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Authors

Zhang-James, Yanli

Helminen, Emily C

Liu, Jinru

et al.

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ARTICLE

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Evidence for similar structural brain anomalies in youth and adult attention-deficit/hyperactivity disorder: a machine learning analysis

Yanli Zhang-James¹, Emily C. Helminen², Jinru Liu³, The ENIGMA-ADHD Working Group, Barbara Franke^{4,5,6}, Martine Hoogman^{4,5} and Stephen V. Faraone^{1,7}

Abstract

Attention-deficit/hyperactivity disorder (ADHD) affects 5% of children world-wide. Of these, two-thirds continue to have impairing symptoms of ADHD into adulthood. Although a large literature implicates structural brain differences of the disorder, it is not clear if adults with ADHD have similar neuroanatomical differences as those seen in children with recent reports from the large ENIGMA-ADHD consortium finding structural differences for children but not for adults. This paper uses deep learning neural network classification models to determine if there are neuroanatomical changes in the brains of children with ADHD that are also observed for adult ADHD, and vice versa. We found that structural MRI data can significantly separate ADHD from control participants for both children and adults. Consistent with the prior reports from ENIGMA-ADHD, prediction performance and effect sizes were better for the child than the adult samples. The model trained on adult samples significantly predicted ADHD in the child sample, suggesting that our model learned anatomical features that are common to ADHD in childhood and adulthood. These results support the continuity of ADHD's brain differences from childhood to adulthood. In addition, our work demonstrates a novel use of neural network classification models to test hypotheses about developmental continuity.

Introduction

Attention-deficit/hyperactivity disorder (ADHD) is a common disorder affecting 5% of children and 3% of adults¹. It is associated with injuries², traffic accidents³, increased health care utilization^{4,5}, substance abuse^{6,7}, criminality⁸, unemployment¹, divorce⁹, suicide^{10,11}, AIDS risk behaviors¹², and premature mortality¹³. The cost of adult ADHD to society is between \$77.5 and \$115.9 billion each year¹⁴.

ADHD is highly heritable (76% heritability)¹⁵. A role for brain dysfunction in the etiology of ADHD was suspected for some time by the mechanism of action of the

medications that treat ADHD¹⁶, as well as supported by findings from genome-wide association studies (GWAS)^{17,18}. Although many prior magnetic resonance imaging (MRI) studies had suggested structural and functional differences between the brains of children with ADHD and those without^{19–25}, machine learning (ML) MRI diagnostic classifiers for ADHD have reported inconsistent results. We and others have examined this body of literature and reported large variations in choices of MRI modalities, ML models, cross-validation and testing methods, and sample sizes. Notably, many prior studies risked data leakage and accuracy inflation by using cross-validation methods without an independent test set²⁶. In addition, the largest dataset that ML classifiers have used thus far was the ADHD-200 Global Competition dataset consisting of 776 children, adolescents, and young adults (7–21 years old²⁷). Only a few studies

Correspondence: Stephen V. Faraone (sfaraone@childpsychresearch.org)

¹Department of Psychiatry and Behavioral Sciences, SUNY Upstate Medical University, Syracuse, NY, USA

²Department of Psychology, Syracuse University, Syracuse, NY, USA

Full list of author information is available at the end of the article

A list of the ENIGMA-ADHD Working Group members and their affiliations are listed at the end of the paper.

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examined classifiers for adults with ADHD and they all used extremely small datasets (<100 subjects^{28–30}).

The Enhancing Neuro Imaging Genetics Through Meta-Analysis (ENIGMA) ADHD Working Group created a large collaborative dataset with sufficient power to detect small effects. The ENIGMA-ADHD working group found small, statistically significant sub-cortical volumetric reductions³¹, cortical thinning, and reduced surface area³² to be associated with ADHD in children but not adults. Two-thirds of youth with ADHD will continue to have impairing symptoms of the disorder into young adulthood and that persistence continues to decline with age³³. The term adult ADHD refers to childhood onset ADHD that has persisted into adulthood, which is how it is defined in DSM 5 and in the ENIGMA-ADHD studies. The ENIGMA-ADHD study found small but significant ADHD vs. control differences in regional volumes and cortical thicknesses for children but not adolescents or adults^{19,34,35}. Other studies show that ADHD participants whose brains become more neurotypical were more likely than others to show remission of symptoms^{36,37}. But, although these longitudinal studies show reductions in case vs. control differences, they also suggest that those differences should be evident to some degree in cases that persist into adulthood.

Although the expectation of finding substantial continuity between childhood and adult ADHD has been widely accepted^{33,38,39} and recently confirmed by a large GWAS⁴⁰, this idea has been challenged⁴¹. Thus, given these prior data and the controversy about the continuity of ADHD into adulthood, we sought to test the idea that the ADHD-associated volumetric reductions seen in children with ADHD would be detected in adults with ADHD by applying ML algorithms. Given that symptoms and impairments persist into adulthood for most children with ADHD^{42,43}, we hypothesized that ADHD-related brain structure differences in adults would be consistent with those observed in children.

