

Undetected Story of Adult ADHD: A Case Based Short Commentary

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Abstract

Prevalence of adult ADHD and its treatment is increasing all around the world. However, number of undiagnosed cases of Adult ADHD is also increasing. Undiagnosed cases pose potential threat to patient, family and society at large. Hence need of spreading awareness about the disorder is imperative. Case based communication is aimed to help sensitize, educate and enable medical doctors like psychiatrist, family practitioners, and pediatricians to diagnose ADHD adults. It is challenge to diagnose adult ADHD because of varying presentation, overlapping co morbid conditions, and above all lack of awareness or index of suspicion. Insomnia and forgetfulness since young age of this patient were adequate to trigger the alarm. Careful and well oriented history taking along with screening test can help clinician diagnose most treatable neuro developmental disorder.

Keywords: ADHD Adult; Chronic Insomnia; Forgetfulness; Impatient Adults; Neurodevelopmental Disorder

Introduction

Diagnosis of adult ADHD dodges psychiatrist all around the world even today and mostly remains under diagnosed [1,2]. In some of the countries diagnosis of adult ADHD has not been included in medical curriculum. In such countries medical doctors don't know that ADHD progresses beyond childhood and demands pharmacological treatment [1]. People at large have less awareness and clarity about adult form of this disease. However, since last 5 to 6 years public awareness is increasing [1]. Reasons behind such under diagnosis are varying presentations of adult ADHD, close and confusing similarity with anxiety disorder, often overlapped by co morbid psychiatric diseases [2]. Many features of adult ADHD appear less convincingly psychopathological. E.g. rash driving, spousal scuffles or violence, inner restlessness, overfriendly behavior, forgetfulness, fidgeting, refraining to participate in organized or structured activities, poor time management, habit of procrastination, very often change of job, often doing jobs half finished, etc. Clinical picture of Adult ADHD is not uniform [1]. Many adult ADHD patients develop coping strategies to minimize or hide their sufferings and disturbances from themselves and from others. Varying degree of ADHD in adults contribute to non-uniformity. Clinical picture lacks single most diagnosable symptom [2] or couple of easily diagnosable feature/s like washing hands in OCD, delusion or auditory hallucinations in case of schizophrenia or severe nervousness or psychomotor retardation in case of Major Depressive Disorder. Intensity of hyperactivity and loss of concentration seen in pediatric ADHD is not seen among adult ADHD; detection of this 'change of clinical picture' too demands diagnostic skills. On the other hand, behavior of pediatric ADHD shouts its own diagnosis quite loudly to make diagnostic skills insignificant. In contrast to such vivid pediatric picture, adult ADHD pose diagnostic challenge in every way to those clinicians who are less familiar to adult ADHD profile. To add to this confusion; behavioral aberrations of many adult ADHD patients are usually considered within extended normal limits.

Clinical picture don't blatantly indicate behavioral psychopathology like that of delusion/hallucination. Hence, diagnosis of adult ADHD is commonly missed [2].

Why is it important to diagnose and treat adult ADHD?

To discuss illustrious answer of this question is not objective of this article; however intimate relationship of this question too cannot be denied. Varying degree of adult ADHD can also be deleterious in some of the occupations like drivers, bankers, accountants, managers, supervisors, teachers, etc. Many adult ADHD, though not all of them, drive vehicles faster and recklessly enough to be a potential danger to self and others [3]. Adult ADHD banker/accountant cannot afford to commit errors due to impaired working memory. Russell Berkley repeatedly pointed out 'impaired working memory' a major hurdle which goes unnoticed among most of the adult ADHD people. Impulsivity or unpredictable anger outbursts of manager/teacher/supervisor can be detrimental to occupation. Spousal conflicts or domestic violence or inadvertent parenting is one of the less identified but major impact of adult ADHD on human life [4]. Association of ADHD with divorces, criminal behavior or conduct disorder or road side aggression or road rage or delinquency and anti-social personality disorder [4] cannot be undermined. Higher rates of school drop outs, higher rates of substance abuse by adolescent ADHD, repeated change of jobs, incarceration, bad police records, increased intimate partner violence (IPV), ADHD co morbid with anti social personality disorder (ASPD), etc. demands timely treatment to curtail such complications of disease itself [2,4]. Thus, awareness is growing that untreated patients of adult ADHD can attribute many negative consequences as if they are a potential threat to self and society [5]. Such short trailer of adverse impact of adult ADHD alone (impact of co morbid conditions is not considered) highlights the need of spreading awareness and insistence on treatment of adult ADHD. So, this case based discussion is aimed to sensitize and familiarize psychiatrists and family physicians. Study of case report enhances clinical acumen [6], because case report/s are reflected upon easily like that of stories, remembered for long, and thus become applicable instrument in the hands of clinicians to facilitate diagnosis. So this case based discussion also aims to enhance diagnostic skills of clinicians [6].

