OCD can also benefit from working towards having healthy levels of trust and adult attachment.

Trust and Attachment

Clients who seek treatment for ADHD-OCD may exhibit avoidant behaviors as well as low levels of trust and unhealthy adult attachment. The helper can take these underlined issues into consideration for adapting therapeutic approaches accordingly (Berry & Danquah, 2016). Certain modifying aspects of therapy can include helping the client realize personal strengths (Welfare, Farmer, & Lile, 2013) in order to help the client with being confident of choices, work
within the pace of the client, as well as include being supportive throughout therapy sessions, help the client to recognize a support network, and to establish security within the therapeutic relationship before moving on to deeper work (Berry & Danquah, 2016). Such clients may be oversensitive to challenges in dysfunctional core beliefs and even have difficulty with trusting the helper. Thus, helping clients who have difficulty with trust and suffer from dysfunctional patterns of attachment can require extra care on behalf of the counsellor or therapist.

Helping the client to establish trust and healthier levels of adult attachment can be progressive throughout the course of therapy. Part of such an ongoing process is to revisit childhood memories and help the client to establish a connection between a disruption in childhood development (Erikson & Erikson, 1998; Newman & Newman, 1991) and current dysfunctional patterns. Again, the client may be experiencing ongoing behaviors that relate to constantly seeking unresolved developmental issues from childhood, such as a lack of love and affection from caregivers (Peck, 1978).

Growth in self-awareness is a good first step for the client who is experiencing such negative and dysfunctional patterns. Helping the client to change such patterns is another challenge. Several treatment approaches can be used in order to help the client. Next, we will discuss the importance of helping the client to process traumatic memories within a safe environment and use of the therapeutic window (Briere & Scott, 2015). It is important to help the client process traumatic memories within an optimal level of emotional distress.

The Therapeutic Window

As clients with ADHD-OCD will likely have experienced some form of childhood trauma related to abuse (Abramovitch, Dar, Mittelman, & Wilhelm, 2015), counsellors and therapists can include some focus on helping the client to process and resolve traumatic
TREATMENT OF COMORBIDITY OF ADHD-OCD

memories. Counsellors and therapists must be careful working with possible traumatized clients and be sure to set a pace that is comfortable for the client (Briere & Scott, 2015). Processing painful memories can cause distress and emotional turmoil for clients and thus helping the client work through such a process should be done at a comfortable pace for the client.

However, the client should experience some emotional stimulation but not too much, keeping the client within a certain window of opportunity, or the therapeutic window (Briere & Scott, 2015) appears to work best. The client should be able to experience a certain amount of activated emotional distress related to traumatic memories or events (Briere & Scott, 2015). If the client does not experience enough activation of such emotions then processing trauma related memories will most likely not be effective. The client should experience the traumatic memories again so that moving beyond these memories and relieving related symptoms can occur. Thus, clients can process trauma related memories and emotions, which can help to move forward with treatment of related symptoms of ADHD-OCD.

Making sure the client does not go too far into distress is also important and helpers may at times have to slow the client’s pace. Guiding the client this way can mean using a softer voice and reminding the client of being in a safe environment (Briere & Scott, 2015), which can help to keep a pace necessary for effective processing of traumatic memories.

Clients may also have suffered an accumulation of ongoing trauma and simply working on past memories may not be enough. Clients may need to work on recognition and changes of cognitions over time in which trauma-focused cognitive behavioral therapy (TF-CBT) can be an effective treatment approach (Kira, Ashby, Omidy, & Lewandowski, 2015). We will now look at how such a treatment approach can help clients with ADHD-OCD by focusing on trauma related
dysfunctional patterns of thinking. Clients can be helped in changing the perceived meaning of the traumatic memories or events.

**Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

Counsellors and therapists should consider the effects of ongoing trauma with clients and not just a single traumatic event (Kira, Ashby, Omidy, & Lewandowski, 2015), as well as meaning placed on such memories. Helping clients to become self-ware of underlined cognitions and behaviors, and then to work towards changing dysfunctional patterns can be important work and done through a cognitive behavioral model approach (Kira, Ashby, Omidy, & Lewandowski, 2015). Such discoveries can involve listening to the client’s story for clues of possible dysfunctional patterns related to past trauma, such as childhood abuse and disrupted childhood development (Erikson & Erikson, 1998; Newman & Newman, 1991). Again, we appear to have come back to disruption in the developmental stages of childhood. If trauma occurs in adulthood, it is likely to also disrupt already learned stages of development. For example, already learned trust and attachment may perhaps become disrupted in adulthood due to a traumatic event.