Materials and methods

MRI samples

The current study was approved by all contributing members of the ENIGMA-ADHD Working Group, which provided T1-weighted structural MRI (sMRI) data from 4183 subjects from 35 participating sites (by Aug. 2019). Each participating site had approval from its local ethics committee to perform the study and to share de-identified, anonymized individual data. Images were processed using the consortium's standard segmentation algorithms in FreeSurfer (V5.1 and V5.3)³¹. A total of 151 variables were used including 34 cortical surface areas, 34 cortical thickness measurements, and 7 subcortical regions from each hemisphere, and intracranial volume (ICV). Subjects missing more than 50% of variables were removed. Remaining

missing values and outliers (outside of 1.5 times the inter-quartile range (iqr 1.5)) were replaced with imputed values using multiple imputation with chained equations in STATA15. The final ML dataset consisted 4042 subjects from 35 sites, among which 45.8% were non-ADHD controls ($n = 1850$, male to female ratio (m/f) = 1.42) and 54.2% ADHD participants ($n = 2192$, m/f = 2.79). Ages ranged from four to 63 years old; 60.7% were children (age <18 years, $n = 2454$) and 39.3% were adults (age ≥ 18 years, $n = 1588$). ADHD diagnosis was significantly biased by sex ($X^2_{(1)} = 66.9$, $p < 0.0001$), sites ($X^2_{(1)} = 146.73$, $p < 0.0001$), and age ($X^2_{(1)} = 4.28$, $p = 0.04$).

To balance the confounding factors, we took the following steps. First, we randomly assigned samples to training (~70%), validation (~15%), and test (~15%) subsets within each diagnosis, sex, age subgroup (child vs. adult), and site to ensure that the train/validation/test subsets have the same composition of these variables. Twelve sites that provided only cases or only controls (total 203 subjects) were excluded during the initial train/validation/test split because their samples cannot provide an unbiased learning during the training and validation steps. These samples were added to the test set for final test evaluation. Supplementary Table 1 shows the sample splitting from each site. Next, we balanced the training set for the case and control groups within each sex, age, and site subgroup by random oversampling of the under-represented diagnostic group, a procedure commonly used to deal with class imbalance. The resulting balanced training set is described in Table 1. The validation and test sets were not balanced by age, sex, and site, however due to our sample splitting procedures, they contain the same demographic samples as the training set. In addition, the test set also contains samples from sites that had been excluded from the training set due to not having a site-specific control group.

Table 1 Training set sample characteristics after balancing for age and sex.

Diagnosis		Child (age <18)		Adult (age ≥ 18)	
		Female	Male	Female	Male
Control	N of subjects	352	714	224	373
	Mean age	11.3	11.6	31.9	28.1
	SD of age	2.9	2.9	11.5	9.4
ADHD	N of subjects	352	714	224	373
	Mean age	11.0	11.8	32.2	28.8
	SD of age	2.6	2.7	10.6	9.4

SD standard deviation, N total numbers.

Feature preprocessing

The high correlation among the 151 MRI features suggested the need for feature dimension reduction. Many prior studies have opted for feature selection in which the most important features were retained rather than using all MRI features. Although this approach reduces the numbers of input features, it does not remove the highly correlated relationships among the selected features. As prior MRI studies also suggested small but widespread differences between children with and without ADHD, we chose to use principal factors factor analysis (PFFA) for dimension reduction. With varimax rotation, PFFA on sMRI features of the training set identified 46 factors that explained >90% of the variance. This means that the reduced numbers of 46 non-correlated factors were able to represent majority (>90%) of the variance within the training dataset. We then computed factor scores for subjects in the validation and test sets based on the training set PFFA. We compared the original MRI and PFFA features in a screening pipeline for nine different ML models (see below) to determine which set of features were better for the classifiers.

Machine learning framework

Our ML framework starts with a screening pipeline in which nine different ML models were thoroughly evaluated. We used only training and validation sets for this purpose and we also compared the results of the original MRI features and the PFFA factors. Children and adults were combined for the screening analysis. The screening pipeline utilized Scikit-Learn's grid search algorithm⁴⁴ to search a large hyperparameter space for each of the models (see Supplementary Fig. 1 for details on these models and their hyperparameter spaces). We then compared both the training and validation scores of all the possible combinations of the hyperparameter sets. We used the area under the receiver operating characteristic (ROC) curves (AUC) as a measure of accuracy. To avoid overfitting, we chose the model having the highest validation AUC and smaller training AUC. Because multi-layer perceptron (MLP) neural network models were found to be better than other models in meeting this criterion, we used MLP in the following analysis.

More detailed hyperparameter tuning for MLP was carried out using the Keras API (version 2.3.1), the TensorFlow library (version 1.14.0), and HyperOpt⁴⁵. The neural network hyperparameters and their spaces are: the numbers of layers (1–3, model deteriorates quickly when more than 3 layers were used), numbers of units in each layer (4–500) and dropout rates in each layer (0.1–0.9), learning rate (0.00001–0.01) and batch normalization size (4–256). These hyperparameters were chosen for the HyperOpt tuning because of their important role in effective learning, avoiding local minimum and overfitting.

The numbers of layers and units determines the complexity of the model. The ideal complexity of the neural network ensures a converging model that was able to learn the predictive features but not overfit the training examples. Early stopping was also implemented to avoid overfitting. We tested different activation functions (relu, selu, tanh), and optimizers (Adam, SGD, RMSprop, Adagrad, Adamax, Nadam). We used binary cross entropy as the loss function. Best model architecture and hyperparameters were chosen based on the lowest total validation loss. Final test scores were obtained on the test set with ensemble learning approach⁴⁶. All ML algorithms were written in Python 3.5.

