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Atypical functional connectivity in adolescents and adults with persistent and remitted ADHD

Giorgia Michelini[1], Joseph Jurgiel[2], Ioannis Bakolis[3], Celeste H. M. Cheung[1], Philip Asherson[1], Sandra K. Loo[2], Jonna Kuntsi[1]*, Iman Mohammad-Rezazadeh[2,4]*

***Running title**: Atypical connectivity in persistent and remitted ADHD*

*Joint senior authors

[1]King's College London, MRC Social, Genetic and Developmental Psychiatry Centre, Institute of Psychiatry, Psychology and Neuroscience, London, UK

[2]Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles (UCLA), Los Angeles, USA

[3]King's College London, Department of Biostatistics, Institute of Psychiatry, Psychology and Neuroscience, London, UK

[4]HRL Laboratories, Malibu, USA

ABSTRACT

Background: We previously provided initial evidence for cognitive and event-related potential markers of persistence/remission of attention-deficit/hyperactivity disorder (ADHD) from childhood to adolescence and adulthood. In this follow-up study, using a novel brain-network connectivity approach, we aimed to examine whether functional connectivity reflects a marker of ADHD remission, or an enduring deficit unrelated to ADHD outcome. **Methods:** High-density EEG was recorded in 110 adolescents and young adults with childhood ADHD (87 persisters, 23 remitters) and 169 typically-developing individuals during an arrow-flanker task, eliciting cognitive control. Functional connectivity was quantified with network-based graph-theory metrics before target onset (pre-stimulus), during target processing (post-stimulus) and in the degree of change between pre-stimulus/post-stimulus. ADHD outcome was examined with parent-reported symptoms and impairment using both a categorical (DSM-IV) and a dimensional approach. **Results:** Graph-theory measures converged in indicating that, compared to controls, ADHD persisters showed increased connectivity in pre-stimulus theta, alpha and beta and in post-stimulus beta (all $p<.01$), and reduced pre-stimulus/post-stimulus change in theta connectivity ($p<.01$). In the majority of indices showing ADHD persister-control differences, ADHD remitters differed from controls (all $p<.05$), but not from persisters. Similarly, connectivity measures were not associated with continuous outcome measures of ADHD symptoms and impairment in participants with childhood ADHD. **Conclusions:** Adolescents and young adults with persistent and remitted ADHD share atypical over-connectivity profiles and reduced ability to modulate connectivity patterns with task demands, compared to controls. Brain connectivity impairments may represent enduring deficits in individuals with childhood ADHD irrespective of diagnostic status in adolescence/young adulthood.

INTRODUCTION

A coherent communication between different brain regions, or brain functional connectivity, is thought to have a key role in cognition and behavior (1-3). Accumulating evidence suggests that atypical connectivity may be implicated in neurodevelopmental disorders (4-6), such as attention-deficit/hyperactivity disorder (ADHD). Most studies to date have investigated brain connectivity in ADHD using functional magnetic-resonance imaging (fMRI), with reduced connectivity within and between brain regions/sub-networks during resting (e.g., within the default-mode network (DMN) and between DMN and executive networks) observed in individuals with ADHD (7-11). Evidence of increased resting-state connectivity within and between these regions, however, has also been reported in ADHD (4, 12-16). Examining brain connectivity during task performance further allows a more direct characterization of connectivity alterations underlying the impairments in cognition and behavior associated with ADHD (17, 18). Task-based fMRI studies of ADHD show hypo-connectivity in fronto-striato-cerebellar networks during sustained attention (19) and inhibition (20-22), and hyper-connectivity within the DMN (20) and between networks of reward/cognitive control integration (23). Using the sub-second temporal resolution of electroencephalography (EEG), previous studies have further shown hypo- and hyper-connectivity in slower and faster brain oscillations from different cortical regions during rest in individuals with ADHD (24-26). Available task-based studies in children and adolescents with ADHD indicate reduced fronto-parietal theta-alpha connectivity (28, 30), but also increased connectivity in alpha (27) and beta (29). No study to date has examined task-based EEG connectivity in adults with ADHD. Overall, despite inconsistencies regarding which brain networks may be hypo- and hyper-connected, available evidence points to atypical brain connectivity in ADHD.

While atypical functional connectivity has been documented both in children (7-9) and adults (10, 11, 31) with ADHD, little is known on how these alterations map onto ADHD developmental outcomes. ADHD persists, in full or in partial remission, in the majority of adolescents and adults clinically

diagnosed in childhood (32, 33). Yet, the evidence that some individuals remit across development may suggest the presence of (1) neural processes that are markers of remission, improving concurrently with clinical profiles and distinguishing individuals with persistent and remitted ADHD (ADHD "persisters" and "remitters", respectively); and of (2) enduring deficits that are unrelated to the clinical outcome, remaining impaired in both remitters and persisters (34). The identification of such measures may help elucidate the mechanisms underlying remission/persistence, and point to candidate biomarkers for the development of new interventions for ADHD. Most studies to date, using cognitive-performance indices, found that executive functioning measures do not distinguish between ADHD persisters and remitters, and are thus insensitive to ADHD outcomes (35-39). Fewer studies have investigated the neural underpinnings of remission/persistence. In a recent follow-up of adolescents and young adults with childhood ADHD, we found that cognitive and event-related potential (ERP) markers of executive control (inhibition, working memory, conflict monitoring) were insensitive to ADHD outcome (38-40). Instead, cognitive measures and EEG activity of preparation-vigilance and error detection were markers of remission, distinguishing ADHD remitters from persisters.

Considering the important role of brain connectivity in behavior and cognition (1-3), investigating this brain-wide neural mechanism may provide new insight into the neural pathways of ADHD persistence/remission. Only three studies to date have examined functional connectivity in remitted and persistent ADHD, using fMRI (31, 41, 42). Two of these studies, using small samples, reported that ADHD persisters showed lower functional connectivity than remitters and controls between the DMN and executive network during rest (31) and between the thalamus and frontal areas during response preparation (41). Resting-state medial-dorsolateral functional associations in the prefrontal cortex, implicated in cognitive control, was instead unrelated to ADHD outcome, and reduced in both ADHD remitters and persisters, compared to controls (31). Another study, however, found higher connectivity in ADHD remitters than controls, with persisters showing intermediate profiles between

remitters and controls (42). Investigating brain connectivity using the excellent temporal resolution of EEG may provide further information in relation to ADHD remission/persistence by capturing fast and transient changes in functional connectivity (not captured by fMRI) during cognitive processes (43, 44). Yet, most EEG connectivity studies in ADHD to date present methodological limitations, such as the use of connectivity metrics contaminated by volume-conduction artefacts (i.e., the spreading and mixing of multiple brain sources at the scalp), which may produce inflated connectivity estimates (45, 46). Recently developed network approaches, such as graph theory, may be further applied to characterize brain connectivity between large-scale brain networks and identify connectivity alteration (2, 4, 47). Initial graph-theoretic evidence from two task-based studies shows atypical functional connectivity in children with ADHD (48, 49). No study to date has examined EEG connectivity in relation to longitudinal ADHD outcome.

In the present EEG study, we aimed to investigate brain functional connectivity during a cognitive control task in a follow-up of adolescents and adults with and without childhood ADHD. In previous analyses on these data we have shown that attention-vigilance cognitive processes and ERPs of error detection were markers of remission, while cognitive-ERP measures of executive and conflict processes were insensitive to ADHD outcome (39). Here, we aimed to test whether functional connectivity patterns, measured with graph-theory and connectivity metrics not contaminated by volume conduction, represent markers of ADHD remission or enduring deficits. We hypothesized that both ADHD remitters and persisters would display functional connectivity alterations during this task evoking high levels of cognitive control, consistent with most studies examining cognitive and EEG markers of executive processes (35-39).

METHODS

Sample

The sample consisted of 279 participants who were followed up on average 5.8 years (SD=1.1) after assessments in childhood (50), including 110 adolescents and young adults who met DSM-IV criteria for combined-type ADHD in childhood (10 sibling pairs and 90 singletons) and 169 control participants (76 sibling pairs and 17 singletons) (38). Participants with ADHD were initially recruited from specialized ADHD clinics, and controls from schools in the UK (50). Exclusion criteria at both assessments were: IQ<70, autism, epilepsy, brain disorders, and any genetic/medical disorder associated with externalizing behaviors that might mimic ADHD. Among those with childhood ADHD, at follow-up 87 (79%) continued to meet clinical (DSM-IV) levels of ADHD symptoms and impairment (ADHD persisters), while 23 (21%) were below the clinical cut-off (ADHD remitters) (51). Among ADHD remitters, 14 displayed ≥5 symptoms of inattention or hyperactivity-impulsivity, but did not show functional impairment. Participants attended a single research session for clinical, IQ and cognitive-EEG assessments. An estimate of IQ was derived with the vocabulary and block design subtests of the Wechsler Abbreviated Scale of Intelligence (WASI) (52). ADHD persisters, remitters and controls did not differ in age, but there were significantly more males in the remitted group than in the other two groups, with no females among ADHD remitters (Table 1) (38, 39). ADHD persisters showed lower IQ compared to remitters and controls (38, 51). 47% of participants with childhood ADHD were on drug treatment at follow-up, but the proportion of participants on medication did not differ between ADHD persisters and remitters (χ^2=1.95, p=0.16) (38). A 48-hour ADHD medication-free period was required before assessments. Parents of all participants gave informed consent following procedures approved by the London-Surrey Borders Research Ethics Committee (09/H0806/58).

