

A Retrospective Evaluation of an Adult with Attention-Deficit/Hyperactivity Disorder (ADHD) in Childhood: A Case Study

Harjit Singh s/o Harnam Singh, SNCP
Special Needs Community Service Worker
&

Guo-Hui Xie EdD, BCET, BCSE, BCRT, FCP, FCoT, HonFRSAS
Special Needs Consultant, EYRAS Council Member
Visiting Professor, Universidade de São José, Macau, PRC

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Abstract

Many adult clients have repeatedly asked the authors if the onset of attention-deficit/hyperactivity disorder (ADHD) could happen during the adulthood. The current understanding of the condition of ADHD is that it is a neurodevelopmental disorder whose onset takes place in childhood before the age of 6 years. The triad of impairments in ADHD consists of inattention, hyperactivity and impulsivity. The exact cause of ADHD remains evasive and hence, it is unknown. However, current medical studies have strongly indicated neurogenetic causality pinpointing to its constitutional origin and development impairment of the executive functioning cortex in the brain. In other words, ADHD tends to run in families though environmental factors and lifestyle may worsen or improve the symptoms rather than causing the disorder. In this short paper, the authors have chosen to focus on a case study of a male vicenarian's ADHD whose onset purportedly happened during his emerging adulthood phase.

Key Words: Adult-ADHD, Attention-Deficit/Hyperactivity Disorder (ADHD), Childhood-ADHD, Wender-Utah Rating Scale

Introduction

The question of whether there is an adulthood onset of attention-deficit/hyperactivity disorder (ADHD) has often been asked by many who feel "scattered, inattentive, restless, or overwhelmed know if ADHD is to blame?" (Low, 2020, para. 1). Such is an issue has posed a challenge to those who do not feel they exhibited ADHD symptoms when they were younger, since most often than not, the behavioral disorder is diagnosed in the childhood. Interestingly, due to the nature of the authors' job working with adults with special needs, they have been repeatedly asked by their clients if ADHD could occur in adulthood or if there was ever such a condition of ADHD-adulthood onset? One explanation given by the authors to their adult clients is that when they were younger, such a condition could have been missed out during its onset or that the progression of the childhood disorder was not properly observed or monitored. Another explanation is misdiagnosis or underdiagnosis. Hence, when ADHD-like symptoms appear later in life, many have mistaken them for the possibility of ADHD-adulthood onset subtype!

Returning to the question asked if an adult can get ADHD, the short answer is a straight NO! Low (2020) has stated plainly that 'adults don't suddenly get ADHD' (para. 7). In fact, several symptomatic criteria must first be met in childhood before the age of 12 years. Technically speaking,

this means ADHD does not occur in adulthood. That is to say that if an adult develops ADHD, s/he must also have it as a child. It is highly possible that an individual may not have been identified or diagnosed with the disorder until much later in life. Conversely, if a person 'did not present these symptoms as a child, then ... current symptoms may be the result of something else' (Low, 2020, para. 8), and it could be indicative of one of the following issues: depression disorder, anxiety disorder or mood disorder.

ADHD: What is it?

The term attention-deficit disorder (ADD) was first introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980), which was the reference manual used to diagnose mental conditions in the United States. In 1994, the definition of ADD was revised in the fourth edition of DSM to include three subtypes: (i) the predominantly hyperactive-impulsive type; (ii) the predominantly inattentive type; and (iii) the combined type (in the current DSM-5, these are now referred to as 'presentations').

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder characterized by excessive amounts of the following signs and symptoms – (i) inattention, (ii) recklessness, (iii) hyperactivity that can evolve gradually into inner restlessness in adulthood, and (iv) impulsivity that

are often pervasive, impairing, and otherwise age-inappropriate (DSM-5, American Psychiatric Association, 2013, p. 59-65; also refer to ICD-11, World Health Organization, 2018, under the diagnostic code: 6A05 Attention-Deficit/Hyperactivity Disorder; for more information, also see Foreman, 2006; Mayes, Bagwell, & Erkulwater, 2008; Parrillo, 2008, p. 63;). There are also those individuals with ADHD who struggle with challenging emotional regulation (also known as emotional dysregulation disorder; see Retz et al., 2012, for detail) and have executive dysfunction (Barkley, 2010).

Moreover, there are comorbidities of ADHD associated with other mental disorders (including depression disorders, anxiety disorders, bipolar disorders, and personality disorders) (Ray & Hinnant, 2009) and substance use disorders (Zulauf et al., 2014), which can cause additional impairment, especially in modern society. Although people with ADHD struggle to stay focused in a given activity or be on-task, they are not particularly interested in completing the given activity. However, they are often show an unusually prolonged and intense level of attention for activities that interest them or they find such tasks rewarding (Katzman et al., 2017). This has been known as hyperfocus (Hupfeld, Abagis, & Shah, 2019; Phillips, 2018).