Analysis pipeline

Our main analysis pipeline starts with two base models that used data from the corresponding age groups during the model training and validation phase and tested also on data from their corresponding age groups. The child model used only child samples during model training, validation, and hyperparameter optimization, and tested on child test set. The adult model, similarly, was trained and validated on the adult samples and tested on the adult test set. We examined models using MRI features only, as well as those included age and sex information. We also trained a combined model that uses all the training data from both child and adult groups and compared the performance with the age-specific models.

Next, we sought to determine if the model trained and validated on the adult samples, the adult model, could be used to predict child ADHD, and vice versa. We hypothesized that if the ADHD vs. control sMRI differences seen in children are also present in adult ADHD brains, then the base models for each age group should be able to predict ADHD in the other age group. To create the largest test sets possible, we tested the child model on all the adult samples, and the adult model on all the child samples.

Model evaluation

The sigmoid function in the output layer of the neural network generates a continuous score that assesses the probability for each individual to be classified as ADHD. We name this continuous output the brain risk score. Using the brain risk scores, we calculated Cohen's *d* effect sizes for child and adult test sets. We computed ROC curves and used the area under the ROC curve (AUC) as our primary measure of accuracy. The AUC and its confidence intervals were calculated in Stata 15 using the empirical method and compared with nonparametric approach by DeLong et al.⁴⁷. We also computed precision-recall (PR) curves and reported the area under the PR curves, as well as the Brier loss for the final models as measures of accuracy and goodness of fit.

Results

The screening results (Supplementary Fig. 1) showed that principal factors as input features greatly improved the classifiers' performance compared with original MRI features, as demonstrated by higher validation AUCs achieved in many models. Using principal factors, MLP outperformed all other models and was chosen as the base model and used in the following main analysis after additional fine-tuning the hyperparameters. The final MLP models' hyperparameters were listed in Supplementary Table 2.

Figure 1A (top portion) shows the test set AUCs (as dots) and their 95% confidence intervals (as horizontal lines) for the base models using only MRI factors. The model trained and validated on child data predicted child ADHD with a significant AUC 0.64 (95%CI 0.58–0.69). In contrast, the

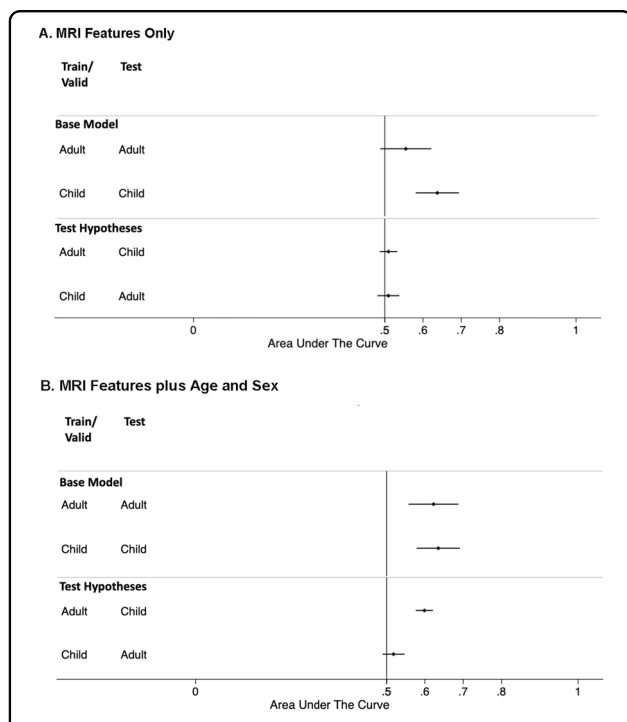


Fig. 1 Area under the receiver operating characteristic curve for the test results. Area under the receiver operating characteristic curve (AUC) accuracy statistics for the held-out test results were plotted (as dots) with their 95% confidence intervals (as horizontal lines). The vertical line at an AUC of 0.5 indicates a chance level of diagnostic accuracy. If the 95%CI does not overlap with the 0.5 vertical line, it indicates significant predictive accuracy. **A** AUC comparison of the models using only MRI features. **A** AUC comparison of the models using MRI features plus age and sex. In both **A** and **B**, the Top portion shows the base models, where models were trained and validated in child or adult samples and tested on their corresponding age groups; Bottom portion tests the hypotheses that if model trained/validated on child samples can also predict adult ADHD and vice versa. Note that test sample consists of combined training, validation, and test sets from the other age group because they are not used in the model optimization and training.

model trained and validated on adult data was not significant AUC (0.56, 95%CI 0.49–0.62, $p = 0.057$). ROC curves for the two base models are in Supplementary Fig. 2A. The difference between the two base models' AUCs was not significant ($X^2_{(1)} = 3.4$, $p = 0.065$). The areas under the precision-recall curve (AUPRC) were higher for the adult model (AUPRC = 0.74) than the child model (AUPRC = 0.68). Using the model predicted brain risk scores, we calculated the Cohen's d effect sizes in the test set to be 0.47 for child samples (95%CI: 0.27–0.68) and 0.15 (–0.08–0.39) for the adult samples.

After adding age and sex as predictors, the adult model (Fig. 1B, top) increased the AUC to 0.62 (95%CI 0.56–0.69, $p = 0.002$). Although prediction AUC was now significant, the increase from the base model without age and sex was not statistically significant ($X^2_{(1)} = 2.01$, $p = 0.15$). The AUPRC for the adult model also slightly increased to 0.79. Adding age and sex as predictors to the child model did not affect either the AUC, nor the AUPRC. ROC curves of two models are plotted in Supplementary Fig. 2B. The Cohen's d effect sizes in the test set were 0.48 for children (95%CI: 0.27–0.69) and 0.39 (0.15–0.63) for adults. All above models had similarly small Brier scores (0.25).