[Table 1 about here]

ADHD diagnosis

The Diagnostic Interview for ADHD in Adults (DIVA) (53) was conducted by trained researchers with parents of the ADHD probands, to assess DSM-IV-defined ADHD presence and persistence of the 18 ADHD symptoms. Evidence of impairment commonly associated with ADHD was assessed with the Barkley's functional impairment scale (BFIS) (54). Parent-report DIVA and impairments were used to determine ADHD status, as these were validated against objective markers (cognitive-performance and EEG measures) in this sample, whereas the same objective markers showed limited agreement with self-reported ADHD (55). Participants were classified as "affected" at follow-up if they showed ≥6 items in either the inattention or hyperactivity-impulsivity domains on the DIVA, and ≥2 areas of impairments on the BFIS. We defined ADHD outcome using a categorical definition of persistence based on diagnoses, as well as a dimensional approach based on continuous levels of symptoms of ADHD and impairments.

Task

The task was an adaptation of the Eriksen Flanker paradigm designed to increase cognitive load (56, 57). In each trial a central fixation mark was replaced by a target arrow (a black 18mm equilateral triangle). Participants had to indicate whether this arrow pointed towards the left or right by pressing corresponding response buttons with their left or right index fingers. Two flanker arrows identical in shape and size to the target appeared 22mm above and below the center of the target arrow 100ms before each target. Both flankers either pointed in the same (congruent) or opposite (incongruent) direction to the target. Cognitive control and conflict monitoring are maximal during incongruent trials. When the target appeared, both target and flankers remained on the screen for 150ms, with a new trial every 1650ms. Two-hundred congruent and 200 incongruent trials were arranged in 10 blocks of 40 trials. Only incongruent trials, known to elicit greater ADHD-control differences (39, 57), were considered in the present analysis. For further details, see Supplement.

EEG recording and processing

The EEG was recorded from a 62-channel extended 10-20 system (Brain Products, GmbH, Munich, Germany), using a 500Hz sampling-rate, impedances under 10kΩ, and recording reference at FCz. The electro-oculograms (EOGs) were recorded from electrodes above and below the left eye and at the outer canthi. Raw EEG recordings were down-sampled to 256Hz, re-referenced to the average of all electrodes (turning FCz into an active channel), and filtered using Butterworth band-pass filters (0.10-30 Hz, 24 dB/oct). All trials were visually inspected and sections containing electrical or movement artefacts were removed manually. Ocular artefacts were identified using Independent Component Analysis (ICA) (58). Sections of data containing artefacts exceeding ±100µV or with a voltage step ≥50µV were automatically rejected. The artefact-free data were segmented in epochs between -650–1000 ms stimulus-locked to incongruent stimuli. Both trials with correct and incorrect responses were examined (39). Only data containing ≥20 clean segments for condition were included in analyses, leaving 271 participants (83 ADHD persisters, 22 remitters, 166 controls) for correctly-responded trials and 240 (75 ADHD persisters, 20 remitters, 145 controls) for incorrectly-responded trials.

Connectivity analysis

Calculation of functional connectivity

We examined functional brain connectivity with the imaginary part of coherence (iCoh), a functional association index able to detect interactions between EEG signals occurring with a certain time delay, thus ignoring instantaneous interaction between neighboring electrodes likely produced by volume conduction (45, 59, 60) (for further explanation, see Supplement). Values of iCoh for all possible electrode pairs (62x62) were computed in the theta (4-8 Hz), alpha (8-12 Hz) and beta (12-20 Hz) bands (Figure 1), which have previously been implicated in cognitive processes engaging top-down control networks requiring coherent activity between brain areas (61-63), such as the fronto-parietal network (64-67).

[Figure 1 about here]

Graph-theory metrics

The high multi-dimensionality of the iCoh measures was disentangled with a graph-theory approach. Unthresholded weighted iCoh matrices were used, in line with previous studies (6, 68-70), where each connection is equivalent to the measured iCoh of two electrodes. Graph-theory metrics measure the degree of network segregation (i.e., the tendency of brain regions to form local clusters with dense functional interconnections), and network integration and efficiency (i.e., the capacity of the network to become interconnected and efficiently exchange information between brain regions) (2, 71). The following commonly-used graph measures were calculated (6, 49, 69, 72, 73): average clustering coefficient (the probability of neighboring nodes of being inter-connected, reflecting local connectedness); global efficiency (how efficient the network is in transferring information); characteristic path length and diameter (respectively, the average number of edges along the shortest paths, and the largest possible distance, between all possible pairs of nodes). Values of iCoh and graph-theory metrics were computed with the BioNeCT toolbox (https://sites.google.com/site/bionectweb/home; (3)) and Matlab custom scripts separately for correctly- and incorrectly-responded trials in stimulus-locked windows, before target (pre-stimulus; -500–0 ms) and during target processing (post-stimulus; 0–500 ms).

Statistical analyses

Categorical analysis based on diagnostic status

Connectivity metrics were examined with random-intercept linear models (i.e., multilevel regression models) in Stata 14 (StataCorp, College Station, TX), testing for effects of group (ADHD persisters vs remitters vs controls), time window (pre-stimulus vs post-stimulus), response (correct vs incorrect) and their interaction (group-by-window-by-response). When the three-way interaction was not statistically significant, only statistically significant main effects and two-way interactions were

included. For all measures, the within-group degree of change from pre-stimulus to post-stimulus was compared across groups using difference scores. All models controlled for age and took into account the degree of clustering due to family status. Cohen's d effect sizes are presented along with test statistics, where d≥0.20 is a small effect, d≥0.50 a medium effect and d≥0.80 a large effect (74). Given the large number of hypotheses tested, sensitivity analyses applied multiple-testing corrections with false discovery rate (FDR) on post-hoc tests with the "multproc" package (75).

Since 80% of our sample consisted of males, but groups were not fully matched on sex (Table 1), analyses were performed on the whole sample and then repeated with females (15 ADHD persisters, 41 controls) removed. As in this sample ADHD persisters had a lower IQ than remitters (38), and childhood IQ predicted ADHD outcome at follow-up (51), all analyses were also re-run controlling for IQ to examine whether IQ contributes to the results. Finally, to examine brain connectivity within and between cortical regions, analyses were repeated using iCoh values within and between clusters of electrodes in different scalp regions (anterior/central/posterior) and between the two hemispheres (left/right) (for further details, see Supplement).

Dimensional analysis with ADHD symptoms/impairment

The association between connectivity and the continua of ADHD symptoms and impairment within individuals with childhood ADHD were examined with random-intercept linear models using DIVA ADHD symptom and impairment scores as independent variables, controlling for age and sex and clustering for family status. All analyses were re-run, firstly, correcting for multiple testing, and, secondly, controlling for IQ.

RESULTS

Differences between ADHD persisters, remitters and controls

Post-hoc analyses revealed that, in correctly-responded trials, ADHD persisters showed greater clustering coefficient, global efficiency and mean iCoh, and lower path length and diameter compared to controls at all frequency bands in the pre-stimulus window, and only in beta in the post-stimulus windows (Table 2, Figure 2). ADHD remitters showed lower pre-stimulus diameter in theta and beta, lower pre-stimulus path length in alpha and beta, and lower post-stimulus diameter in beta, compared to controls. ADHD remitters did not differ from persisters in any connectivity measure in correctly-responded trials, except diameter in beta (where remitters were intermediate between controls and persisters, and significantly differed from both groups) (Table 2). These findings indicate increased functional connectivity in both ADHD persisters and remitters compared to controls during correct trials. In error trials, group differences only emerged for clustering coefficient, global efficiency and mean iCoh in post-stimulus theta: both ADHD persisters and remitters showed reduced values in these measures (indicating lower connectivity) compared to controls, but did not differ from each other (Table 2). All three groups showed increased connectivity (greater clustering coefficient, global efficiency and mean iCoh; decreased path length and diameter) in incorrect compared to correct trials, in both pre-stimulus and post-stimulus windows (Table S1-S2). All main and interaction effects are shown in Table S2.

[Table 2 about here]

[Figure 2 about here]

Among measures showing significant group-by-window interactions (all in theta, all except diameter in alpha, none in beta; Table S2), significant within-group differences in changing from pre-stimulus to post-stimulus windows emerged in all groups for all theta connectivity measures, in controls only for clustering coefficient, path length and mean iCoh in the alpha band, and in both ADHD groups for

global efficiency in alpha (Table 3). ADHD persisters and remitters exhibited a significantly lower degree of change than controls in all measures of theta connectivity, but no differences emerged between the two ADHD groups (Table 3).

[Table 3 about here]

Multiple-testing corrections (controlling the FDR at 15%) on post-hoc group comparisons (separately for ADHD persisters vs controls, ADHD remitters vs controls, ADHD persisters vs remitters) showed that all significant group differences that were statistically significant remained significant, except for the difference between ADHD persisters and remitters in beta diameter. All significant group differences on measures of pre-stimulus/post-stimulus change remained statistically significant.

