Clinical features and suicidal behavior in major depression with comorbid attention-deficit hyperactivity disorder

Sir,

Delibas et al.\(^1\) compared suicidality, onset, and severity of depression between adult inpatients with major depressive disorder (MDD) with or without a comorbid diagnosis of attention-deficit hyperactivity disorder (ADHD). They found that depression begins earlier in patients with comorbid ADHD and that this group had increased lifetime suicidal behaviors compared to depressed subjects without comorbid ADHD. We raise a few arguments which we believe are crucial to put the study results in the right perspective:

1. For starters, the nosological status of a diagnosis of adult ADHD continues to be debated. Whereas
proponents argue for the existence of a spontaneous “late onset” ADHD, the naysayers suggest that many such cases are a result of “late identification” and not, “late onset.” This being a cross-sectional study, it is not possible to ascertain which disease condition (MDD or ADHD) occurred first. However, the Wender–Utah rating scale, which the authors have used, assesses childhood ADHD symptoms. It can therefore be surmised that, in this sample, all adult ADHD cases represented those with symptom continuation from childhood and adolescence. Given this fact, we argue that the author’s major finding about earlier age of onset of depression in those with depression and concurrent ADHD may actually be a methodological artefact, because ADHD symptoms usually start earlier in life than depression and depression is commonly comorbid with ADHD.

2. We are also concerned that the authors have not defined a suicide attempt, their major outcome variable, anywhere in the text of the paper. In fact, Table 3 in the paper clearly indicates the operational definition of attempt employed - attempts requiring medical attention. This definition is not a standard one. It is more suitable for medically serious attempts and clearly excludes attempts at the lower end of the severity spectrum.

3. When study groups are matched for certain variables (in this case, age and gender), comparing the same parameters between groups (Table 1 in the paper), without providing adequate justification, appears redundant. Equally superfluous are the comparison of variables such as total ADHD score, number of ADHD criteria, and ADHD rating scale scores between groups divided on the basis of a diagnosis of ADHD.

A relatively minor, yet significant, issue in the context of the study hypothesis is the lack of statistical correction for multiple comparisons of related suicidal constructs (Table 3 in the paper), an approach that has been previously recommended. After applying a Bonferroni correction (0.05/3 = 0.017), lifetime suicidal ideation would no longer be different between groups.

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**Conflicts of interest**
There are no conflicts of interest.

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