The combined model with MRI features produced an overall test AUC of 0.60 (95%CI 0.55–0.64). The test AUC was 0.64 (95%CI 0.58–0.69) on the child subset and 0.54 (95%CI 0.47–0.60) on the adult subset, comparable to those from the age-specific models. Similarly, the combined model with MRI, age, and sex features produced an overall AUC of 0.63 (95%CI 0.59–0.67). The subset test AUC was 0.65 (95%CI 0.60–0.71) on the child subset and 0.56 (95%CI 0.49–0.63) on the adult subset, also statistically comparable to those of the age-specific models.

Because the training samples had been balanced for age and sex, these variables are not predictive of ADHD for either the child or adult test sets. To verify this, linear regression using only age and sex and their interactions to predict ADHD in the child and adult samples resulted in non-significant AUCs (child AUC 0.51, 95%CI: 0.45–0.57; adult AUC 0.46, 95%CI: 0.39–0.53).

Tests of hypotheses

For models using only MRI features, neither the adult nor child models were successful at predicting ADHD in the other age group (Fig. 1A, bottom). However, the adult model that used both MRI features and age and sex was able to predict the child samples significantly (AUC = 0.60, 95%CI: 0.58–0.62, Fig. 1B bottom). The Cohen's d effect size for children, based on the adult model predictions, was 0.17 (95%CI: 0.10–0.24), smaller than those predicted by their age-corresponding models. The child model that used both MRI features and age and sex did

not significantly predict ADHD when applied to the adult samples (AUC = 0.53, 95%CI: 0.49, 0.56, Fig. 1B bottom). ROC curves of both models tested on the different age groups are plotted in Supplementary Fig. 2C.

Discussion

Consistent with previous ENIGMA ADHD findings^{31,32}, we found that the ability of sMRI data to discriminate people with and without ADHD is much stronger for children than adults, which is consistent with a broader literature showing that ADHD-associated structural brain differences diminish with age^{19,34–37}. While the ENIGMA ADHD study did not find any significant differences between ADHD and control subjects for adults, our adult model did achieve a significant AUC 0.62 (95%CI 0.56–0.69) and a high area under the PR curve (AUPRC = 0.79). Consistent with the ENIGMA findings, our model-predicted brain risk scores had a larger effect size for the children than adults in both the models using MRI features and those with age and sex added. Notably, our effect sizes were two times greater than the largest of those individual regions reported in prior ENIGMA ADHD studies for both children (Cohen's $d = -0.21$) and adults (Cohen's $d = -0.16$)^{31,32}.

Only a handful of prior ML studies attempted to classify ADHD from controls using only sMRI data. Most used resting-state functional MRI (rs-fMRI), or rs-fMRI in combination with another MRI modality, sometimes including cognitive measurements such as IQ. Many prior studies reported model performance on a cross-validation dataset without using an independent test set. We and many others have warned about the risk of data leakage and model overfitting when using only cross-validation without an independent test set^{26,48–51}. Among those that reported independent test results, classification accuracies varied from 37 to 93%, with an average of 68% (ref. 26). Notably, it is difficult to directly compare the accuracy scores with our AUC scores since many of these studies used imbalanced datasets. Nevertheless, one study, among those, reported classifiers built with only sMRI features. In that study, Yoo and colleagues examined various combinations of fMRI, sMRI features, and genetic data from a balanced cohort of 94 children and adolescents. The unimodal sMRI classifier, using the cortical thickness and volumes, achieved an accuracy of 69.4% and AUC 0.65 in a small independent test set (18 ADHD and 18 typically developing children)⁵². Although the AUC is comparable to our child model, it is not clear how well this model would generalize to other samples given the extremely small sample sizes in both training and test sets. Nevertheless, the authors reported a better AUC (0.70) with a multi-modal classifier built with features from both diffusion tensor imaging and sMRI data⁵².

Although our results from the child and adult base models show that sMRI data are not sufficiently predictive to be useful in clinical practice, they provide crucial pieces of evidence that will be useful in future attempts at predictive modeling. We are the first to confirm in the largest possible adult ADHD MRI sample available, that adults with ADHD differ significantly from adults without ADHD on sMRI features. Only a few prior studies attempted to classify adult ADHD from controls, but all used extremely small dataset (<100 (refs. 28–30)). Although these studies reported higher accuracies (74%–80%), all were based on cross-validation results and none reported prediction performance on independent test sets. The improvements we found by adding age and sex to the adult model indicate that these demographic variables must moderate the predictive ability of sMRI features. These demographics moderate the sMRI effects because our regression models show that the demographic variables on their own have no predictive utility (which was fixed in advance by balancing the case and control training samples by age and sex). It is possible that there are different age subgroups within the adult dataset that demonstrate different patterns of MRI features. For example, many regions of the brain, including prefrontal cortex, do not fully mature until early adulthood, around age 25 (ref. 53). Perhaps the age group “adults” should not include developing brains prior to age 25. However, we cannot assess for such age effects due to the sample sizes of more refined age groups. Future work should recruit more MRI data particularly for under-represented adolescent and older adult age groups. We have also shown that ML methods dramatically increase the ADHD vs. Control effect size compared with the prior univariate ENIGMA analyses.