All results remained unchanged when rerunning analyses on the male-only sample (Table S3-S4), except that the p-values of certain tests that were statistically significant in the full sample became trend-level effects (p=0.05-0.10) (Supplement). All effect sizes were similar to those on the full sample, suggesting that these non-significant results may be due to lower power in this smaller sample.

Results of group comparisons on connectivity measures in pre- and post-stimulus were largely unchanged when IQ was included as a covariate in categorical analyses (Table S5), while few differences between persisters and controls on measures of pre-stimulus/post-stimulus change in theta and alpha connectivity during error trials were no longer significant (Table S6).

Results of analyses on group differences in local connectivity within cortical regions (within anterior/central/posterior regions and within left/right hemispheres) and these three cortical regions and two hemispheres, were consistent with those on whole-brain connectivity (Supplement).

Association with ADHD symptoms and impairment

In dimensional analyses on participants with childhood ADHD, no association emerged between ADHD symptoms and any connectivity measure in theta, alpha or beta frequencies in correct or error trials (Table 4). Functional impairment was not associated with any connectivity measure in the theta band, but showed associations with a subgroup of measures in alpha and beta in correct and error trials (Table 4). Results remained largely unchanged when controlling for IQ (Table S7). Statistically significant associations were no longer significant when applying multiple-testing corrections (Supplement).

[Table 4 about here]

DISCUSSION

Using a network-based EEG functional connectivity approach, our results indicate that ADHD persisters show widespread over-connectivity underlying cognitive-control processes compared to controls, as well as reduced adjustments of connectivity with changed task demands. ADHD remitters showed similar impairments as persisters, and differed from controls in most measures of connectivity and connectivity adjustments. These findings indicate that hyper-connectivity and reduced ability to modulate connectivity patterns with task demands characterize adolescents and young adults with both persistent and remitted ADHD. Atypical functional connectivity during cognitive-control processes may thus represent an enduring deficit in adolescents and adults with childhood ADHD, irrespective of their current diagnostic status.

Two main connectivity impairments emerged in individuals with persistent ADHD compared to controls. Firstly, ADHD persisters showed increased global connectivity (higher iCoh), network segregation (higher clustering coefficient), efficiency (higher global efficiency) and integration (lower path length and diameter) at all frequency bands prior to target onset in trials with correct behavioral responses, as well as during target processing in beta oscillations. The increases in functional connectivity are consistent with a previous EEG study reporting pre-target over-connectivity in children with ADHD (29), and more generally supports evidence indicating hyper-connectivity in ADHD (20, 23, 27, 28). Connectivity in theta, alpha and beta oscillations during cognitive tasks is associated with cognitive processes engaging control networks and requiring coordination of activity between distributed brain areas (61-63). Here, over-connectivity in these frequency ranges in persistent ADHD may reflect exaggerated interactions between brain regions, both during the inactive pre-stimulus period and during cognitive target processing. Considering the high cognitive demands induced by incongruent stimuli in this highly effortful task, which requires a response at every trial, increased connectivity (especially in the beta band) may reflect hyper-connectivity in executive control

networks. Secondly, while all groups showed increased theta connectivity in changing from pre-stimulus to post-stimulus windows, this change was reduced in ADHD persisters compared to controls. This result in individuals with ADHD may point to a reduced ability to modulate brain connectivity patterns in slow oscillations from a relatively inactive context to a condition requiring cognitive engagement. This finding is in line with previous reports indicating reduced regulation of brain activity in ADHD between different cognitive states (76-78). Overall, these findings show widespread connectivity impairments underlying cognitive-control processes in ADHD persisters, and advance our understanding of the neural underpinnings of persistent ADHD in adolescence and early adulthood.

Our study represents the first investigation into EEG connectivity in adolescents and adults with remitted ADHD. In several connectivity measures sensitive to impairments in persisters, ADHD remitters were impaired compared to controls and indistinguishable from persisters, consistent with our hypotheses. ADHD remitters also showed the same reduction in all measures of pre-stimulus/post-stimulus change in theta connectivity displayed by persisters. As such, brain connectivity impairments were insensitive to ADHD outcome (remission/persistence) in adolescence and early adulthood, and may represent enduring deficits irrespective of current diagnostic status. Findings from dimensional analyses supported these results, as most connectivity measures were unrelated to continuous levels of ADHD symptoms and impairments in participants with childhood ADHD. Of note, while results of categorical analyses were largely unchanged after correcting for multiple testing, the few significant associations between connectivity and functional impairment did not survive multiple-testing corrections. Overall, these connectivity findings in remitters are consistent with previous cognitive-EEG studies, including our previous analyses on this sample (38, 39), reporting that executive-functioning measures were insensitive to ADHD outcomes in adolescence and adulthood (35-39). They also partially align with results from a previous resting-state connectivity fMRI study, which found over-connectivity in remitters compared to controls and no differences between remitters and persisters (42). A clinical implication is that connectivity

impairments in executive-control processes may not be suitable targets for interventions for ADHD, consistent with previous evidence of no effects of stimulants on EEG connectivity in ADHD (25, 79). Future EEG studies should examine whether connectivity during less effortful activities, such as rest or non-executive processes, represent markers of remission, similar to cognitive-EEG measures of non-executive processes in our previous studies (38-40).

Of note, while widespread group differences emerged in correctly-responded trials, group differences in error trials, likely representing a failure of cognitive control, emerged only in three measures of post-stimulus theta connectivity. The limited group differences in incorrect responses may suggest that a failure in brain connectivity may attenuate the differences in brain-network profiles of neurotypical individuals from individuals with ADHD, who are prone to making more incorrect responses (39). In addition, all groups showed greater connectivity before and during incorrect responses than correct responses. A suboptimal pattern of pre-stimulus and post-stimulus over-connectivity underlying cognitive control processes may thus lead to a dysfunctional behavioral response, both in neurotypical individuals and in individuals with childhood ADHD. Future family model-fitting analyses (80) will investigate the phenotypic and etiological associations between brain connectivity and cognitive-performance impairments in ADHD, which will provide new insights into the inter-relationships between these impairments.

A limitation of this study is that, despite the large sample, the low ADHD remission rate at follow-up resulted in a relatively small group of remitters. Therefore, we could not exclude the possibility that some non-significant group differences could be due to low power. However, the moderate effect sizes (d=0.38-0.53) between ADHD remitters and controls, but negligible or small (d=0.02-0.36) between remitters and persisters, in measures showing ADHD persister-control differences suggest that we had sufficient power to detect, with the current sample sizes, differences in connectivity with at least moderate effect sizes. In addition, our sample included young adults as well as adolescents,

who are still undergoing rapid cortical maturation. While analyses controlled for age, future follow-up assessments with participants having reached adulthood could provide further insight into developmental patterns. Finally, while the current EEG connectivity analyses allowed precise temporal resolution and connectivity estimates unaffected by volume-conduction artefacts, the relatively poor spatial resolution of scalp-EEG did not allow precise localization of the brain networks. Yet, results of local connectivity within and between cortical regions were consistent with those of whole-brain analyses, indicating comparable effects in more localized networks.

In conclusion, we report new evidence of shared atypical connectivity profiles in adolescents and young adults with persistent and remitted ADHD. These connectivity alterations may represent enduring deficits and neural signatures associated with having a history of childhood ADHD, but unrelated to current diagnostic status. Connectivity impairments underlying executive processes may represent associated characteristics or risk factors in ADHD (81), which do not follow the developmental pathways of clinical profiles. Future studies should explore the presence of potential compensatory mechanisms in individuals with remitted ADHD that enable developmental improvements in clinical profiles and non-executive cognitive processes (38-40), despite persistence of enduring connectivity alterations.

