by Peter Jaksa, Ph.D.

Getting Evaluated for Adult AD/HD

The good news is that AD/HD can be diagnosed and treated at any age.

CONTRARY TO SOME MISCONCEPTIONS, most children with AD/HD do not "grow out of it" as they mature into adulthood. Research studies indicate that 60 percent or more of these children continue to have significant impairment into adulthood. Thus, poor school performance, for example, may evolve into poor job performance and career failures. Childhood problems with disorganization and forgetfulness may become adulthood problems, such as remembering to pay bills on time or managing routine household tasks.

The large majority of research, media coverage and public discussion of AD/HD over the past two decades has focused on children and adolescents. Only in the past few years have we seen a significant increase in awareness about AD/HD in adults. Unfortunately, it is likely that the large majority of adults with AD/HD still remain undiagnosed and untreated.

The good news is that AD/HD can be diagnosed and treated at any age. Adults can benefit from treatment, including medication and therapy, as much as children and adolescents. If you are an adult and have concerns that you might have AD/HD, it certainly is worthwhile to consider pursuing a diagnostic evaluation. The risks associated with undiagnosed and untreated AD/HD in adulthood are many, including increased risk for job and career failure, marital problems and divorce, financial problems and substance abuse.

The Comprehensive Evaluation for AD/HD

A diagnostic evaluation can be provided by a qualified licensed health care professional. It should be said that AD/HD cannot be diagnosed accurately from just brief office observations or from talking to the person. Clinicians will vary somewhat in the procedures and testing materials they use; however, certain protocols are considered essential for a comprehensive evaluation. A comprehensive diagnostic assessment should include:

- A thorough diagnostic interview, including a detailed history of past and current functioning
- A comprehensive history (developmental, medical, academic, work, social, family)
- AD/HD symptom checklists
- Standardized behavior rating scales for AD/HD
- Other types of psychometric testing as deemed necessary by the clinician
- Review of past evaluations and school records
- Screening for the presence of other co-morbid conditions

The Structured Clinical Interview and Review of Records

The single most important part of a comprehensive evaluation for AD/HD is a structured or semi-structured interview to provide a detailed history of past and current behavior for the individual. This interview allows the clinician to cover a broad range of topics, discuss relevant issues in more detail and ask

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follow up questions. The examiner will likely ask questions about the person's health history, developmental history going back to early childhood, academic history, work history, family and marital history and social history.

Many professionals find it helpful to review old report cards and other school records, going back to kindergarten or preschool. If such records are available, they should be brought to the first appointment. Copies of reports from any previous psychological testing should also be brought to the appointment. For adults who experience problems in the workplace, job evaluations should be brought for review if these are available.

Participation of a Significant Other

When possible, it is important for the clinician to interview a significant other (spouse, other family member, parent, etc.) who knows the person well. Many adults with AD/HD report having a spotty or poor memory of their past, particularly memories of their childhood. They may recall specific details, but forget important events or other facts. The person being evaluated may be asked to have his or her parents or an adult sibling fill out a retrospective AD/HD questionnaire describing childhood behavior.

Gender Difference Considerations

Clinical guidelines for diagnosis of AD/HD are provided in the diagnostic manual of the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* also known as the DSM-IV (American Psychiatric Association, 2000). For a variety of reasons, AD/HD appears to be underdiagnosed in females. DSM-IV diagnostic criteria are not as well suited for diagnosing AD/HD in girls and women. Girls with AD/HD are less likely to be hyperactive compared to boys their age, and consequently are less disruptive and less apt to draw attention from the adult caretakers in their lives. The onset of AD/HD symptoms generally occurs later in girls, frequently not before the middle school years. Women with AD/HD are more likely to experience co-existing depression and anxiety disorders. These gender differences should be considered when reviewing the history and assessing current symptoms in female patients.

AD/HD Symptom Checklists and Standardized Behavior Rating Scales

During an evaluation, the clinician uses the DSM-IV to determine the extent to which the symptoms found in the diagnostic criteria apply to the individual currently and since childhood. Other self-report and collateral report standardized behavior-rating scales may be used, such as the Brown ADD Scales-Adult Version and the Conners Adult Attention Rating Scale.