The results from our hypothesis testing provide further information that is useful in understanding the continuity of child and adult ADHD. Consistent with our hypothesis, the adult model, trained only on adult samples, significantly predicted ADHD in the child samples. This suggests that the adult model learned combinations of structural features relevant for discriminating the sMRI scans from children with and without ADHD. This implies that some of ADHD's sMRI differences that are relevant for persistent cases are also relevant in childhood (only some of which will be persistent into adulthood). This conclusion must, however, be considered equivocal because the child model did not successfully predict ADHD in the adult samples. To resolve this issue, future studies will need to find a way to better discriminate sMRI features associated with the onset of ADHD and those associated with the persistence of ADHD.

Our work should be interpreted in the context of several limitations. First, because we combined data across many sites, we inherit all the limitations of the original studies.

Heterogeneity of methods across studies may have added noise to the combined dataset that made it difficult to discriminate the data from people with and without ADHD. Second, we only used structural imaging data. Incorporating other imaging modalities might provide clearer results and conclusions. Third, we used pre-defined structures from ENIGMA standard image processing pipeline as features. It is possible that other methods such as one using 3D images as input features, in a convolutional neural network, would uncover useful features leading to increased classification accuracy. However, the 3D images are not available. Finally, our use of neural networks makes it difficult to clarify the importance of each brain region in the model's algorithm.

Despite these limitations, we have shown that a neural network approach is able to detect case-control sMRI differences in adults with ADHD that could not be detected with standard analyses. We have also provided some evidence for the continuity of sMRI findings from childhood into adulthood.

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Author details

¹Department of Psychiatry and Behavioral Sciences, SUNY Upstate Medical University, Syracuse, NY, USA. ²Department of Psychology, Syracuse University, Syracuse, NY, USA. ³University of Illinois at Urbana-Champaign, Champaign, IL, USA. ⁴Department of Human Genetics, Radboud University Medical Center, Nijmegen, The Netherlands. ⁵Donders Institute for Brain, Cognition and Behaviour, Nijmegen, The Netherlands. ⁶Department of Psychiatry, Radboud University Medical Center, Nijmegen, The Netherlands. ⁷Department of Neuroscience and Physiology, SUNY Upstate Medical University, Syracuse, NY, USA

Code availability

The machine learning codes were freely accessible from the GitHub repository (https://github.com/ylzhang29/ADHD_MLP) for research purposes.

Conflict of interest

Dr. Barbara Franke has received educational speaking fees from Shire and Medice. Dr. Stephen V Faraone received income, potential income, travel expenses continuing education support and/or research support from Takeda, OnDosis, Tris, Otsuka, Arbor, Ironshore, Rhodes, Akili Interactive Labs, Enzymotec, Sunovion, Supernus, and Genomind. With his institution, he has US patent US20130217707 A1 for the use of sodium-hydrogen exchange inhibitors in the treatment of ADHD. He also receives royalties from books published by Guilford Press: *Straight Talk about Your Child's Mental Health*, Oxford University Press: *Schizophrenia: The Facts* and Elsevier: *ADHD: Non-Pharmacologic Interventions*. He is Program Director of www.adhdinadults.com. Dr. Asherson has served as a consultant and as a speaker at sponsored events for Eli Lilly, Novartis, and Shire, and he has received educational/research awards from Eli Lilly, GW Pharma, Novartis, QbTech, Shire, and Vifor Pharma. Dr. Banaschewski has served in an advisory or consultancy role for Actelion, Eli Lilly, Hexal Pharma,

Lundbeck, Medice, Neurim Pharmaceuticals, Novartis, Oberberg GmbH, and Shire; he has received conference support or speaking fees from Eli Lilly, Medice, Novartis, and Shire; he has been involved in clinical trials conducted by Shire and Viforpharma; and he has received royalties from CIP Medien, Hogrefe, Kohlhammer, and Oxford University Press. Dr. Bellgrove has received speaking fees and travel support from Shire. 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Dr. Brandeis has served as an unpaid scientific consultant for an EU-funded neurofeedback trial. Dr. Buitelaar has served as a consultant, advisory board member, and/or speaker for Eli Lilly, Janssen-Cilag, Medice, Roche, Shire, and Servier. Dr. Coghill has served in an advisory or consultancy role for Eli Lilly, Medice, Novartis, Oxford Outcomes, Shire, and Viforpharma; he has received conference support or speaking fees from Eli Lilly, Janssen McNeil, Medice, Novartis, Shire, and Sunovion; and he has been involved in clinical trials conducted by Eli Lilly and Shire. Dr. Dale is a founder of and holds equity in CorTechs Labs, Inc., and has served on the scientific advisory boards of CorTechs Labs and Human Longevity, Inc., and he receives funding through research grants with GE Healthcare. Mr. Earl is co-inventor of the Oregon Health and Science University Technology #2198 (co-owned with Washington University in St. Louis), FIRMM: Real time monitoring and prediction of motion in MRI scans, exclusively licensed to Nous, Inc., and any related research. Any potential conflict of interest has been reviewed and managed by OHSU. Dr. Fair is a founder of Nous Imaging, Inc.; any potential conflicts of interest are being reviewed and managed by OHSU. Dr. Haavik has received speaking fees from Biocodex, Eli Lilly, HB Pharma, Janssen-Cilag, Medice, Novartis, and Shire. Dr. Hoekstra has received a research grant from and served on the advisory board for Shire. Dr. Karkashadze has received payment for article authorship and speaking fees from Sanofi and from Pifarma. Dr. Konrad has received speaking fees from Eli Lilly, Medice, and Shire. 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The ENIGMA-ADHD Working Group