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FINANCIAL DISCLOSURES

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REFERENCES

1. Deco G, Kringelbach M (2016): Metastability and Coherence: Extending the Communication through Coherence Hypothesis Using a Whole-Brain Computational Perspective. *Trends Neurosci*. 39:432.
2. Bullmore E, Sporns O (2009): Complex brain networks: graph theoretical analysis of structural and functional systems. *Nat Rev Neurosci*. 10:186-198.
3. Coben R, Mohammad-Rezazadeh I, Frohich J, Jurgiel J, Michelini G (2017): Imaging brain connectivity in autism spectrum disorder. *Autism Imaging and Devices*: CRC Press.
4. Castellanos FX, Aoki Y (2016): Intrinsic Functional Connectivity in Attention-Deficit/Hyperactivity Disorder: A Science in Development. *Biol Psychiatry Cogn Neurosci Neuroimaging*. 1:253-261.
5. Kitzbichler MG, Khan S, Ganesan S, Vangel MG, Herbert MR, Hamalainen MS, et al. (2015): Altered development and multifaceted band-specific abnormalities of resting state networks in autism. *Biol Psychiatry*. 77:794-804.
6. Xing M, Tadayonnejad R, MacNamara A, Ajilore O, DiGangi J, Phan KL, et al. (2017): Resting-state theta band connectivity and graph analysis in generalized social anxiety disorder. *Neuroimage Clin*. 13:24-32.
7. Fair DA, Posner J, Nagel BJ, Bathula D, Dias TG, Mills KL, et al. (2010): Atypical default network connectivity in youth with attention-deficit/hyperactivity disorder. *Biol Psychiatry*. 68:1084-1091.
8. Sripada C, Kessler D, Fang Y, Welsh RC, Prem Kumar K, Angstadt M (2014): Disrupted network architecture of the resting brain in attention-deficit/hyperactivity disorder. *Hum Brain Mapp*. 35:4693-4705.
9. Sun L, Cao Q, Long X, Sui M, Cao X, Zhu C, et al. (2012): Abnormal functional connectivity between the anterior cingulate and the default mode network in drug-naive boys with attention deficit hyperactivity disorder. *Psychiatry Res*. 201:120-127.
10. Castellanos FX, Margulies DS, Kelly C, Uddin LQ, Ghaffari M, Kirsch A, et al. (2008): Cingulate-precuneus interactions: a new locus of dysfunction in adult attention-deficit/hyperactivity disorder. *Biol Psychiatry*. 63:332-337.
11. Uddin LQ, Kelly AM, Biswal BB, Margulies DS, Shehzad Z, Shaw D, et al. (2008): Network homogeneity reveals decreased integrity of default-mode network in ADHD. *J Neurosci Methods*. 169:249-254.
12. Barbera ADJ, Lisa A., Wexlera JL, Nebela MB, Caffo BS, Pekara JJ, Mostofsky SH (2015): Connectivity supporting attention in children with attention deficit hyperactivity disorder. *Neuroimage Clin*. 7:68-81.
13. Hoekzema E, Carmona S, Ramos-Quiroga JA, Richarte Fernandez V, Bosch R, Soliva JC, et al. (2014): An independent components and functional connectivity analysis of resting state fMRI data points to neural network dysregulation in adult ADHD. *Hum Brain Mapp*. 35:1261-1272.
14. McCarthy H, Skokauskas N, Mulligan A, Donohoe G, Mullins D, Kelly J, et al. (2013): Attention network hypoconnectivity with default and affective network hyperconnectivity in adults diagnosed with attention-deficit/hyperactivity disorder in childhood. *JAMA Psychiatry*. 70:1329-1337.
15. Tian L, Jiang T, Wang Y, Zang Y, He Y, Liang M, et al. (2006): Altered resting-state functional connectivity patterns of anterior cingulate cortex in adolescents with attention deficit hyperactivity disorder. *Neurosci Lett*. 400:39-43.
16. Sidlauskaite J, Sonuga-Barke E, Roeyers H, Wiersema JR (2016): Altered intrinsic organisation of brain networks implicated in attentional processes in adult attention-deficit/hyperactivity disorder: a resting-state study of attention, default mode and salience network connectivity. *Eur Arch Psychiatry Clin Neurosci*. 266:349-357.

17. Ernst M, Torrisi S, Balderston N, Grillon C, Hale EA (2015): fMRI functional connectivity applied to adolescent neurodevelopment. *Annu Rev Clin Psychol*. 11:361-377.
18. Finn ES, Scheinost D, Finn DM, Shen X, Papademetris X, Constable RT (2017): Can brain state be manipulated to emphasize individual differences in functional connectivity? *Neuroimage*.
19. Rubia K, Halari R, Cubillo A, Mohammad AM, Brammer M, Taylor E (2009): Methylphenidate normalises activation and functional connectivity deficits in attention and motivation networks in medication-naive children with ADHD during a rewarded continuous performance task. *Neuropharmacology*. 57:640-652.
20. van Rooij D, Hartman CA, Mennes M, Oosterlaan J, Franke B, Rommelse N, et al. (2015): Altered neural connectivity during response inhibition in adolescents with attention-deficit/hyperactivity disorder and their unaffected siblings. *Neuroimage Clin*. 7:325-335.
21. Cubillo A, Halari R, Ecker C, Giampietro V, Taylor E, Rubia K (2010): Reduced activation and inter-regional functional connectivity of fronto-striatal networks in adults with childhood Attention-Deficit Hyperactivity Disorder (ADHD) and persisting symptoms during tasks of motor inhibition and cognitive switching. *J Psychiatr Res*. 44:629-639.
22. Vloet TD, Gilsbach S, Neufang S, Fink GR, Herpertz-Dahlmann B, Konrad K (2010): Neural mechanisms of interference control and time discrimination in attention-deficit/hyperactivity disorder. *J Am Acad Child Adolesc Psychiatry*. 49:356-367.
23. Ma I, van Holstein M, Mies GW, Mennes M, Buitelaar J, Cools R, et al. (2016): Ventral striatal hyperconnectivity during rewarded interference control in adolescents with ADHD. *Cortex*. 82:225-236.
24. Clarke AR, Barry RJ, McCarthy R, Selikowitz M, Johnstone SJ, Hsu CI, et al. (2007): Coherence in children with Attention-Deficit/Hyperactivity Disorder and excess beta activity in their EEG. *Clin Neurophysiol*. 118:1472-1479.
25. Dupuy FE, Clarke AR, Barry RJ, McCarthy R, Selikowitz M (2008): EEG coherence in girls with attention-deficit/hyperactivity disorder: stimulant effects in good responders. *Int J Psychophysiol*. 70:151-157.
26. Barry RJ, Clarke AR, McCarthy R, Selikowitz M, Johnstone SJ (2005): EEG coherence adjusted for inter-electrode distance in children with attention-deficit/hyperactivity disorder. *Int J Psychophysiol*. 58:12-20.
27. Murias M, Swanson JM, Srinivasan R (2007): Functional connectivity of frontal cortex in healthy and ADHD children reflected in EEG coherence. *Cereb Cortex*. 17:1788-1799.
28. Mazaheri A, Fassbender C, Coffey-Corina S, Hartanto TA, Schweitzer JB, Mangun GR (2014): Differential oscillatory electroencephalogram between attention-deficit/hyperactivity disorder subtypes and typically developing adolescents. *Biol Psychiatry*. 76:422-429.
29. Silberstein RB, Pipingas A, Farrow M, Levy F, Stough CK, Camfield DA (2016): Brain functional connectivity abnormalities in attention-deficit hyperactivity disorder. *Brain Behav*. 6:e00583.
30. Mazaheri A, Coffey-Corina S, Mangun GR, Bekker EM, Berry AS, Corbett BA (2010): Functional disconnection of frontal cortex and visual cortex in attention-deficit/hyperactivity disorder. *Biol Psychiatry*. 67:617-623.
31. Mattfeld AT, Gabrieli JD, Biederman J, Spencer T, Brown A, Kotte A, et al. (2014): Brain differences between persistent and remitted attention deficit hyperactivity disorder. *Brain*. 137:2423-2428.
32. Faraone SV, Biederman J, Mick E (2006): The age-dependent decline of attention deficit hyperactivity disorder: a meta-analysis of follow-up studies. *Psychol Med*. 36:159-165.
33. Sibley MH, Swanson JM, Arnold LE, Hechtman LT, Owens EB, Stehli A, et al. (2016): Defining ADHD symptom persistence in adulthood: optimizing sensitivity and specificity. *J Child Psychol Psychiatry*.
34. Halperin JM, Schulz KP (2006): Revisiting the role of the prefrontal cortex in the pathophysiology of attention-deficit/hyperactivity disorder. *Psychol Bull*. 132:560-581.

