Bridging the service divide

Invited commentary on... Attention-deficit hyperactivity disorder in adults

Philip P. Asherson

Most child and adolescent mental health services recognise the existence of, and need for treatment in, attention-deficit hyperactivity disorder (ADHD). Many specialist multidisciplinary ADHD clinics have been developed in recent years, and many paediatricians have included the treatment of ADHD as an important part of their clinical activity. A good deal of the justification for this increase in therapeutic activity has been the demonstration that ADHD is indeed a predictor of adult mental health problems. General adult psychiatry, however, has not followed suit in identifying and treating substantial numbers of affected people. It is likely none the less that an increasing load in adult psychiatry will develop. A rising number of young people will enter adult life still receiving stimulant medication or other treatment for ADHD, and adult psychiatrists are likely to be consulted. Furthermore, an increasing number of adults are likely to recognise themselves as having been disabled by ADHD and therefore to seek assistance. In many cases, individuals with adult ADHD who require specific treatment for the condition will have been treated unsuccessfully for disorders with overlapping symptom profiles such as anxiety, depression, bipolar disorder and antisocial personality disorder.

In support of adult ADHD?

Zwi & York (2004, this issue) present some of the available evidence supporting adult ADHD as a valid diagnostic entity. Their article shows that there remain many unanswered questions on the suitability of current definitions for adult ADHD, the size of the potential problem and long-term outcome for patients with the disorder. While further research is indicated for many common psychiatric conditions, the current state of the literature on adult ADHD is particularly weak, reflecting the general lack of recognition, in both clinical and research practice, of the disorder in the adult population. For this reason most research has been generated by child psychiatrists and psychologists following up patient groups they have been evaluating from childhood. Although the literature base is not large, the research is entirely consistent in demonstrating the continuity of ADHD into adult life (Faraone *et al*, 2000*a*). This is in contrast to the popular view that ADHD is essentially a benign condition that children grow out of by the time they are adults, as suggested but not demonstrated (Barkley, 2000) by the influential paper of Hill & Schoener (1996).

Different perceptions of ADHD

In fact, the existence of clinically significant ADHD in adult life is no longer viewed as controversial among large sections of the child psychiatric, paediatric and research communities. Child and adolescent psychiatrists are well aware that many of the children they treat successfully with stimulant medication continue to require treatment beyond late adolescence, when psychiatric care is passed over to family doctors and adult psychiatric services. In addition, they see ADHD in the parents of the children they are treating, owing to the high familial rate of the condition: around 20% of parents of children with ADHD are expected to have ADHD themselves (Faraone *et al*, 2000*b*). In contrast, the reluctance of adult psychiatrists to recognise ADHD as a valid disorder beyond the childhood years is surprising, given the considerable psychiatric morbidity that is well documented to be associated with the disorder in adult life and the existence of effective treatments in the form of stimulant medication.

There are several reasons why this difference in perception between child and adult psychiatrists has come about, the most obvious being that child psychiatrists frequently come into direct contact with individuals with ADHD and see for themselves the often dramatic changes in behaviour and mental state that result from the use of stimulants. More fundamental are differences in training, with child psychiatry focusing on developmental approaches in which the onset and progression of behaviours are documented throughout the life span. In contrast, adult psychiatrists are trained to focus on the development of symptoms and behavioural change from a premorbid baseline. For this reason,

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Box 1 Persistent symptoms of adult ADHD

- Internal restlessness, agitation
- Uncontrolled and ceaseless thought processes
- Poorly controlled mood, which is typically volatile and fluctuating
- Low self-esteem
- Sleep problems, particularly initial insomnia
- Inability to focus on tasks that are not immediately rewarding or stimulating
- Forgetfulness
- Disorganisation, problems with time-keeping, procrastination

symptoms and behaviours associated with ADHD that start in early childhood and are persistent and non-fluctuating are viewed as behavioural traits, rather than symptoms of a treatable disorder. Adults face similar problems of diagnostic recognition with other childhood-onset developmental disorders such as autistic-spectrum disorders, although the treatment implications are less dramatic owing to the absence of targeted drug treatments.

A further difference is that child psychiatry has traditionally focused on objective descriptions of behaviours, whereas adult psychiatry focuses on subjective psychopathology and the mental state examination. For this reason, the signs of ADHD given in the DSM–IV criteria are essentially a list of behaviours that are maladaptive and inconsistent with the developmental level, whereas adults with ADHD have in most cases gained a degree of control over their external behaviours, which are therefore less overtly disruptive. Nevertheless, adults with ADHD describe in detail persistent symptoms that affect their daily lives (Box 1). As with other common psychiatric disorders such as anxiety and minor depression these symptoms are not qualitatively different from normal every day experiences, but they become clinically significant if they are more frequent and severe than usual, are uncontrolled and give rise to significant subjective distress in addition to psychosocial impairments at work and in personal relationships.

The fact that symptoms of adult ADHD overlap with those of personality disorder, anxiety and affective disorders and may therefore lead to difficulties in diagnosis and treatment does not make them any less valid. Importantly, where the symptoms overlap between ADHD and adolescent- or adult-onset disorders it is usually possible to make the distinction, since symptoms causing clinical impairment start early in life, persist over time and do not tend to fluctuate. There may of course be difficulties in obtaining accurate accounts of childhood behaviours from adult patients, although parents or older relatives can often provide such information. As in other areas of adult psychiatry, informant reports on current behaviour are useful to delineate the extent of psychosocial impairments in addition to the subjective complaints of individual patients. Finally, it should be recognised that many individuals currently presenting with adult ADHD will not have received the diagnosis as a child, often because the condition was less widely recognised when they were young.

Treatment with stimulants

Adult psychiatrists are also reluctant to use stimulant medications, a situation that is not helped by the current lack of licensing for their use in the adult population. This remains the case despite more than 200 controlled studies of stimulant efficacy and safety in children (Spencer *et al*, 1996; Schachter *et al*, 2000) and consistent evidence for similar high response rates among adults with ADHD (Faraone *et al*, 2004). Stories of adults selling stimulants on the black market remain anecdotal and have little relevance to individuals who are appropriately diagnosed and treated. There is no evidence that tolerance and addiction are a consequence of the appropriate therapeutic use of stimulants, and a number of studies have now demonstrated that the rate of drug misuse and addiction is in fact reduced by up to 50% among individuals treated for ADHD with stimulants (Huss & Lehmkuhl, 2002).

The European Consensus Statement

Experience of psychiatrists working with adult ADHD is consistent. The European Network for Adult ADHD has recently been established, in which clinicians from across Europe have come together and are currently working on a consensus statement for the diagnosis and treatment of ADHD in adults (http://www.parnassia-oud.nl/circ_volw2/zp_adhd/euro_netwerk/). What is most striking is the common perspective on the best way to diagnosis and treat adult ADHD, the impression being that direct clinical experience across diverse European countries is very similar. Overall, the evidence for the validity of adult ADHD is strong, and clinical experience suggests that it is a robust and stable concept with clear clinical implications. Nevertheless, this is an area where insufficient systematic research has been carried out on presentation, overlap with comorbid disorders, outcome and response to pharmaceutical and psychological interventions in this patient group.

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