Geraldo F. Busatto^{8,9}, Anna Calvo¹⁰, Mara Cercignani¹¹, Tiffany M. Chaim-Avancini^{12,13}, Matt C. Gabel¹¹, Neil A. Harrison^{11,14}, Luisa Lazaro^{15,16,17}, Sara Lera-Miguel¹⁸, Mario R. Louza¹⁹, Rosa Nicolau¹⁸, Pedro G. P. Rosa^{12,13}, Martin Schulte-Rutte^{20,21}, Marcus V. Zanetti^{13,19}, Sara Ambrosino²², Philip Asherson²³, Tobias Banaschewski²⁴, Alexandr Baranov²⁵, Sarah Baumeister²⁴, Ramona Baur-Streubel²⁶, Mark A. Bellgrove²⁷, Joseph Biederman^{28,29}, Janita Bralten^{4,5}, Ivanei E. Bramati³⁰, Daniel Brandeis^{24,31,32}, Silvia Brem^{31,32}, Jan K. Buitelaar^{5,33}, Francisco X. Castellanos^{34,35,36}, Kaylita C. Chantiluke³⁷, Anastasia Christakou^{37,38}, David Coghill^{39,40,41}, Annette Conzelmann^{42,43}, Ana I. Cubillo³⁷, Anders M. Dale^{44,45}, Patrick de Zeeuw⁸, Alysa E. Doyle^{29,46}, Sarah Durston⁸, Eric A. Earl⁴⁷, Jeffrey N. Epstein^{48,49}, Thomas Ethofer^{50,51}, Damien A. Fair^{47,52}, Andreas J. Fallgatter^{50,53}, Thomas Frodl^{54,55,56}, Tinatin Gogberashvili⁵⁷, Jan Haavik^{58,59}, Catharina A. Hartman⁶⁰, Dirk J. Heslenfeld⁶¹, Pieter J. Hoekstra⁶⁰, Sarah Hohmann¹¹, Marie F. Høvik^{59,62}, Neda Jahanshad⁶³, Terry L. Jernigan⁶⁴, Bernd Kardatzki⁵¹, Georgii Karkashadze⁵⁷, Clare Kelly^{34,65,66}, Gregor Kohls⁶⁷, Kerstin Konrad^{67,68}, Jonna Kuntsi¹⁰, Klaus-Peter Lesch^{69,70,71}, Astri J. Lundervold^{58,72}, Charles B. Malpas^{73,74,75}, Paulo Mattos^{30,76}, Hazel McCarthy^{55,77}, Mitul A. Mehta⁷⁸, Leyla Namazova-Baranova²⁵, Joel T. Nigg^{47,52}, Stephanie E. Novotny⁷⁹, Ruth L. O’Gorman Tuura^{80,81}, Eileen Oberwelland Weiss^{68,82,83}, Jaap Oosterlaan^{84,85,86}, Bob Oranje²², Yannis Paloyelis⁷⁸, Paul Pauli⁴³, Kerstin J. Plessen^{87,88}, J. Antoni Ramos-Quiroga^{89,90,91,92}, Andreas Reif⁹³, Liesbeth Reneman^{94,95}, Katya Rubia³⁷, Anouk Schranter⁹⁴, Lena Schwarz⁵⁰, Lizanne J. S. Schweren⁶⁰, Jochen Seitz⁸², Philip Shaw^{96,97}, Tim J. Silk^{98,99,100}, Norbert Skokauskas^{55,101}, Juan Carlos Soliva Vila⁹², Michael C. Stevens^{79,102}, Gustavo Sudre⁹⁶, Leanne Tamm^{103,104}, Paul M. Thompson¹⁰⁵, Fernanda Tovar-Moll^{30,106}, Theo G. M. van Erp¹⁰⁷, Alasdair Vance¹⁰⁰, Oscar Vilarroya^{92,108}, Yolanda Vives-Gilabert¹⁰⁹, Georg G. von Polier⁸², Susanne Walitza³¹, Yuliya N. Yoncheva³⁴ and Georg C. Ziegler⁶⁹