35. Pazvantoglu O, Aker AA, Karabekiroglu K, Akbas S, Sarisoy G, Baykal S, et al. (2012): Neuropsychological weaknesses in adult ADHD; cognitive functions as core deficit and roles of them in persistence to adulthood. *J Int Neuropsychol Soc*. 18:819-826.
36. Biederman J, Petty CR, Ball SW, Fried R, Doyle AE, Cohen D, et al. (2009): Are cognitive deficits in attention deficit/hyperactivity disorder related to the course of the disorder? A prospective controlled follow-up study of grown up boys with persistent and remitting course. *Psychiatry Res*. 170:177-182.
37. McAuley T, Crosbie J, Charach A, Schachar R (2014): The persistence of cognitive deficits in remitted and unremitted ADHD: a case for the state-independence of response inhibition. *J Child Psychol Psychiatry*. 55:292-300.
38. Cheung CH, Rijsdijk F, McLoughlin G, Brandeis D, Banaschewski T, Asherson P, et al. (2016): Cognitive and neurophysiological markers of ADHD persistence and remission. *Br J Psychiatry*. 208:548-555.
39. Michelini G, Kitsune GL, Cheung CH, Brandeis D, Banaschewski T, Asherson P, et al. (2016): Attention-Deficit/Hyperactivity Disorder Remission Is Linked to Better Neurophysiological Error Detection and Attention-Vigilance Processes. *Biol Psychiatry*. 80:923-932.
40. James S-N, Cheung CH, Rommel A-S, Rijsdijk F, McLoughlin G, Brandeis D, et al. (2017): Peripheral Hypoarousal but Not Preparation-Vigilance Impairment Endures in ADHD Remission. *Journal of Attention Disorders*.
41. Clerkin SM, Schulz KP, Berwid OG, Fan J, Newcorn JH, Tang CY, et al. (2013): Thalamo-cortical activation and connectivity during response preparation in adults with persistent and remitted ADHD. *Am J Psychiatry*. 170:1011-1019.
42. Francx W, Oldehinkel M, Oosterlaan J, Heslenfeld D, Hartman CA, Hoekstra PJ, et al. (2015): The executive control network and symptomatic improvement in attention-deficit/hyperactivity disorder. *Cortex*. 73:62-72.
43. Coben R, Mohammad-Rezazadeh I, Cannon RL (2014): Using quantitative and analytic EEG methods in the understanding of connectivity in autism spectrum disorders: a theory of mixed over- and under-connectivity. *Front Hum Neurosci*. 8:45.
44. McLoughlin G, Makeig S, Tsuang MT (2014): In search of biomarkers in psychiatry: EEG-based measures of brain function. *Am J Med Genet B Neuropsychiatr Genet*. 165b:111-121.
45. Nolte G, Bai O, Wheaton L, Mari Z, Vorbach S, Hallett M (2004): Identifying true brain interaction from EEG data using the imaginary part of coherency. *Clin Neurophysiol*. 115:2292-2307.
46. Nunez PL, Srinivasan R, Westdorp AF, Wijesinghe RS, Tucker DM, Silberstein RB, et al. (1997): EEG coherency. I: Statistics, reference electrode, volume conduction, Laplacians, cortical imaging, and interpretation at multiple scales. *Electroencephalogr Clin Neurophysiol*. 103:499-515.
47. Rubinov M, Sporns O (2010): Complex network measures of brain connectivity: uses and interpretations. *Neuroimage*. 52:1059-1069.
48. Xia S, Foxe JJ, Sroubek AE, Branch C, Li X (2014): Topological organization of the "small-world" visual attention network in children with attention deficit/hyperactivity disorder (ADHD). *Front Hum Neurosci*. 8:162.
49. Liu T, Chen Y, Lin P, Wang J (2015): Small-World Brain Functional Networks in Children With Attention-Deficit/Hyperactivity Disorder Revealed by EEG Synchrony. *Clin EEG Neurosci*. 46:183-191.
50. Kuntsi J, Wood AC, Rijsdijk F, Johnson KA, Andreou P, Albrecht B, et al. (2010): Separation of cognitive impairments in attention-deficit/hyperactivity disorder into 2 familial factors. *Arch Gen Psychiatry*. 67:1159-1167.
51. Cheung CH, Rijsdijk F, McLoughlin G, Faraone SV, Asherson P, Kuntsi J (2015): Childhood predictors of adolescent and young adult outcome in ADHD. *J Psychiatr Res*. 62:92-100.
52. Wechsler D (1999): *Wechsler Abbreviated Scale of Intelligence (WASI)*. Harcourt Assessment.
53. Ramos-Quiroga JA, Nasillo V, Richarte V, Corrales M, Palma F, Ibanez P, et al. (2016): Criteria and Concurrent Validity of DIVA 2.0: A Semi-Structured Diagnostic Interview for Adult ADHD. *J Atten Disord*.

54. Barkley RA, Murphy K (2006): *Attention Deficit Hyperactivity Disorder: A Clinical Workbook*. 3rd Edition ed. New York: Guildford Press.
55. Du Rietz E, Cheung CH, McLoughlin G, Brandeis D, Banaschewski T, Asherson P, et al. (2016): Self-report of ADHD shows limited agreement with objective markers of persistence and remittance. *J Psychiatr Res*. 82:91-99.
56. Albrecht B, Brandeis D, Uebel H, Heinrich H, Mueller UC, Hasselhorn M, et al. (2008): Action monitoring in boys with attention-deficit/hyperactivity disorder, their nonaffected siblings, and normal control subjects: evidence for an endophenotype. *Biol Psychiatry*. 64:615-625.
57. McLoughlin G, Palmer JA, Rijsdijk F, Makeig S (2014): Genetic overlap between evoked frontocentral theta-band phase variability, reaction time variability, and attention-deficit/hyperactivity disorder symptoms in a twin study. *Biol Psychiatry*. 75:238-247.
58. Jung TP, Makeig S, Humphries C, Lee TW, McKeown MJ, Iragui V, et al. (2000): Removing electroencephalographic artifacts by blind source separation. *Psychophysiology*. 37:163-178.
59. Hinkley LB, Owen JP, Fisher M, Findlay AM, Vinogradov S, Nagarajan SS (2010): Cognitive Impairments in Schizophrenia as Assessed Through Activation and Connectivity Measures of Magnetoencephalography (MEG) Data. *Front Hum Neurosci*. 3:73.
60. Palva S, Palva JM (2012): Discovering oscillatory interaction networks with M/EEG: challenges and breakthroughs. *Trends Cogn Sci*. 16:219-230.
61. Buzsaki G, Draguhn A (2004): Neuronal oscillations in cortical networks. *Science*. 304:1926-1929.
62. Uhlhaas PJ, Singer W (2006): Neural synchrony in brain disorders: relevance for cognitive dysfunctions and pathophysiology. *Neuron*. 52:155-168.
63. Wang XJ (2010): Neurophysiological and computational principles of cortical rhythms in cognition. *Physiol Rev*. 90:1195-1268.
64. Klimesch W, Freunberger R, Sauseng P (2010): Oscillatory mechanisms of process binding in memory. *Neurosci Biobehav Rev*. 34:1002-1014.
65. Klimesch W, Sauseng P, Hanslmayr S (2007): EEG alpha oscillations: the inhibition-timing hypothesis. *Brain Res Rev*. 53:63-88.
66. Halgren E, Boujon C, Clarke J, Wang C, Chauvel P (2002): Rapid distributed fronto-parieto-occipital processing stages during working memory in humans. *Cereb Cortex*. 12:710-728.
67. Capotosto P, Babiloni C, Romani GL, Corbetta M (2009): Frontoparietal cortex controls spatial attention through modulation of anticipatory alpha rhythms. *J Neurosci*. 29:5863-5872.
68. Hardmeier M, Hatz F, Bousleiman H, Schindler C, Stam CJ, Fuhr P (2014): Reproducibility of functional connectivity and graph measures based on the phase lag index (PLI) and weighted phase lag index (wPLI) derived from high resolution EEG. *PLoS One*. 9:e108648.
69. Boersma M, Kemner C, de Reus MA, Collin G, Snijders TM, Hofman D, et al. (2013): Disrupted functional brain networks in autistic toddlers. *Brain Connect*. 3:41-49.
70. van den Heuvel MP, Mandl RC, Stam CJ, Kahn RS, Hulshoff Pol HE (2010): Aberrant frontal and temporal complex network structure in schizophrenia: a graph theoretical analysis. *J Neurosci*. 30:15915-15926.
71. Sporns O (2014): Contributions and challenges for network models in cognitive neuroscience. *Nat Neurosci*. 17:652-660.
72. Ahmadlou M, Adeli H, Adeli A (2012): Graph theoretical analysis of organization of functional brain networks in ADHD. *Clin EEG Neurosci*. 43:5-13.
73. Fraga Gonzalez G, Van der Molen MJ, Zaric G, Bonte M, Tijms J, Blomert L, et al. (2016): Graph analysis of EEG resting state functional networks in dyslexic readers. *Clin Neurophysiol*. 127:3165-3175.
74. Cohen J (1988): *Statistical power analysis for the behavioral sciences*. 2nd ed. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
75. Simes RJ (1986): An improved Bonferroni procedure for multiple tests of significance. *Biometrika*. 73:751-754.

76. Rommel AS, Kitsune GL, Michelini G, Hosang GM, Asherson P, McLoughlin G, et al. (2016): Commonalities in EEG Spectral Power Abnormalities Between Women With ADHD and Women With Bipolar Disorder During Rest and Cognitive Performance. *Brain Topogr*.
77. Skirrow C, McLoughlin G, Banaschewski T, Brandeis D, Kuntsi J, Asherson P (2015): Normalisation of frontal theta activity following methylphenidate treatment in adult attention-deficit/hyperactivity disorder. *Eur Neuropsychopharmacol*. 25:85-94.
78. Cheung CH, McLoughlin G, Brandeis D, Banaschewski T, Asherson P, Kuntsi J (2017): Neurophysiological correlates of attentional fluctuation in attention-deficit/hyperactivity disorder. *Brain Topography*.
79. Clarke AR, Barry RJ, McCarthy R, Selikowitz M, Johnstone SJ, Abbott I, et al. (2005): Effects of methylphenidate on EEG coherence in attention-deficit/hyperactivity disorder. *Int J Psychophysiol*. 58:4-11.
80. James SN, Cheung CH, Rijsdijk F, Asherson P, Kuntsi J (2016): Modifiable Arousal in Attention-Deficit/Hyperactivity Disorder and Its Etiological Association With Fluctuating Reaction Times. *Biol Psychiatry Cogn Neurosci Neuroimaging*. 1:539-547.
81. Johnson MH (2012): Executive function and developmental disorders: the flip side of the coin. *Trends Cogn Sci*. 16:454-457.