Case Report

50 year old father of two sons, govt. employed walked in OPD for consultation. He was neatly dressed and well groomed. His mannerism was within normal limits, e.g. defying mentally sick person's picture. He had come alone. He was not referred by anybody. He searched for psychiatry clinic frantically on his own because of his panic like symptoms; he was suffering every night since 3 days. His apprehension had increased also because he was left with only one day's stock of medicine. He had anticipated renewal of prescription and supply of medicine was difficult because of Covid-19 lockdown. He was under psychiatrist's treatment for insomnia since almost eight years now (since 2012). He couldn't have visited his psychiatrist who practices in another city; he anticipated as a result of Covid-19 lockdown city boundaries were sealed and traffic across the city was highly prohibited.

His presenting complaints were insomnia, ruminations, worries, and lack of interest in daily routine along with panic like attacks only at night since last three days. He describes that he feels dry mouth, thirst, mild palpitation while asleep which awakens him and later keeps him awake for some time. While interacting further he said that he believes lockdown period is responsible for his presenting complaints. While answering how lockdown period could have caused such symptoms; he replied that staying home all the time has changed his day's schedule and life-style. As a result of empty day without any work he is exposed to haunting thoughts all the time. Lockdown seems to have escalated his anxiety because of restriction on movement.

Detail history: Insomnia which started at the age of 20 was one of the major sufferings to compel him consult psychiatrist. Insomnia was almost daily experience. It was initial insomnia. But his sleep was also not sound. Insomnia causes his mornings dull due to unsatisfactory sleep. As long as he consumes medicine he used to sleep well. But this consistent and routine experience of many years was shattered since last 3 days; he started experiencing panic like attacks even if he was taking medicine regularly.

While exploring further he revealed that sometimes he talks with self. He recollected that occasionally onlookers or known people told him that he was muttering with himself. Sometimes he mutters irrelevantly. He smiles with self. Muttering or smiling with self did not

pose any significant dysfunction so he was not bothered. He further revealed that he must have inherited this habit of muttering from his mother who used to speak with herself loudly.

He suffers from forgetfulness to significant extent. He told that his forgetfulness was since almost 25 years i.e. since youth. Forgetfulness was experienced daily, in routine activities. His forgetfulness affects his personal, occupational, and social life. Occasionally he forgets to carry on certain daily activities. This history compelled me to investigate if he belongs to profile of (symptomatology) adult ADHD. So, following questions were asked to ascertain the diagnosis of adult ADHD (See table 1).

Do you find yourself always in hurry? E.g. inner restlessness?	Yes
Do you impulsively intervene people? or without intimating, like even if they are busy doing something you throw your questions at them?	He said Yes, most of the time.
Can you sit still in a meeting? Can you concentrate and if yes; maintain it for sufficient period?	No, I never sit silent, most of the time I scribble with pencil on a blank paper. Many times he said, he gets up from the meeting, goes out and come back to sit again. He is very impatient; he adds. No, I lack concentration. It is noticeable during official training.
Do you always find yourself fidgeting? Or moving feet/hands/trunk/seat unknowingly?	Yes, In fact, he said, he likes always to move around.
Do you speak before other person finishes his sentence?	Yes
Do you follow other person when he/she is directly speaking to you? Do you comprehend immediately everything he or she has said to you?	No he said. He added further that he cannot answer if asked question relevant to conversation. He needs to ask or enquire again even if told once or just before.
Do you drive fast? Can you wait in a queue?	He is not driving fast since last 6 years. Initially he used to drive fast. But now -a-days; he had observed that his speed increases without his awareness or actual need, may be because of his rumination he explained. He avoids queue. But if compelled he waits in a queue with restlessness; he explained.