Working with clients of ADHD-OCD can involve discovering meaning that is attached to past and ongoing traumatic memories. If the client has suffered from trauma related to not having basic needs met during childhood development (Newman & Newman, 1991), then there can be a constant recurring feeling of abandonment and lack of trust within current relationships. Again, helping the client to realize this connection to past childhood experiences is the first stage in helping to process and change meaning to past events as well as become aware of and change related cognitions. Part of helping such clients can include cognitive processing, such as using cognitive processing therapy (Lenz, Bruijn, Serman, & Bailey, 2014). Focusing on the client’s beliefs surrounding past and current events can be part of processing cognitions.
Cognitive Processing Therapy (CPT)

Originally for treatment of PTSD, cognitive processing therapy (CPT) would most likely benefit clients who have ADHD-OCD. Helping clients to process painful memories related to trauma is one aspect of this treatment approach but also to help clients become aware of and process intrusive thoughts (Lenz, Bruijn, Serman, & Bailey, 2014). Intrusive thoughts can be part of the symptomology of trauma (Dykshoom, 2014) as well as OCD (Podea, Suciu, Suciu, & Ardelean, 2009). As we can see, trauma and OCD are further connected.

Again, by helping clients to reinterpret traumatic memories, clients can better cope with intrusive thoughts (Lenz, Bruijn, Serman, & Bailey, 2014). We can also consider that clients of ADHD-OCD may misinterpret everyday healthy social functioning in a negative manner which can also relate to such intrusive thoughts as well as negative reactive behaviors. Results can include helping the client to process and interpret social interaction with new meaning attached.

Thus, clients should also be able to better deal with secondary emotions that result from misinterpreting social interactions or past trauma. For example, depression may result from such distortions of thinking and behaviors which can be improved upon when clients begin to experience new perspectives and attached meaning. Helping clients to process distorted cognitions can therefore be considered a key aspect of treatment of ADHD-OCD. As both ADHD and OCD can include symptoms related to trauma, as well as possible distorted thinking, CPT (Lenz, Bruijn, Serman, & Bailey, 2014) should be a useful and effective treatment approach. We can also consider cognitive behavioral therapy (CBT) as an effective treatment approach to help treat underlined dysfunctional patterns of thinking and behaviors.
Cognitive Behavioral Therapy (CBT)

If impulsivity is an issue with certain clients who are diagnosed with ADHD and possibly OCD, and who have suffered from trauma, then treatment with use of CBT can be an effective approach (Ramsay, 2017). CBT can help the client target dysfunctional patterns of thinking and behaviors associated with impulsivity and compulsivity, as well as negative and exaggerated thoughts (Westbrook, Kennerly, & Kirk, 2011). Clients can be helped to increase awareness of such patterns, thoughts, and behaviors, and then to work on positive growth and change. Such clients can require help to change personal perspectives and meaning associated with relationships and interactions with others. Results can include helping such clients better understand how to navigate the social environment.

Clients may suffer from avoidance behaviors and overly blaming of self or taking too much or too little responsibility for behaviors and interactions with others, as well as have possible distorted thinking patterns that contribute to maintenance cycles. CBT can help target thoughts and feelings that can contribute towards impulsivity and compulsivity, by also targeting and questioning impulsive and compulsive behaviors. The result is to help clients not only change distorted thinking patterns and cognitions but impulsive and compulsive behaviors associated with such patterns, as well as developing better ways of coping with related symptoms. Mindfulness based CBT (Janssen, et al., 2015) techniques can also be used to help clients to learn to stay present in the moment as well as with further growth in awareness and acceptance of certain thoughts and feelings.
TREATMENT OF COMORBIDITY OF ADHD-OCD

**Mindfulness Based Cognitive Behavioral Therapy (CBT)**

Studies suggest that mindfulness based CBT is a possible effective treatment approach to help clients reduce related symptoms, especially for ADHD (Janssen, et al., 2015) and trauma. Mindfulness in general may help reduce related symptoms of OCD as well. Clients can learn to stay present with and accept certain thoughts and feelings instead of reacting negatively. A thought may be perceived as only a thought and not necessarily reality.

We can deduce that “through mindfulness, trauma survivors [and clients with ADHD-OCD] may build strength and resilience by acquiring a sense of control, developing internal resources for symptom reduction and healing, and facilitating the meaning-making process” (Goodman & Calderon, 2012, p.254). Thus, helping the client to be mindful of possible new meanings towards negative and exaggerated thoughts can help to reduce reactive behaviors. The client may begin to experience better control over impulsive and compulsive behaviors. Clients may learn to accept certain thoughts and feelings. Acceptance and commitment therapy (ACT) (Hallis, Cameli, Dionne, & Knäuper, 2016) can also be a beneficial treatment approach for clients with ADHD-OCD.

