Attention-deficit hyperactivity disorder (ADHD) is a common disorder affecting children and adults. Many young people treated with stimulants, as well as those in whom ADHD went unrecognised in childhood, need treatment as adults. Stimulants and atomoxetine effectively reduce ADHD symptoms at all ages and should be a standard treatment in general adult psychiatric practice.

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Most child and adolescent mental health services recognise the existence – and need for treatment – of a condition characterised by high levels of inattentiveness, impulsiveness and restless overactivity. The symptoms defining attention-deficit hyperactivity disorder (ADHD) are regarded as a source of disability in children and adolescents and a risk to adult psychological adjustment. Numerous specialist multidisciplinary ADHD clinics have been developed and many paediatricians include treatment of ADHD as an important part of their clinical activity.

A good deal of the justification for this therapeutic activity is the demonstration that ADHD is a predictor of adult mental health problems. Furthermore, effective treatment with stimulant medication increases the immediate value of the clinical diagnosis (Taylor et al., 2004). General adult psychiatry, however, has not yet followed suit in identifying and treating substantial numbers of affected people. Yet it is likely that an increasing load in adult psychiatry will develop. Young people are entering adult life while still receiving medication for ADHD, and adult psychiatrists are needed to take over psychiatric treatment when symptoms persist. An increasing number of adults are recognising themselves – or being recognised by family members, general practitioners, probation officers, drug and alcohol specialists, psychologists and others – as being disabled by ADHD and requiring assistance. In addition there is a pool of adult psychiatric patients in whom the diagnosis of ADHD has gone unrecognised and for whom treatments put in place for alternative diagnoses, such as anxiety, depression, cyclothymia and personality disorder, are ineffective.

VALIDITY OF THE ADULT DIAGNOSIS

Evidence for the validity of adult ADHD and descriptions of its clinical diagnosis and management are given in detail elsewhere (Faraone et al., 2000; Weiss et al., 2002; Weiss & Murray, 2003; Asherson, 2005). The disorder in adults is not as well studied as it is in children. However, there are sufficient data and unanimous agreement among clinical experts on the validity of the adult diagnosis. Although there is evidence that ADHD symptoms show an age-dependent decline, there is no evidence that the disorder disappears in adolescence and adulthood, and considerable evidence that in the majority symptoms persist and are frequently associated with clinical and psychosocial impairments.

Furthermore, it is well established that ADHD symptoms in adults show the same responsiveness to stimulant and non-stimulant medications as that seen in children (Faraone et al., 2004; Simpson & Posker, 2004). For these reasons UK and European experts in a recent review of available data on the efficacy of extended-release preparations in the treatment of ADHD include recommendations for their use in adults (Banaschewski et al., 2006).

A key question is the number of children with ADHD who continue to show ADHD in adult life. Studies that followed children identified with ADHD, as well as controls, into adulthood have been included in a meta-analysis of 32 publications (Faraone et al., 2006). When the ADHD samples included only those who met full diagnostic criteria for ADHD the rate of persistence was approximately 15% at age 25 years. However, the rate was far higher – approximately 65% – when individuals fulfilling the DSM-IV definition of ADHD in partial remission were included, referring to the persistence of some symptoms associated with significant clinical impairments.

Our own data support this conclusion. In an epidemiological survey of schoolchildren from the London district of Newham, E.T. and colleagues measured ADHD behaviours at ages 7 and 17 years. Levels of inattentive and restless activity had indeed diminished. However, 17-year-olds previously characterised as ‘hyperactive’ showed a level of hyperactivity similar to that seen in the control group of normal 7-year-olds. Although this meant that most no longer met full diagnostic criteria, the relative distance between them and controls was unchanged. Importantly, the degree to which hyperactive behaviour was above the age norm was strongly related to poor social adjustment in terms of lack of friends, occupation and constructive activity. Deficits associated with high levels of psychiatric morbidity were also seen when the same people were followed up at age 26 years (further information available on request) and these are all the more significant because of increasing demands in adult life for self-organisation and the ability to plan ahead.

DIAGNOSIS IN ADULTS

Wender (1998) provided a list of adult behaviours linked to childhood ADHD (see also Weiss & Murray, 2003; Asherson, 2005). Motor hyperactivity may be replaced by a subjective sense of restlessness, difficulty in relaxing and settling down and dysphoria when inactive. Attention deficits may well persist in a lack of concentration on detail, the need to re-read materials several times, forgetting activities and appointments, losing things and losing the thread of conversations. Thoughts are unfocused and ‘on the go’ all the time. Mood changes are often rapid shifts into depression or excitability,
irritability and temper outbursts that inter-
fer with personal relationships. Disorgan-
sation is prominent, tasks are not com-
pleted, problem-solving is lacking in
strategy and time management is partic-
ularly poor. Impulsivity continues and leads
to problems in teamwork, abrupt initiation
and termination of relationships, and a
tendency to make rapid and facile decisions
without full analysis of the situation.

Although most people experience such
symptoms at times, individuals with ADHD
experience these to a severe degree most of
the time. As in other common adult psychi-
atriic disorders, such as anxiety and depres-
sion, ADHD symptoms are continuously
distributed throughout the population
(Asherson, 2004). Clinical thresholds are
therefore determined on the basis of usual
clinical practice, which recognises disorder
when the symptoms are sufficiently fre-
quent or severe to cause personal distress,
distress to others, interference with psycho-
social function or health complications.

In making the correct diagnosis there
are potential traps for the inexperienced
ADHD diagnostician. First, ADHD symp-
toms may be not be evident in the clinic
or other highly structured environments.
The reason is that ADHD symptoms may
respond to (decrease in) situations that are
highly novel or salient to the individual,
such as an important psychiatric evalu-
ation. It is therefore important to base men-
tal state descriptions on a typical week and
a variety of normal situations. Second,
ADHD symptoms start early in life, by de-
finition before the age of 7 years, and are
persistent and non-episodic. They are there-
fore more trait-like than symptom-like,
since there is no clear change from a pre-
morbid state, and can therefore be mistaken
for character traits that may be deemed re-
sistant to psychopharmacological interven-
tion. Third, mood instability is extremely
common in adult ADHD and can lead to
diagnoses of minor affective disorders or
personality disorder. Clinical experience
suggests that mood instability in the con-
text of ADHD frequently responds to stim-
ulants in the same timescale as ‘core’
symptoms of the disorder.

Many adults with ADHD have other
problems: antisocial personality, alcohol
misuse, substance dependence, dysthymia,
cyclotymia, anxiety disorders and general
and specific learning difficulties. Early-onset
and persistent antisocial behaviour is a parti-
cularly common association that sometimes
leads to persistent impulsive antisocial

PHILIP ASHERSON, MRCPsych, PhD, WAI CHEN, MRCPsych, MRC, Social, Genetic and Developmental
Psychiatry Centre, Institute of Psychiatry, London; BRIDGET CRADDOCK, BSc, MB, CHB, MRCPsych,
Glycynffig Hostel, Bridgend; ERIC TAYLOR, FRCPsych, FRCP, PhD, MRC, Social, Genetic and Developmental
Psychiatry Centre, Institute of Psychiatry, London, UK

Correspondence: Philip Asherson, MRC, Social, Genetic and Developmental Psychiatry Centre, Institute
of Psychiatry, Denmark Hill, London SE5 8AF, UK. Email: p.asher@op.kcl.ac.uk

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