

The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided. The patient described in this column is a composite with characteristics of several real patients.

Assessment of adult attention-deficit/hyperactivity disorder

A 27-year-old man was referred by his family doctor to the screening clinic to be evaluated for adult attention-deficit/hyperactivity disorder (ADHD). The patient did not have a history of diagnosed childhood ADHD; however, he mentioned that he always had difficulty with his emotions, fluctuating moods and long periods of restlessness and sadness. He also said people often remarked that he was irritable.

The patient reported that he dropped out of university in his early twenties and that he now thinks undiagnosed ADHD was the cause. He mentioned having gone to a detoxification centre for alcohol addiction at that time and that he has had relapses but is now sober. He reported using cocaine occasionally and marijuana regularly.

The man described himself as disorganized and restless. He said he has problems with interpersonal relationships and that his marriage ended in divorce the previous year. He reported being under a lot of stress and taking an antidepressant. The man lost his job the previous year and has been taking vocational retraining courses. He reported feeling unable to pay attention owing to ADHD, and he requested a trial of medications to validate the ADHD diagnosis and improve functioning. In addition, he said his child was being evaluated for symptoms of childhood ADHD.

This patient's presentation has some features suggestive of ADHD, including difficulty paying attention be-

tween tasks, affective lability, inattentiveness and impulsivity, which led his family doctor to refer him.

Many symptoms of adult ADHD (especially when they are not severe) overlap with features of acceptable young adult behaviour, including multitasking in real and virtual environments, changing goals in response to constantly changing environments, and greater acceptability of personality traits such as impulsivity in an era of evolving social networks. Screening questionnaires and rating scales are not recommended for initial diagnosis owing to a high false-positive rate.¹ The patient's symptoms need to be examined at greater depth and validated by someone who has known the patient for a long time. Importantly, long-standing impairment beginning in childhood due to symptoms of ADHD must be confirmed.² While the age and symptom criteria of childhood symptoms for diagnosis of adult ADHD has been modified in DSM-5,^{3,4} it is important that the core symptoms causing functional impairment be present. In the absence of confirmation of the patient's symptoms from other sources and documentation of difficulties in school, the diagnosis of ADHD should have a high threshold.

In this particular case, the patient mentioned difficulties only in university, and they were accompanied by substance use. The diagnosis of adult ADHD in this patient is challenging because of several factors, including lack of symptoms specific to ADHD, lack of objective quantitative measures, malingering and diagnostic inaccuracy.^{5,6} A systematic diagnosis of ADHD should involve self-report,

clinical interview, collateral information, childhood documentation and neuropsychological testing.^{2,7} Given that this is unlikely to happen outside of research clinics or private psychological assessments, an abbreviated version of the assessment should include a clinical interview, collateral information and, importantly, confirmation of long-standing impairment and early onset. In addition, mood, anxiety, personality and substance use disorders need to be explored and treated early.

Diagnosis of ADHD in a child commonly leads parents to seek a referral for evaluation of adult ADHD.² Stimulant misuse and sharing is common among younger individuals with and without a diagnosis of ADHD.⁸ Patients often request a trial of stimulant medications, and response could validate the diagnosis.⁸ First, the magnitude of cognitive enhancement is minimal in healthy individuals, whereas the subjective experience could be clinically significant.^{9,10} Second, a trial of stimulants is nonspecific and diagnostically noninformative, and this is further complicated by the prevalence of comorbid disorders in adults with ADHD.¹⁰⁻¹² Finally, it is vital to remember that stimulants can make a real difference^{13,14} once a systematic diagnosis of ADHD is made, but clinicians must avoid putting the cart before the horse.

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Psychopharmacology for the Clinician columns are usually based on a case report that illustrates a point of interest in clinical psychopharmacology. They are about 650 words long. Columns can include a bibliography which will be available only on the journal website.

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