**Acceptance and Commitment Therapy (ACT)**

Research suggests that ACT can be an effective treatment approach for OCD, anxiety, and depression, by helping the client to work through negative thoughts and feelings, rather than to change them (Hallis, Cameli, Dionne, & Knäuper, 2016). An ACT treatment approach should work well with clients of ADHD-OCD.

Research also suggests that combining cognitive therapy with ACT can be even more effective for positive treatment outcomes (Hallis, Cameli, Dionne, & Knäuper, 2016). “Clients can be taught greater flexibility by learning how to detect, challenge, and dispute cognitions.
while, at the same time, learning acceptance, diffusion, mindfulness and values-based response flexibility” (Hallis, Cameli, Dionne, & Knäuper, 2016). Counsellors and therapists can help clients to decide which thoughts and feelings to change and which to accept or diffuse.

From an ACT perspective, thoughts and feelings and be viewed from a contextual perspective, and how these affect the client, rather than from how often such thoughts and feelings occur (Hallis, Cameli, Dionne, & Knäuper, 2016). By combining CT and ACT, clients can be helped towards recognizing the meaning of such thoughts and feelings, and either to work towards change or acceptance. The results should lead to a reduction in anxiety and depression, as well as increased ability to have healthy relationships and achieve desired goals. However, such clients most likely require help with motivation.

**Motivation Enhancement Therapy (MET)**

MET can be considered an effective treatment approach for individuals who suffer from anxiety (Korte & Schmidt, 2015) and addictions (Miller, Zweben, DiClemente, Rychtarik, 1995). However, such an approach to treatment should help clients who suffer with ADHD-OCD who can require additional motivation. MET can be adapted to take into consideration the client’s reasons for lack of motivation, such as feelings of low self-worth (Peck, 1978) or uncontrollable compulsive behaviors. MET focuses on helping the client to utilize existing resources and perhaps strengths in order to increase internal motivation towards change (Miller, Zweben, DiClemente, Rychtarik, 1995). The goal is to help the client increase motivation for work necessary for positive growth and change, as well as an increased desire for such growth.

Helping the client to increase self-awareness of personal strengths and resources should help improve upon feelings of low self-worth and to help the client better understand the value of
TREATMENT OF COMORBIDITY OF ADHD-OCD

necessary work involved in and outside of therapy. The client must feel as if she or he is of value enough and worth the effort towards positive growth.

Lastly, we will take a brief look at helping clients to further understand possible implications of medication use. As both ADHD and OCD have possible causation related to areas of the brain (Brem, Grünblatt, Drechsler, Riederer, & Walitza, 2014), counsellors and therapists are encouraged to seek further research on possible medications for ADHD and OCD, and to incorporate such understanding into treatment via talk therapy.

Implications of Medications

Taking ethical considerations into account, counsellors and therapists who treat clients with ADHD-OCD should be knowledgeable of possible pharmacology in order to monitor possible implications towards the bond with the client, possible cultural diversity, general wellbeing (King & Anderson, 2004), and treatment approaches. Medications can cause mood swings for example, which may affect the client’s view of the counsellor or therapist. The client can also have difficulty with motivation and not take medications with strict adherence to prescribed times throughout the day. Clients may also suffer from addictions and abuse alcohol or other substances which may affect use of medications. Overall, counsellors and therapists can monitor the affects of possible medications during ongoing treatment.

Conclusion

Clients who suffer from ADHD-OCD can suffer from impulsive and obsessive-compulsive desire to react towards others across various environmental settings, genders, cultural environments, and social situations in a negative manner and without control of such reactive-type of behaviors. Such socially perceived inappropriate behaviors can be damaging towards being able to have healthy relationships in general and on achieving desired goals.
TREATMENT OF COMORBIDITY OF ADHD-OCD

The manner in which individuals relate to others and influence responses appears to be a key factor for maintaining healthy relationships and obtaining desired goals in general. However, ADHD-OCD can cause impairment in regards to being able to function at a healthy level due to chaotic and obsessive type of thinking and behavior (Ravindran, da Silva, Ravindran, Richter, & Rector, 2009). Therefore, a large part of an effective treatment approach has been placed on possible cognitive restructuring (Ravindran, da Silva, Ravindran, Richter, & Rector, 2009). Helping the client to create new perspectives and meaning can help to reformulate behaviors.

However, clients of ADHD-OCD appear to most likely suffer from feelings of low self-worth which can possibly hinder motivation and positive growth and change (Peck, 1978). Also, helping clients to change ingrained patterns appears to be quite challenging as well. Such clients require possible lengthy therapy and extra care on behalf of the counsellor or therapist. An eclectic and individualized approach to treatment appears to be appropriate for such clients.
References


TREATMENT OF COMORBIDITY OF ADHD-OCD


TREATMENT OF COMORBIDITY OF ADHD-OCD