To determine if an individual has ADHD, symptoms of the condition that cause problems should take place in at least two settings (e.g., in school or home, during work or leisure time) for a duration of six months or more. In children, problems in paying attention during lesson in class often may result in poor academic performance. With the new fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the age of onset criterion for ADHD has been changed from, ‘some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years’ (DSM IV-TR;

American Psychiatric Association, 2004), to ‘several inattentive or hyperactive-impulsive symptoms present prior to age 12 years’ (DSM-5; American Psychiatric Association, 2013). According to Sanders et al. (2019), ‘[T]he modification thus comprised two changes: increasing the age of onset of symptoms from before 7 years to before 12 years, and removing the requirement for the “onset of symptoms causing impairment” to the “onset of symptoms”. Both changes widen the definition of ADHD and potentially lead to the widening of treatment recommendations’ (p. 2).

According to the US-based National Resource Center on ADHD (2008), ‘[T]here is no single medical, physical, or genetic test for ADHD. However, a diagnostic evaluation can be provided by a qualified mental health care professional or physician who gathers information from multiple sources’ (p. 2). Currently, the ADHD diagnostic assessment for individuals (i.e., children, adolescents and adults) with ADHD can be quite challenging. Bressler (2022) argued that the challenge with diagnosing ADHD is ‘that the characteristics associated with the disorder – such as difficulties with focusing, shifting/dividing attention, managing frustration, organization/poor time-management, working memory, and staying engaged – are common symptoms that could have a breadth of etiologies’ (para. 10). Arguably, the well-regarded gold standard approach in diagnosing ADHD is to rely on an evidenced-based assessment that adheres to the diagnostic criteria listed in the DSM-5 (American Psychiatric Association, 2013) ‘along with the inclusion of multi-informant/multimethod methods ... that should incorporate empirically validated research and, when possible, test data about key clinical populations to guide and increase confidence with clinical impressions’ (Bressler, 2022, para. 14). Table 1 below shows examples of ADHD assessment tools for children and adults.re Examples of ADHD testing tools for adults are

Table 1. Assessment Tools for ADHD in Children and Adults

Children	Adults
<ul style="list-style-type: none"> • Behavior Assessment System for Children (BASC-3) • Child Behavior Checklist (CBCL) • Connors Comprehensive Behavior Scale (CBRS) 	<ul style="list-style-type: none"> • Adult ADHD Self-Report Scale (ASRS-v1.1) • Barkley Adult ADHD Rating Scale-IV (BAARS-IV) • Connors Adult ADHD Rating Scales (Connors-3, CAARS)

Is there an Adult-ADHD?

The focus of this paper is on the adult-ADHD (A-ADHD for short): ‘a mental health condition with a short attention span, hyperactivity and socio-occupational dysfunction’ (Focus Medica, 2022, para. 1). Its symptoms emerge during the early

childhood phase and continue into adulthood phase. In some cases, the condition of ADHD is not clearly recognizable or properly diagnosed until the person is an adult. “Adult-ADHD symptoms may not be as clear as ADHD symptoms in children” (Mayo Clinic, 2022, para. 2). In adults, though the

degree of severity or frequency of occurrence of hyperactivity may decrease, the struggle with impulsiveness, restlessness and difficulty paying attention may persist.

According to Katzman et al. (2017), A-ADHD is associated with “profound functional and psychosocial disability, leading to serious personal and societal costs” (p. 2). Attentional dysfunction is the most prominent feature in the condition and it is also found to be correlated with impairment in focused and sustained attention (Bálint et al., 2009). Those with A-ADHD also suffer neuropsychological challenges associated with deficiencies in inhibition (Murphy, 2002; Ossmann & Mulligan, 2003), working memory (Alderson et al., 2013; Ossmann & Mulligan, 2003), executive functioning (Boonstra et al., 2005; Spencer et al., 2008), decision making (Mowinckel et al., 2015), and emotional dysregulation (Retz et al., 2012). A-ADHD also produces negative consequences for adults’ self-esteem and the quality of interpersonal relationships, with both co-workers or colleagues and significant others (Das et al., 2012; Kirono et al., 2015).

A Case Study of an Adult with A-ADHD

This is a case study of a foreign male student, YX, in his mid-twenties, who had just completed his final year studies at a private college, during the time of this writing. YX made a self-referral to a counselor (via e-counseling) for help through a friend’s recommendation after being nagged by his ageing parents for already more than a decade for his ‘weird’ behavioral problems: being impatient, easily frustrated or irritated, frequent outbursts of anger or short temper, and mood swings – all these challenges are suspected to be caused by his poor impulse modulation.