Table 1: These are Common questions to rule out adult ADHD. Answers given by patient are mentioned in right-hand column.

History further revealed that he was and is quite overactive. He explained further on his own (voluntarily he elaborates and expands his history) that his over activity is not goal oriented like some other colleagues who remain active for the purpose. Hence, he blames himself for his diminished goal directed ability and feels frustrated and helpless. Thus, he does not like his over activity he adds. He further adds that he is habituated to go out of house very frequently, move aimlessly on roads even when during holidays or on Sunday when he happens to be at home. His family disregards this habit and now started ignoring because he persistently continued being mobile.

Detailed past history further revealed that he was taking medicine from a psychiatrist since 2012 for insomnia and rumination of thoughts. Stressor for this symptom/s was marriage of his sister 'he mentioned voluntarily on his own'. Back then his sister had married a boy from another cast against the wishes of his parents and family. It was love marriage. Soon after he started suffering from ruminating thoughts which used to deprive him of sleep. He told that rumination was a significant obstacle in his daily life. He used to get lost in thoughts not only when he is alone but even in company of other person. Now also he remains unaware of his surrounding when he gets lost in his thoughts; again he volunteered.

Answering the question about fast driving he denied immediately but added in the second breath that his driving behavior seems to have changed since couple of years. He used to drive fast earlier. But now a day he drives slowly though it is not a consistent. He further explained voluntarily on his own that his speed increases automatically while driving; may be because of cycling thoughts he volunteered again. Lack of behavioral consistency is seen among ADHD adults.

His psychiatrist kept him on Clonazepam, Lorazepam, Olanzapine, etc. alternatively since last 8 years. At present he was taking olanzapine 5 mg at night since couple of months to get sleep. He used to get sleep with that medicine till last couple of days.

Negative history: He declined symptoms of delusions or hallucination. He did not have symptoms suggestive of OC features, depression and hypomania. He was non-diabetic, non-hypertensive. There was no history suggestive of IHD, CVE.

His personal history disclosed that he abuses alcohol occasionally. History is not suggestive of alcohol addiction or tolerance. He had not consumed alcohol since almost one month as result of Covid-19 lockdown. There is no history suggestive of craving or alcohol withdrawal syndrome. His childhood history was positive for lack of concentration, fidgety, low score in examination due to errors, indicate presence of pediatric ADHD. He does not remember many details of his childhood or school life. However, he remembers that schooling was not happy and easy. His sleep was normal then in duration and used to be undisturbed. He affirms that anxiety and depression like mental set up was not experienced by him before marriage of his sister.

His occupational history revealed that he works for government. He has 10 am to 5 pm Job. His behavior or ability to work in office is not worthy of appreciation; he regretted loudly. Further exploration revealed that he cannot sit quietly in meetings, cannot concentrate long enough, does not remain aware what the other person is saying even if it is one to one talk, forgets to comply with the orders of officials, make many mistakes, etc.

His family history is positive for psychiatric illness. His mother was suffering from some (?) mental illness.

With all these answers probability of adult ADHD was high so authenticated screening scale or questionnaire to confirm the diagnosis was applied.

Adult ADHD self report scale (i.e. ASRSv.I.I) score was strongly positive. Part A score was 6/6 positive and part B score was 8/18. Diagnostic requirement or key to confirm adult ADHD is score of Part A 4/6. Score of part B is considered indicative of adult ADHD. In this Case score was strongly positive.

Treatment and follow up: (1) Olanzapine 5 mg at night was continued. (2) Fluoxetine 20 mg once a day (OD) (3) Atomoxetine 10 mg OD, and (4) Trazodone 100 mg at night started.