TABLES

Table 1. Sample demographics divided by group, with tests for differences between ADHD persisters, remitters and controls

	ADHD-R (n=23)	ADHD-P (n=87)	Ctrl (n=169)	Group Comparison			
					Ctrl vs ADHD-P	Ctrl vs ADHD-R	ADHD-P vs ADHD-R
	M:F	M:F	M:F	p	p	p	p
Gender	23:0	72:15	129:40	.02*	.24	<.01**	.03*
	mean (SD)	mean (SD)	mean (SD)	p	p	p	p
Age	18.89 (3.06)	18.27 (3.03)	18.77 (2.19)	.15	-	-	-
IQ	104.57 (13.63)	96.20 (15.33)	109.98 (12.42)	<.01**	<.01**	.10	.02*

Abbreviations: ADHD-P = ADHD persisters; ADHD-R = ADHD remitters; Ctrl = Control group; F = number of females; M = number of males.

Notes: Group differences on gender were tested via Chi-square test; group differences on age and IQ were tested with linear regressions. Group differences in gender, age and IQ were previously reported in other papers on this sample (38, 39).

***p<.01; *p<.05.*

Table 2. Group comparisons on graph-theory and imaginary coherence measures

			Group comparison					
		Overall Group	**Ctrl vs ADHD-P**		**Ctrl vs ADHD-R**		**ADHD-R vs ADHD-P**	
THETA		**p**	**p**	**d**	**p**	**d**	**p**	**d**
Average clustering coefficient	*Pre, Corr*	0.016*	0.004**	*0.63*	0.880	0.29	0.139	0.35
	Pre, Err	0.544	-	-	-	-	-	-
	Post, Corr	0.401	-	-	-	-	-	-
	Post, Err	<0.001***	<0.001***	0.35	0.017*	0.30	0.955	0.05
Global efficiency	*Pre, Corr*	0.053	0.019*	*0.51*	0.901	0.16	0.145	0.37
	Pre, Err	0.568	-	-	-	-	-	-
	Post, Corr	0.189	-	-	-	-	-	-
	Post, Err	<0.001***	<0.001***	0.35	0.019*	0.30	0.916	0.05
Path length	*Pre, Corr*	0.012*	<0.001***	*0.58*	0.095	0.30	0.130	0.30
	Pre, Err	0.434	-	-	-	-	-	-
	Post, Corr	0.338	-	-	-	-	-	-
	Post, Err	0.122	-	-	-	-	-	-
Diameter	*Pre, Corr*	<0.001***	<0.001***	*0.64*	0.012*	0.49	0.352	0.17
	Pre, Err	0.646	-	-	-	-	-	-
	Post, Corr	0.976	-	-	-	-	-	-
	Post, Err	0.279	-	-	-	-	-	-
Mean imaginary coherence	*Pre, Corr*	0.024*	0.007**	*0.60*	0.952	-0.25	0.140	0.35
	Pre, Err	0.562	-	-	-	-	-	-
	Post, Corr	0.319	-	-	-	-	-	-
	Post, Err	<0.001***	<0.001***	0.35	0.019*	0.30	0.955	0.06
ALPHA		**Overall Group**	**Ctrl vs ADHD-P**		**Ctrl vs ADHD-R**		**ADHD-R vs ADHD-P**	
		p	**p**	**d**	**p**	**d**	**p**	**d**
	Pre, Corr	0.001**	<0.001***	0.44	0.097	0.42	0.636	0.06

	Pre, Err	0.415	-	-	-	-	-	-
Average clustering coefficient	*Post, Corr*	0.328	-	-	-	-	-	-
	Post, Err	0.084	-	-	-	-	-	-
	Pre, Corr	0.003**	0.002**	0.32	0.054	0.39	0.976	0.04
	Pre, Err	0.325	-	-	-	-	-	-
	Post, Corr	0.816	-	-	-	-	-	-
Global efficiency	*Post, Err*	0.152	-	-	-	-	-	-
	Pre, Corr	<0.001***	<0.001***	0.32	0.005**	0.47	0.539	0.13
	Pre, Err	0.709	-	-	-	-	-	-
	Post, Corr	0.201	-	-	-	-	-	-
Path length	*Post, Err*	0.235	-	-	-	-	-	-
	Corr	<0.001***	<0.001***	0.41	0.054	0.30	0.610	0.13
Diameter	*Err*	0.444	-	-	-	-	-	-
	Pre, Corr	0.001**	<0.001***	0.40	0.073	0.39	0.684	0.04
	Pre, Err	0.341	-	-	-	-	-	-
Mean imaginary coherence	*Post, Corr*	0.501	-	-	-	-	-	-
	Post, Err	0.064	-	-	-	-	-	-
		Overall Group	**Ctrl vs ADHD-P**		**Ctrl vs ADHD-R**		**ADHD-R vs ADHD-P**	
BETA		**p**	**p**	**d**	**p**	**d**	**p**	**d**
Average clustering coefficient	*Corr*	<0.001***	<0.001***	*0.79*	0.097	*0.51*	0.101	0.31
	Err	0.135	-	-	-	-	-	-
	Corr	<0.001***	<0.001***	*0.73*	0.137	0.44	0.098	0.31
Global efficiency	*Err*	0.154	-	-	-	-	-	-
	Corr	<0.001***	<0.001***	*0.76*	0.004**	*0.52*	0.090	0.27
Path length	*Err*	0.343	-	-	-	-	-	-
	Corr	<0.001***	<0.001***	**0.83**	0.003**	*0.53*	0.044*	0.31
Diameter	*Err*	0.221	-	-	-	-	-	-

Mean imaginary coherence	*Corr*	<0.001***	<0.001***	*0.77*	0.097	*0.49*	0.101	0.31
	Err	0.135	-	-	-	-	-	-

Abbreviations: ADHD-P = ADHD persisters; ADHD-R = ADHD remitters; Corr = trials with correct responses; Ctrl = Control group; d = Cohen's d effect size; Err = trials with incorrect responses; p = random-intercept linear model significance testing; Pre = pre-stimulus time window; Post = post-stimulus time window.

Notes: Random-intercept linear models tested for main effects of group (ADHD remitters vs ADHD persisters vs controls), time window (pre-stimulus vs post-stimulus) ad response (correctly- vs incorrectly-responded trials), two-way interactions (group-by-window, group-by-response, time window-by-response), and three-way interactions (group-by-window-by-response) on connectivity measures. Full results are presented in Table S2, Supplement. Since neither diameter in the alpha band, nor any measures in the beta band showed a significant group-by-window interaction, post-hoc effects of group were tested for with correctly- and incorrectly-responded trials collapsed across pre-stimulus and post-stimulus time windows. Post-hoc comparisons between groups were run only on measures showing a significant overall group effect. Age was also included as a covariate of no interest in all analyses. Data in correctly-responded trials were available for 83 ADHD persisters, 22 remitters, 166 controls; and in incorrectly-responded trials for 75 ADHD persisters, 20 remitters, 145 controls.

**p<0.05; **p<0.01; ***p<0.001. d≥0.20 = small effect size, d≥0.50 = medium effect (in italics) and d≥0.80 = large effect size (in bold).*

Table 3. Within- and between-group effects on measures of change between pre-stimulus and post-stimulus windows in graph-theory and imaginary coherence measures

		Within-Group Change			Between-Group Change					
		Ctrl	ADHD-P	ADHD-R	Ctrl vs ADHD-P		Ctrl vs ADHD-R		ADHD-R vs ADHD-P	
THETA		**p**	**p**	**p**	**p**	**d**	**p**	**d**	**p**	**d**
Average clustering coefficient	*Corr*	<0.001***	<0.001***	<0.001***	0.001**	0.42	0.010*	0.41	0.981	0.05
	Err	<0.001***	<0.001***	<0.001***	0.011*	0.33	0.618	0.06	0.370	0.26
Global efficiency	*Corr*	<0.001***	<0.001***	<0.001***	0.002**	0.40	0.014*	0.38	0.997	0.04
	Err	<0.001***	<0.001***	<0.001***	0.017*	0.31	0.643	0.06	0.400	0.25
Path length	*Corr*	<0.001***	<0.001***	<0.001***	<0.001***	*0.61*	0.014*	0.44	0.506	0.19
	Err	<0.001***	<0.001***	<0.001***	0.058	0.27	0.776	0.11	0.209	0.36
Diameter	*Corr*	<0.001***	<0.001***	<0.001***	<0.001***	*0.61*	0.016*	0.43	0.499	0.19
	Err	<0.001***	<0.001***	<0.001***	0.058	0.20	0.776	0.14	0.209	0.33
Mean imaginary coherence	*Corr*	<0.001***	<0.001***	<0.001***	0.001**	0.42	0.011*	0.40	0.995	0.05
	Err	<0.001***	<0.001***	<0.001***	0.013*	0.33	0.632	0.06	0.378	0.26
		Ctrl	**ADHD-P**	**ADHD-R**	**Ctrl vs ADHD-P**		**Ctrl vs ADHD-R**		**ADHD-R vs ADHD-P**	
ALPHA		**p**	**p**	**p**	**p**	**d**	**p**	**d**	**p**	**d**
Average clustering coefficient	*Corr*	0.002**	0.910	0.767	0.055	0.27	0.091	0.38	0.704	0.09
	Err	0.001**	0.981	0.599	0.069	0.28	0.267	0.16	0.468	0.13
Global efficiency	*Corr*	0.728	0.004**	0.045*	0.071	0.27	0.147	0.40	0.705	0.11
	Err	0.155	0.029*	0.683	0.019*	0.38	0.140	0.25	0.389	0.15
Path length	*Corr*	0.002**	0.856	0.319	0.124	0.20	0.049*	0.42	0.349	0.23

	Err	0.011*	0.831	0.931	0.023*	0.37	0.094	0.33	0.743	0.07
Mean imaginary coherence	*Corr*	0.020*	0.491	0.472	0.064	0.27	0.111	0.37	0.735	0.08
	Err	0.001**	0.545	0.791	0.015*	0.40	0.087	0.30	0.469	0.13

Abbreviations: ADHD-P = ADHD persisters; ADHD-R = ADHD remitters; Corr = trials with correct responses; Ctrl = Control group; d = Cohen's d effect size; Err = trials with incorrect responses; p = random-intercept linear model significance testing.