During YX’s internship at a local F&B company during the Covid-19 pandemic in his final year, he complained of having problems in focusing and prioritizing the many different tasks he was given. As a result, he had missed project or assignment deadlines and forgotten meetings or social plans. He told the counselor that he had several past broken or unstable relationships, low motivation to perform well in both studies and work, and suffered poor self-esteem and depression, which he never told his parents for fear of causing them to worried about him.

Through e-counseling, YX was asked if he had ever seen a psychologist or a medical practitioner when he was a child for any learning or behavioral problems; his reply was that he was not aware if he

did. His parents had also been consulted (via online) and their answer was a definite ‘no.’ What they could recall of YX during his school years was that he was ... rather disorganized or messy with his things, poor in planning his study schedule, easily stressed, frustrated or anxious, never completed his homework on time or showed poor time management, quick tempered, and trouble with multitasking.

Without any psychological or medical assessment done previously or psychoeducational report available, YX could not be confirmed to have ADHD. In consultation with YX’s counsellor via online, the authors decided that the best way to find out if the client had suffered from an undiagnosed condition of ADHD when he was a child was to administer the 25-item Wender-Utah Rating Scale for ADHD (WURS-25; Ward, Wender, & Reimherr, 1993). The WURS-25 was chosen for administration because it is an appropriate screening tool to aid in the retrospective diagnosis of childhood-attention-deficit/hyperactivity disorder (C-ADHD) in adults. It is an adapted version of the self-report instrument designed to retrospectively assess childhood-ADHD symptoms, based on the Utah criteria (see Ward, Wender, & Reimherr, 1993, for detail; Wender, 1971). Originally, it consisted of 61 items, but was arbitrarily reduced to 25 items that showed the greatest mean difference between patients with ADHD and controls. Ward et al. (1993) reported a sensitivity and specificity of 96% for a cut-off score of 36, and a sensitivity of 86% and specificity of 99% for a cut-off score of 46. Both the long and the short form of the English version of WURS-25 showed good test–retest reliability and internal consistency (Rossini & O’Connor, 1995; Stein et al., 1995). WURS-25 has been translated into several languages, and validation studies have shown similar psychometric properties to those reported by Ward et al. (1993; see also Fossati et al., 2001; Kivisaari et al., 2012; Oncu, Olmez, & Sentark, 2005; Retz-Junginer et al., 2003; Rodriguez-Jimenez et al., 2001; Stein et al., 1995). A Swedish translation of WURS-25 is available and frequently used. However, no validation study of the Swedish version has been published (Kouros et al., 2018).

Table 2 below shows YX’s scores in the WURS-25 administration. He scored 53 on the WURS above the cutoff score of 46. The results suggested that YX had a retrospective C-ADHD. However, he might also have other hidden conditions not identified yet.

Table 2. WURS-25 Results

Scores	
WURS Score	53
Cutoff Score	46 (Predictive having childhood-ADHD)
Maximum Score	100
Minimum Score	0

As mentioned earlier, findings from the study conducted by Ward, Wender, and Reimherr (1993) suggested a cutoff score of 46 or higher correctly identified 86% of the patients with ADHD, 99% of the normal subjects, and 81% of adults with depression. In the case of YX, his WURS-25 results indicated that he had suffered from a retrospective C-ADHD when he was young. Now in his adulthood, there is a possibility that he exhibits symptoms of A-ADHD with depression (Seymour & Miller, 2017). According to Seymour and Miller (2017), '[E]pidemiological studies show the median odds ratio of cooccurring ADHD and depression is 5.5 (95% CI 3.5–8.4) (Angold, Costello, & Erkanli, 1999)' (p. 2). In addition, YX was also noted to display executive dysfunction – a common ADHD comorbidity (also known as executive function deficit or disorder) – when the brain has a hard time with the skills of attention, memory, flexible thinking, and organization or time management (Sonuga-Barke et al., 2008). However, it is not within the scope of this paper to delve into it.

Like A-ADHD, C-ADHD is a neurodevelopmental disorder whose onset occurs during the period of childhood. In other words, the condition can affect the manner an individual behaves and learns. Its classical triad of symptomatic impairments are inattention, impulsivity, and hyperactivity. Like with any condition, symptoms can vary from person to person. Each individual with ADHD has different needs with some requiring more support, while others need less. Having any of these symptoms does not always mean that an individual has ADHD.

Conclusion

At the beginning of the paper, the authors have reiterated that adults do not suddenly develop the condition of ADHD (see Low, 2020, for detail), but must fulfil the DSM-5 criteria for an ADHD diagnosis, i.e., key symptoms that cause impairment must be present in childhood before age 12. Therefore, ADHD does not develop in adulthood. In other words, when an individual has ADHD as an adult, s/he also had it as a child. This means that A-ADHD is more of a misnomer.

In summary, the authors could say that XY has ADHD since childhood but the condition was not

identified until when his case was taken up by a counsellor who referred him for a proper ADHD assessment to be done.

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