Followed up after 8 days revealed that his panic attacks subsided completely, rumination reduced up to 60%, Sleep was sound, Concentration improved up to 70%, inability to sit at one place reduced up to 40 to 60% on a measuring scale of 1 to 100%. His motivation improved; he volunteered. Medicines prescribed for next one month were as follow: (1) Olanzapine 2.5 mg at night to taper off, (2) Fluoxetine 20 mg same dose, (3) Atomoxetine 18 mg in the morning (increased dose), (4) Trazodone 100 mg same dose maintained.

Further plan

Taper off Olanzapine, Trazodone, within two week's time. Maintain patient on Atomoxetine at maximum effective dose along with 20 to 40 mg of Fluoxetine.

Discussion

Presentation of this case is panic disorder. But it was not the complete diagnosis. It was co morbid condition. It is not uncommon in psychiatric OPD to see co morbid conditions presenting as if a complete diagnosis. Co morbid condition of depression along with anxiety

in this case might have (mis) guided earlier psychiatrist to prescribe clonazepam/Lorazepam every time. Being commonly used symptomatic treatment patient was relieved of his symptoms and same line of treatment was continued. Prescription of benzodiazepine for such a long period (8 years) is highly risky [7] but absence of major side effects and patient's lack of awareness of side effects or patient's inability to focus (due to ADHD) on details like adequate self-care, health conscious attitude, or less attachment by family members due to patient's impulsive behavior, and clinician's ignorance of guidelines towards long term use of benzodiazepines might have facilitated such long continuation of benzodiazepine or sedating medication [8].

A multinational study published in 2015 observed that anxiety is second highest prevalent co-morbid conditions found in untreated ADHD adults. Prevalence of anxiety disorders was 36.4% against 46% that of depression among ADHD adults [9]. Presenting complaints of this case indicate prevailing depression and anxiety disorder since long time. E.g. initial insomnia points more towards anxiety, ruminations/lack of interest/negative self image indicate depression. But clinician is ethically bound under mandatory rules to exercises enough care and ability to refrain from 'symptom bases diagnosis' to arrive at underlying diagnosis by taking detail history.

Patient clearly narrates in this case that prominent symptoms like insomnia, rumination and forgetfulness started after sister's marriage. Psychological shock at the age of 20 seems to have flared up the sufferings compelling patient to take treatment. Genetic predisposition in the form of family history of psychiatric illness (mother) made this patient vulnerable. Till the age of 20; though patient had symptoms of ADHD since childhood; was not bothered much to seek treatment. Biederman., *et al.* in 1996 published an article mentioned that psychosocial adversities, psychiatric co morbidities attributes or facilitates progression of ADHD into adult life [1].

Similar thing seems to have occurred in this case.

His frustration on being overtly active without fulfilling any purpose indicates his lack of self esteem, which is also a tangible criterion of adult ADHD (Russell Berkeley); that attributes to impairing emotional stability [2].

His volunteered commentary elaborating his own complaints and reasons thereof indicate his insight into his condition. He provided psychic reasons for escalation of speed while driving discloses his intact insight and ability to analyze self; which is seen among ADHD adults (Russell Berkeley). His adaptation to slow driving indicates his coping ability based on insight and reasoning effective because of less stressful stimuli. Groom., *et al.* of UK has observed similar behavior where ability to adjust speed in low stimulation environment was noticed [3]. Hence some adult ADHD drive fast but not all of them drive fast all the time across the life span.

Complaint of insomnia is quite commonly observed in psychiatric OPD. Rarely clinicians get suspicious to rule out the possibility of adult ADHD. But according to author; it is clinically useful and imperative to rule out adult ADHD when forgetfulness before old age combines with insomnia. Brown TE and McMullen WJ Jr. report (Ann N Y Acad Sci. 2001) that despite many causal factors underlying patho-physiology of ADHD is directly responsible for impairment of sleep or sleep arousal problem. Various sleep related problems like insomnia, narcolepsy, circadian rhythm sleep disorder, restless leg syndrome are associated with ADHD; researchers noted [10]. 25% to 50% sleep problems are associated with ADHD [10]. Hence persistent insomnia across the life span like this case should raise the suspicion of adult ADHD. In this case, symptoms of insomnia along with forgetfulness triggered the spike of suspicion. Secondly, insomnia remained consistently unresolved major complaint, with or without sleep medication. History was not suggesting any other major cause of persisting insomnia. These two factors were enough to indicate need to rule out adult ADHD [5].