Notes: Random-intercept linear models tested for main effects of group (ADHD remitters vs ADHD persisters vs controls), time window (pre-stimulus vs post-stimulus) ad response (correctly- vs incorrectly-responded trials), two-way interactions (group-by-window, group-by-response, time window-by-response), and three-way interactions (group-by-window-by-response) on connectivity measures. Full results are presented in Table S2, Supplement. Post-hoc tests on within- and between-group effects of change were run only on measures showing a significant group-by-window interaction. Since this interaction was not significant in diameter in the alpha band or in any measures in the beta band, post-hoc within- and between-groups effects of change were not tested. Age was also included as a covariate of no interest in all analyses. Data in correctly-responded trials were available for 83 ADHD persisters, 22 remitters, 166 controls; and in incorrectly-responded trials for 75 ADHD persisters, 20 remitters, 145 controls.

**p<0.05; **p<0.01; ***p<0.001. d≥0.20 = small effect size, d≥0.50 = medium effect (in italics).*

Table 4. Dimensional associations between graph-theory and imaginary coherence measures and interview-based DIVA ADHD symptom counts and clinical impairment within the ADHD group only (n=110), controlling for age and gender

		ADHD symptoms		Impairment	
THETA		**β (95% CIs)**	**p**	**β (95% CIs)**	**p**
Average clustering coefficient	*Pre, Corr*	<0.001 (-0.001;0.001)	0.964	<0.001 (-0.001;0.001)	0.163
	Pre, Err	<0.001 (-0.001;0.001)	0.844	<0.001 (-0.000;0.001)	0.110
	Post, Corr	<0.001 (-0.001;0.001)	0.827	<0.001 (-0.001;0.001)	0.111
	Post, Err	-0.001 (-0.002;0.001)	0.315	<0.001 (-0.001;0.001)	0.494
Global efficiency	*Pre, Corr*	<0.001 (-0.001;0.001)	0.685	<0.001 (-0.001;0.001)	0.393
	Pre, Err	<0.001 (-0.001;0.001)	0.969	<0.001 (-0.000;0.001)	0.110
	Post, Corr	<0.001 (-0.001;0.001)	0.667	0.001 (-0.001;0.001)	0.194
	Post, Err	-0.001 (-0.002;0.001)	0.196	-0.001 (-0.001;0.001)	0.120
Path length	*Pre, Corr*	0.029 (-0.127;0.185)	0.716	-0.052 (-0.135;0.032)	0.226
	Pre, Err	-0.017 (-0.148;0.114)	0.797	-0.053 (-0.123;0.016)	0.132
	Post, Corr	0.041 (-0.086;0.169)	0.528	-0.030 (-0.098;0.039)	0.395
	Post, Err	0.053 (-0.045;0.151)	0.290	0.013 (-0.040;0.066)	0.630
Diameter	*Pre, Corr*	0.067 (-0.185;0.320)	0.601	-0.072 (-0.211;0.067)	0.310
	Pre, Err	-0.044 (-0.259;0.170)	0.685	-0.083 (-0.196;0.031)	0.153
	Post, Corr	0.032 (-0.171;0.236)	0.756	-0.059 (-0.167;0.049)	0.287
	Post, Err	0.084 (-0.84;0.251)	0.328	0.008 (-0.080;0.096)	0.861
Mean imaginary coherence	*Pre, Corr*	<0.001 (-0.001;0.001)	0.898	<0.001 (-0.001;0.001)	0.204
	Pre, Err	<0.001 (-0.001;0.001)	0.878	<0.001 (-0.000;0.001)	0.110
	Post, Corr	<0.001 (-0.001;0.001)	0.778	0.001 (-0.001;0.001)	0.134
	Post, Err	-0.001 (-0.002;0.001)	0.268	<0.001 (-0.001;0.000)	0.306
		ADHD symptoms		**Impairment**	
ALPHA		**β (95% CIs)**	**p**	**β (95% CIs)**	**p**
Average clustering coefficient	*Pre, Corr*	<0.001 (-0.001;0.001)	0.894	<0.001 (-0.001;0.001)	0.708
	Pre, Err	<0.001 (-0.001;0.002)	0.578	0.001 (-0.000;0.001)	0.135
	Post, Corr	<0.001 (-0.001;0.001)	0.500	<0.001 (-0.001;0.001)	0.012*
	Post, Err	0.001 (-0.001;0.001)	0.204	0.001 (0.000;0.001)	0.034*
Global efficiency	*Pre, Corr*	<0.001 (-0.002;0.002)	0.794	<0.001 (-0.001;0.001)	0.450
	Pre, Err	<0.001 (-0.001;0.002)	0.738	0.001 (-0.000;0.001)	0.245
	Post, Corr	<0.001 (-0.001;0.001)	0.563	<0.001 (0.000;0.001)	0.046*
	Post, Err	0.001 (-0.001;0.002)	0.216	0.001 (0.001;0.001)	0.031*
Path length	*Pre, Corr*	<0.001 (-0.205;0.205)	0.998	0.043 (-0.069;0.154)	0.452
	Pre, Err	-0.018 (-0.154;0.118)	0.793	-0.044 (-0.117;0.001)	0.229
	Post, Corr	-0.036 (-0.163;0.091)	0.580	-0.066 (-0.133;0.000)	0.050
	Post, Err	-0.062 (-0.152;0.027)	0.172	-0.050 (-0.099;-0.002)	0.042*
Diameter	*Pre, Corr*	-0.042 (-0.344;0.259)	0.784	-0.037 (-0.204;0.129)	0.659

	Pre, Err	-0.085 (-0.290;0.120)	0.417	-0.090 (-0.202;0.022)	0.114
	Post, Corr	-0.058 (-0.270;0.153)	0.588	-0.122 (-0.233;-0.012)	0.030*
	Post, Err	-0.110 (-0.273;0.053)	0.185	-0.079 (-0.168;0.010)	0.083
Mean imaginary coherence	*Pre, Corr*	<0.001 (-0.001;0.001)	0.973	<0.001 (-0.001;0.001)	0.981
	Pre, Err	<0.001 (-0.001;0.002)	0.631	0.001 (-0.000;0.001)	0.156
	Post, Corr	<0.001 (-0.001;0.001)	0.505	<0.001 (0.000;0.001)	0.016*
	Post, Err	0.001 (-0.001;0.001)	0.204	0.001 (0.000;0.001)	0.033*
BETA		**ADHD symptoms**		**Impairment**	
		β (95% CIs)	**p**	**β (95% CIs)**	**p**
Average clustering coefficient	*Pre, Corr*	<0.001 (-0.001;0.001)	0.278	<0.001 (-0.000;0.001)	0.014*
	Pre, Err	<0.001 (-0.001;0.001)	0.613	<0.001 (-0.001;0.001)	0.077
	Post, Corr	<0.001 (-0.001;0.001)	0.435	<0.001 (0.000;0.001)	0.049*
	Post, Err	<0.001 (-0.001;0.001)	0.666	<0.001 (-0.001;0.001)	0.153
Global efficiency	*Pre, Corr*	<0.001 (-0.001;0.001)	0.372	<0.001 (-0.001;0.001)	0.014*
	Pre, Err	<0.001 (-0.001;0.001)	0.650	<0.001 (-0.000;0.001)	0.069
	Post, Corr	<0.001 (-0.001;0.001)	0.572	<0.001 (-0.001;0.001)	0.065
	Post, Err	<0.001 (-0.001;0.001)	0.688	<0.001 (-0.000;0.001)	0.152
Path length	*Pre, Corr*	-0.071 (-0.114;0.081)	0.361	-0.086 (-0.166;-0.006)	0.035*
	Pre, Err	-0.038 (-0.152;0.075)	0.508	-0.054 (-0.115;0.006)	0.080
	Post, Corr	-0.052 (-0.201;0.097)	0.490	-0.066 (-0.146;0.015)	0.110
	Post, Err	-0.046 (-0.164;0.072)	0.444	-0.045 (-0.107;0.017)	0.153
Diameter	*Pre, Corr*	-0.144 (-0.390;0.102)	0.251	-0.148 (-0.277;0.019)	0.024*
	Pre, Err	-0.091 (-0.292;0.109)	0.372	-0.077 (-0.183;0.029)	0.157
	Post, Corr	-0.125 (-0.372;0.121)	0.320	-0.108 (-0.241;0.026)	0.114
	Post, Err	-0.085 (-0.286;0.117)	0.410	-0.057 (-0.163;0.049)	0.294
Mean imaginary coherence	*Pre, Corr*	<0.001 (-0.001;0.001)	0.301	<0.001 (-0.001;0.001)	0.013*
	Pre, Err	<0.001 (-0.001;0.001)	0.620	<0.001 (-0.000;0.001)	0.072
	Post, Corr	<0.001 (-0.001;0.001)	0.478	<0.001 (-0.000;0.001)	0.054
	Post, Err	<0.001 (-0.001;0.001)	0.676	<0.001 (-0.000;0.001)	0.153

Abbreviations: β = regression coefficient; CIs = confidence intervals; Corr = trials with correct responses; Err = trials with incorrect responses; p = random-intercept linear model significance testing; Pre = pre-stimulus time window; Post = post-stimulus time window. Data in correctly-responded trials were available for 105 childhood ADHD participants (83 ADHD persisters, 22 remitters); and in incorrectly-responded trials for 95 childhood ADHD participants (75 ADHD persisters, 20 remitters).