Tests of Vigilance and Attention

Some clinicians prefer to use computerized tests of attention as a source of additional information. These may involve, for example, pressing a key when a letter or symbol appears on the screen. The computerized tests are not diagnostic by themselves, but are used as a supplement and can provide additional information useful in making a diagnosis. Many individuals with AD/HD perform well on these tests, therefore, it should be noted that obtaining a "normal" score does not rule out having AD/HD.

The Role of Psychological Testing in Adult AD/HD Evaluations

Depending on the individual and the concerns being addressed, additional psychological, neuropsychological or psychoeducational testing may be used as needed. These tests do not diagnose AD/HD directly and should not be used by themselves to evaluate for AD/HD. Such tests can provide important information about ways in which AD/HD impacts various areas of functioning for the individual, notably emotional and intellectual functioning. In particular, psychological testing can help determine the presence and effects of co-existing conditions.

Screening and Assessment of Co-Existing Conditions

Research has shown that 60 percent or more of individuals with AD/HD have one or more co-existing conditions. The most common include depression, anxiety disorders, bipolar disorder, substance abuse and addictions and learning disabilities. Many co-existing conditions mimic AD/HD symptoms (distractibility, restlessness, forgetfulness, etc.) and may be mistaken for the disorder.

When there is one or more co-existing conditions with AD/HD, it is essential that all are diagnosed and treated. Failure to treat co-existing conditions often leads to failure in treating the AD/HD. If there are indications of substance abuse, either currently or in the past, a detailed history of substance use and abuse should be taken.

The Medical Examination

Some medical conditions (for example, thyroid problems or seizure disorders) may cause symptoms that mimic AD/HD or may co-exist and complicate the condition. If the individual being evaluated for AD/HD has not had a recent physical exam (within 6–12 months), a medical examination is recommended to rule out medical causes for symptoms. The examining physician may also consider laboratory testing to screen for medical conditions if specific symptoms are uncovered during the interview.

Providing Feedback and Treatment Recommendations

The clinician should integrate the information that has been collected from interviews and testing forms, complete a written summary or report, and provide the person with diagnostic opinions concerning AD/HD as well as any other co-existing conditions. The clinician should review treatment options and assist the individual in planning a course of appropriate medical and psychosocial treatment intervention. Afterwards, the clinician should communicate with the individual's primary care providers, as deemed necessary. ■

Additional Resources

For more information about diagnosis and treatment of AD/HD in adults, please visit the Web site of the National Resource Center on AD/HD (www.help4ADHD.org).

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The text within this article reflects statements and research from the following sources:

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, DC: American Psychiatric Association.

Brown, T.E. (Ed.) (2000). *Attention-deficit disorders and comorbidities in children, adolescents, and adults.* Washington, DC: American Psychiatric Press.

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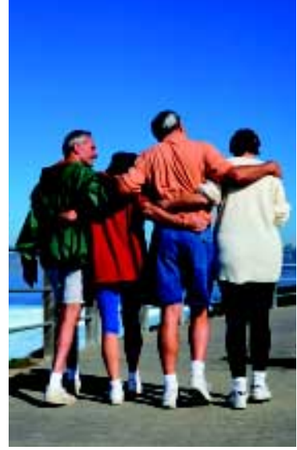

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Note for Health Care Professionals

Limitations of DSM-IV Diagnostic Criteria

The DSM-IV diagnostic criteria for AD/HD were developed based on data from children between the ages of four and 17 (Brown, 2000). Consequently, it appears that these criteria are ideally suited for the diagnosis of children (particularly boys) with AD/HD. Unfortunately these existing criteria are not well suited for diagnosis of AD/HD in adults, and likely underestimate the true rate of AD/HD in the adult population.

The DSM-IV criteria do not adequately assess cognitive impairments associated with AD/HD, particularly impairments in executive functioning. Although the DSM-IV requires onset of some symptoms before age seven, onset of symptoms may not be evident in some individuals until well past that age. Impairment may not be evident in individuals with high intelligence and good coping skills until the person is in high school, in college, in a demanding career position, or in the demanding role of parent and household manager.

Until improved diagnostic criteria for AD/HD in adults are made available, clinicians are advised to use the existing DSM-IV criteria for guidance in diagnosis of adults. Clinicians are encouraged to be aware of individual differences in onset and impact of AD/HD symptoms and to make an appropriate diagnosis on the basis of good clinical judgment even when the DSM-IV criteria are not strictly met for adult patients. ■