Clinicians need to reorient themselves towards increasing prevalence of adult ADHD in general population [9]. 10 to 20% prevalence of Adult ADHD in psychiatric OPD should also weigh high on the minds of psychiatrists [1,5]. Compare the ability of psychiatrists to diagnose Schizophrenia against that of adult ADHD on the basis of prevalence rate. E.g. prevalence of schizophrenia is 1% whereas prevalence of adult ADHD is more that 2 to 5% [1,9]. However, symptoms of schizophrenia are always investigated whereas symptoms of adult ADHD

go un-noticed most of the time [11]. Awareness and clinical habit of inquiring for the symptoms of adult ADHD could possibly help better this picture [11].

In this case; patient was prescribed medications like clonazepam, Lorazepam and Olanzapine since as long as 8 years. Discussion about ethical obligations, good clinical practices do not fall under the objectives of this article; so ignored but remain pertinent.

Clinical presentation of adult ADHD is a diagnostic challenge that differs from case to case. But awareness and familiarity of clinical picture is a solution. To help create awareness and enhance familiarity following text is included.

Common clinical symptoms of adult ADHD is as follows. This picture is neither all inclusive nor pin-pointed. Symptoms not detected in this case are mentioned to familiarize clinicians. Diagnosis of adult ADHD may fall under the categories like probable adult ADHD, mild to severe form of adult ADHD. According to the degree of ADHD in adult symptoms differ. Varying degree of impairment and varied presentation is a rule in adult ADHD [12]. Overlap of co morbid condition/s surely confuses clinician/s. Deberdt., *et al.* observed (2015) in the same study that prevalence of other psychiatric diseases (16%), and no psychiatric disease (11.5%) was also significant enough to dilute the intelligent guess [12].

Impulsivity of adult ADHD is represented unlike that of childhood ADHD in (1) interrupting others when they are busy, (2) difficulty to stand in queue, (3) easily gets angry, (4) change of jobs, (5) difficulty in relationships at job and/or within family [11]. These issues need to be inquired while taking history to rule out adult ADHD.

However, following scenario and couple of the symptoms do indicate (not diagnostic) adult ADHD: over-confident without indications of hypomania, obviously hasty mannerism, simultaneously involved in multiple activities like talking on phone while replying doctor's questions or checking gadgets like phone while talking etc.

Symptoms: short lived mood swings i.e. sad events may not keep them sad or nervous as long as any normal individual may feel, unusual or unreasonable feel of uneasiness/boredom, inability to reflect upon one's own carelessness, keeps projects unfinished, sense of time gets obliterated when engaged in a favorite activity, misses important appointments, cannot stop doing the activity in hand for some time even if asked for, easily forgets earlier unfinished activity to complete after having been distracted to do something else, difficulty in reading long paragraphs at stretch, (one of my adult ADHD patient with normal IQ and absence of learning disorder cannot read even a single sentence without being drifted by his inner thoughts. He can read without distraction when he is put on approximately 100mg of long acting Methylphenidate), exhibits less inhibition to authorities, childlike behavior, tendency to crack jokes during gloomy or sad events, impulsive behavior e.g. acts first and then think or repents, etc. This list is quite long and not yet exhausted. Variation of clinical picture is a real challenge to diagnose adult ADHD [12].

Conclusion

Adult ADHD challenges clinical acumen to be diagnosed due to overlapping co-morbid presentations. Awareness and practice to explore the history will enhance clinical ability to diagnose adult ADHD. More case report publications could help spreading awareness and enhance clinical/diagnostic ability.

Limitations

Case reports and short communications thereof do have inherent advantages as well as limitations e.g. personalized story, difficulty to generalize, lack of longitudinal and horizontal study, etc.

Conflict of Interest

None.

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