Notes: Random-intercept linear models tested for the effect of ADHD symptom count/impairment on each connectivity measure.

**p<0.05.*

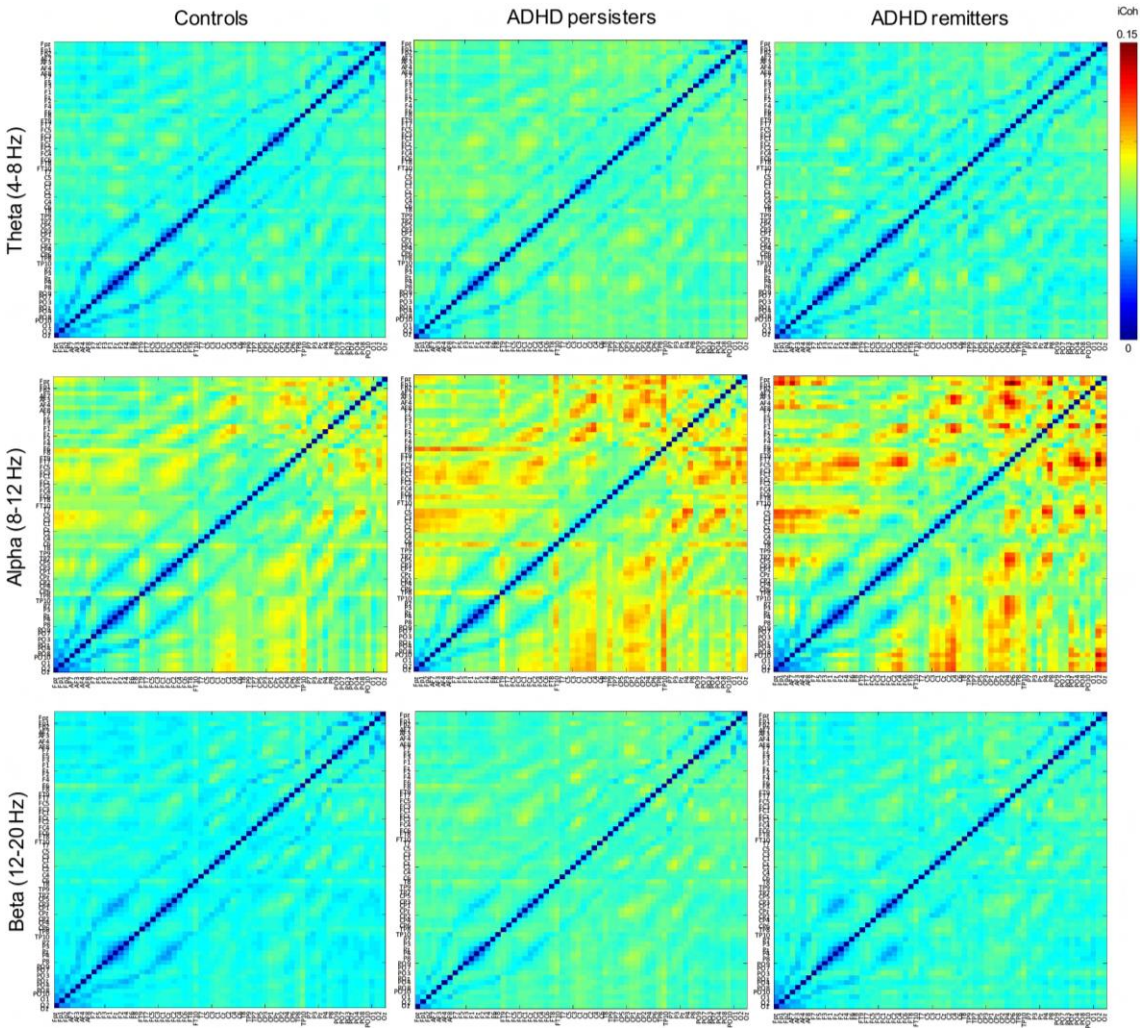

Figure 1. Connectivity matrices showing values of imaginary part of coherence (iCoh) in the pre-stimulus theta, alpha and beta band for correctly-responded trials by group (ADHD persisters, remitters and controls).

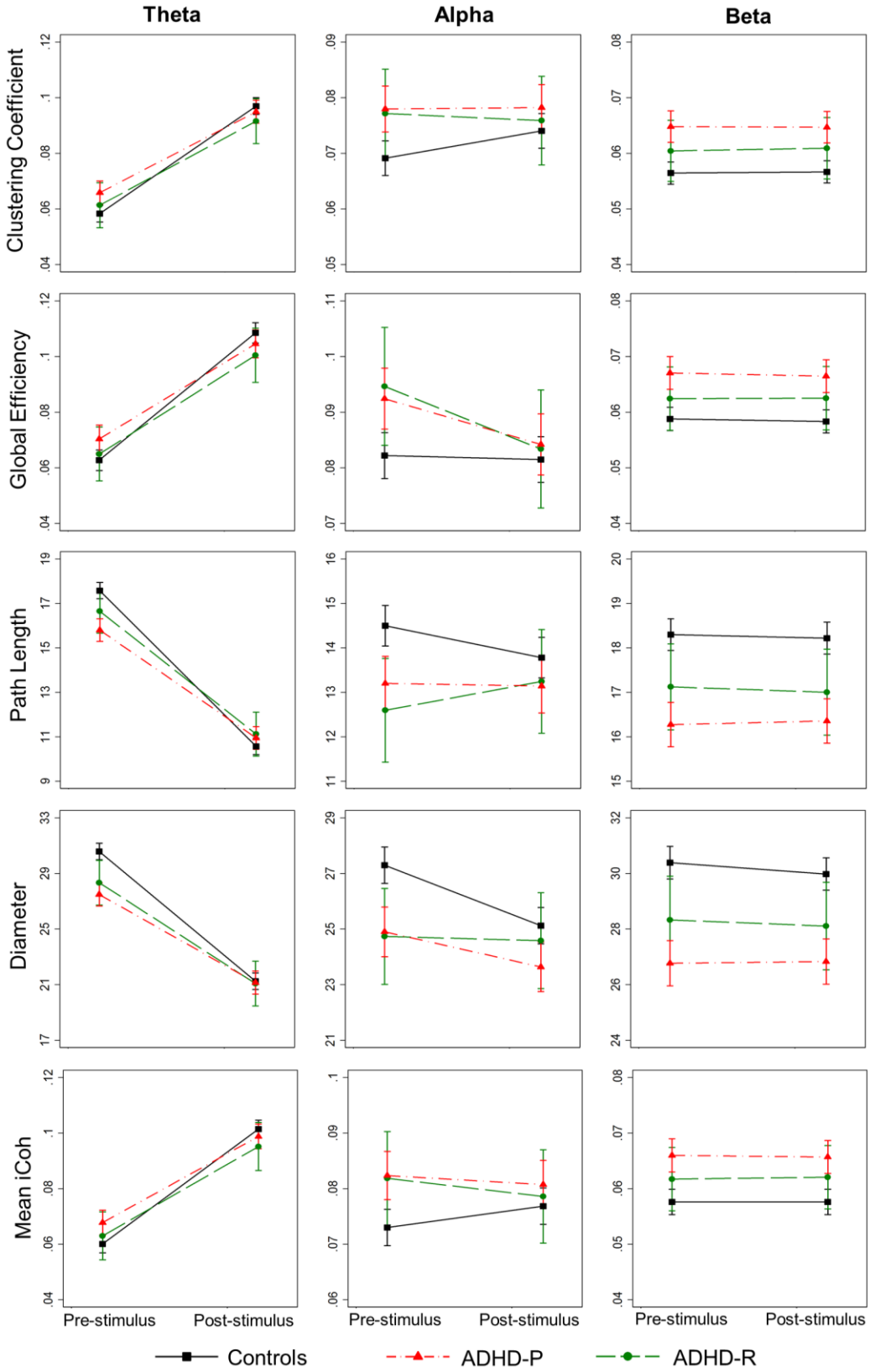

Figure 2. Results of the categorical analyses comparing ADHD persisters, remitters and controls on measures of graph theory and imaginary part of the coherence (iCoh) in the theta, alpha and beta band for correctly-responded trials.