⁸Laboratory of Psychiatric Neuroimaging (LIM21), Hospital das Clinicas HCFMUSP, Faculdade de Medicina, Universidade de Sao Paulo, SP, Brazil. ⁹Department and Institute of Psychiatry, Faculty of Medicine, University of Sao Paulo, Sao Paulo, Brazil. ¹⁰Magnetic Resonance Image Core Facility, Institut d’Investigacions Biomèdiques August Pi i Sunyer (IDIBAPS), Barcelona, Spain. ¹¹Department of Neuroscience, Brighton and Sussex Medical School, Falmer, Brighton, UK. ¹²Laboratory of Psychiatric Neuroimaging (LIM-21), Department and Institute of Psychiatry, Faculty of Medicine, University of São Paulo, Sao Paulo, Brazil. ¹³Center for Interdisciplinary Research on Applied Neurosciences (NAPNA), University of São Paulo, Sao Paulo, Brazil. ¹⁴Sussex Partnership NHS Foundation Trust, Swandean, East Sussex, UK. ¹⁵Institut d’Investigacions Biomèdiques August Pi i Sunyer (IDIBAPS), Barcelona, Spain. ¹⁶Biomedical Network Research Center on Mental Health (CIBERSAM), Barcelona, Spain. ¹⁷Department of Medicine, University of Barcelona, Barcelona, Spain. ¹⁸Department of Child and Adolescent Psychiatry and Psychology, Institute of Neurosciences, Hospital Clínic, Barcelona, Spain. ¹⁹Department of Psychiatry, Faculty of Medicine, University of São Paulo, São Paulo, Brazil. ²⁰Child Neuropsychology Section, University Hospital Aachen, Aachen, Germany. ²¹JARA Translational Brain Medicine, Research Center Juelich, Aachen, Germany. ²²NICHE Lab, Department of Psychiatry, University Medical Center Utrecht, Utrecht, The Netherlands. ²³Social, Genetic and Developmental Psychiatry Centre, Institute of Psychiatry, Psychology and Neuroscience, King’s College London, London, UK. ²⁴Department of Child and Adolescent Psychiatry and Psychotherapy, Central Institute of Mental Health, Medical Faculty Mannheim/Heidelberg University, Mannheim, Germany. ²⁵National Medical Research Center for Children’s Health, Moscow, Russia. ²⁶Department of Biological Psychology, Clinical Psychology, and Psychotherapy, University of Würzburg, Würzburg, Germany. ²⁷Turner Institute for Brain and Mental Health and School of Psychological Sciences, Monash University, Melbourne, Australia. ²⁸Clinical and Research Programs in Pediatric Psychopharmacology and Adult ADHD, Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA. ²⁹Department of Psychiatry, Massachusetts General Hospital, Harvard Medical School, Boston, MA, USA. ³⁰D’Or Institute for Research and Education, Rio de Janeiro, Brazil. ³¹Department of Child and Adolescent Psychiatry and Psychotherapy, Psychiatric Hospital, University of Zurich, Zurich, Switzerland. ³²Neuroscience Center, University of Zurich and ETH Zurich, Zurich, Switzerland. ³³Karakter Child and Adolescent Psychiatry University Center, Nijmegen, The Netherlands. ³⁴Department of Child and Adolescent Psychiatry, NYU Langone Medical Center, New York, NY, USA. ³⁵Nathan Kline Institute for Psychiatric Research, Orangeburg, NY, USA. ³⁶Section of Biomedical Image Analysis, Department of Radiology, University of Pennsylvania, Philadelphia, PA, USA. ³⁷Department of Child and Adolescent Psychiatry, Institute of Psychiatry, Psychology and Neuroscience, King’s College London, London, UK. ³⁸School of Psychology and Clinical Language Sciences, Centre for Integrative Neuroscience and Neurodynamics, University of Reading, Reading, UK. ³⁹Departments of Paediatrics and Psychiatry, The University of Melbourne, Melbourne, Australia.

⁴⁰Murdoch Children's Research Institute, The University of Melbourne, Melbourne, Australia. ⁴¹Division of Neuroscience, University of Dundee, Dundee, UK. ⁴²Department of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy, University Hospital of Tübingen, Tübingen, Germany. ⁴³Department of Psychology (Clinical Psychology II), PFH – Private University of Applied Sciences, Göttingen, Germany. ⁴⁴Departments of Neurosciences, Radiology, and Psychiatry, UC San Diego, San Diego, CA, USA. ⁴⁵Center for Multimodal Imaging and Genetics (CMIG), UC San Diego, San Diego, CA, USA. ⁴⁶Center for Genomic Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, MA, USA. ⁴⁷Department of Behavioral Neuroscience, Oregon Health & Science University, Portland, OR, USA. ⁴⁸Division of Behavioral Medicine and Clinical Psychology, Cincinnati Children's Hospital Medical Center, Cincinnati, OH, USA. ⁴⁹Department of Pediatrics, University of Cincinnati College of Medicine, Cincinnati, OH, USA. ⁵⁰Department of Psychiatry and Psychotherapy, University Hospital of Tübingen, Tübingen, Germany. ⁵¹Department of Biomedical Magnetic Resonance, University of Tübingen, Tübingen, Germany. ⁵²Department of Psychiatry, Oregon Health & Science University, Portland, OR, USA. ⁵³LEAD Graduate School, University of Tübingen, Tübingen, Germany. ⁵⁴Department of Psychiatry and Psychotherapy, Otto von Guericke University, Magdeburg, Germany. ⁵⁵Department of Psychiatry, Trinity College Dublin, The University of Dublin, Dublin, Ireland. ⁵⁶German Center for Neurodegenerative Diseases (DZNE), Magdeburg, Germany. ⁵⁷Laboratory of Neurology and Cognitive Health, National Medical Research Center for Children's Health, Moscow, Russia. ⁵⁸K.G. Jebsen Centre for Neuropsychiatric Disorders, Department of Biomedicine, University of Bergen, Bergen, Norway. ⁵⁹Division of Psychiatry, Haukeland University Hospital, Bergen, Norway. ⁶⁰Department of Psychiatry, Interdisciplinary Center Psychopathology and Emotion Regulation (ICPE), University Medical Center Groningen, University of Groningen, Groningen, The Netherlands. ⁶¹Faculty of Behavioural and Movement Sciences, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands. ⁶²Department of Clinical Medicine, University of Bergen, Bergen, Norway. ⁶³Imaging Genetics Center, Stevens Institute for Neuroimaging & Informatics, Keck School of Medicine, University of Southern California, Los Angeles, CA, USA. ⁶⁴Center for Human Development, UC San Diego, San Diego, CA, USA. ⁶⁵School of Psychology and Department of Psychiatry at the School of Medicine, Trinity College Dublin, the University of Dublin, Dublin, Ireland. ⁶⁶Trinity College Institute of Neuroscience, Trinity College Dublin, The University of Dublin, Dublin, Ireland. ⁶⁷Child Neuropsychology Section, University Hospital RWTH Aachen, Aachen, Germany. ⁶⁸JARA Institute Molecular Neuroscience and Neuroimaging (INM-11), Institute for Neuroscience and Medicine, Research Center Jülich, Jülich, Germany. ⁶⁹Division of Molecular Psychiatry, Center of Mental Health, University of Würzburg, Würzburg, Germany. ⁷⁰Laboratory of Psychiatric Neurobiology, Institute of Molecular Medicine, I.M. Sechenov First Moscow State Medical University, Moscow, Russia. ⁷¹Department of Neuroscience, School for Mental Health and Neuroscience (MHeNS), Maastricht University, Maastricht, The Netherlands. ⁷²Department of Biological and Medical Psychology, University of Bergen, Bergen, Norway. ⁷³Developmental Imaging Group, Murdoch Children's Research Institute, The University of Melbourne, Melbourne, Australia. ⁷⁴Clinical Outcomes Research Unit (CORe), Department of Medicine, Royal Melbourne Hospital, The University of Melbourne, Melbourne, Australia. ⁷⁵Melbourne School of Psychological Sciences, The University of Melbourne, Melbourne, Australia. ⁷⁶Federal University of Rio de Janeiro, Rio de Janeiro, Brazil. ⁷⁷Centre of Advanced Medical Imaging, St James's Hospital, Dublin, Ireland. ⁷⁸Department of Neuroimaging, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK. ⁷⁹Olin Neuropsychiatry Research Center, Hartford Hospital, Hartford, CT, USA. ⁸⁰Center for MR Research, University Children's Hospital, Zurich, Switzerland. ⁸¹Zurich Center for Integrative Human Physiology (ZIHP), Zürich, Switzerland. ⁸²Child and Adolescent Psychiatry, University Hospital RWTH Aachen, Aachen, Germany. ⁸³Cognitive Neuroscience (INM-3), Institute for Neuroscience and Medicine, Research Center Jülich, Jülich, Germany. ⁸⁴Clinical Neuropsychology Section, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands. ⁸⁵Emma Children's Hospital Amsterdam Medical Center, Amsterdam, The Netherlands. ⁸⁶Department of Pediatrics, VU Medical Center, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands. ⁸⁷Child and Adolescent Mental Health Centre, Copenhagen, Denmark. ⁸⁸Division of Child and Adolescent Psychiatry, Department of Psychiatry, University Hospital Lausanne, Lausanne, Switzerland. ⁸⁹Department of Psychiatry, Hospital Universitari Vall d'Hebron, Barcelona, Catalonia, Spain. ⁹⁰Group of Psychiatry, Addictions and Mental Health, Vall d'Hebron Research Institute, Barcelona, Barcelona, Spain. ⁹¹Biomedical Network Research Centre on Mental Health (CIBERSAM), Barcelona, Catalonia, Spain. ⁹²Department of Psychiatry and Forensic Medicine, Universitat Autònoma de Barcelona, Barcelona, Spain. ⁹³Department of Psychiatry, Psychosomatic Medicine and Psychotherapy, University Hospital Frankfurt, Frankfurt, Germany. ⁹⁴Department of Radiology and Nuclear Medicine, Amsterdam University Medical Centers, Amsterdam, The Netherlands. ⁹⁵Brain Imaging Center, Amsterdam University Medical Centers, Amsterdam, The Netherlands. ⁹⁶National Human Genome Research Institute, Bethesda, MD, USA. ⁹⁷National Institute of Mental Health, Bethesda, MD, USA. ⁹⁸School of Psychology, Deakin University, Geelong, Australia. ⁹⁹Developmental Imaging Group, Murdoch Children's Research Institute, The University of Melbourne, Melbourne, Australia. ¹⁰⁰Department of Paediatrics, The University of Melbourne, Melbourne, Australia. ¹⁰¹Institute of Mental Health, Norwegian University of Science and Technology, Trondheim, Norway. ¹⁰²Department of Psychiatry, School of Medicine, Yale University, New Haven, CT, USA. ¹⁰³Department of Pediatrics, Cincinnati Children's Hospital Medical Center, Cincinnati, OH, USA. ¹⁰⁴College of Medicine, University of Cincinnati, Cincinnati, OH, USA. ¹⁰⁵Imaging Genetics Center, Stevens Institute for Neuroimaging & Informatics, Keck School of Medicine, University of Southern California, Los Angeles, CA, USA. ¹⁰⁶Morphological Sciences Program, Federal University of Rio de Janeiro, Rio de Janeiro, Brazil. ¹⁰⁷Clinical and Translational Neuroscience Laboratory, Department of Psychiatry and Human Behavior, University of California Irvine, Irvine, CA, USA. ¹⁰⁸Hospital del Mar Medical Research Institute (IMIM), Barcelona, Spain. ¹⁰⁹Instituto ITACA, Universitat Politècnica de València, València, Spain