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Unrecognized Attention-Deficit Hyperactivity Disorder in Adults Presenting for Outpatient Psychotherapy

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ABSTRACT

Adult patients with significant childhood and current symptoms of attention-deficit hyperactivity disorder (ADHD), but whose ADHD had not been previously recognized, were evaluated by three clinical consultants working with diverse referral populations. These 60 adults shared common characteristics of physical and mental restlessness, impulsivity, disabling distractibility, low self-esteem, self-loathing, and a gnawing sense of underachievement. Specific learning or behavior problems were often present. These patients were chronically disaffected. The diagnosis of ADHD appeared to be missed because these individuals presented with atypical symptoms or had found ways to compensate for their deficits. Descriptive generalizations are offered concerning their coping strategies. These adults had sought previous psychiatric care for non-ADHD symptoms but had numerous unsuccessful treatment attempts. Most patients had been treated for mood or anxiety disorders. Traditional defense analysis had little beneficial effect and aggravated problems of self-esteem; modifications of the psychotherapeutic process are recommended. In open clinical trials without formal measures, the majority of such patients appeared to respond to low doses of antidepressants (i.e., desipramine 10–30 mg daily) and seemed to lose the therapeutic effect at higher antidepressant doses.

INTRODUCTION

FOR YEARS IT WAS BELIEVED that, with maturation and development, children outgrew the major symptoms of attention-deficit hyperactivity disorder (ADHD). However, accumulating clinical and research data have demonstrated that ADHD often persists into adolescence and adulthood and that adults with ADHD continue to suffer from symptoms of distractibility, impulsivity, emotional lability and disorganization

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(Biederman et al. 1990, Elliot 1988, Gittelman-Klein et al. 1985, Weiss et al. 1985, Wender 1987). It is less clear whether this cluster of symptoms are found in adults who have never received a diagnosis of ADHD in childhood.

We suspect that the prevalence of this disorder in adults is obscured by selective diagnosis in childhood. Attentional problems are often overlooked in children, particularly when their dysfunction is mild or mitigated by temperament, cognitive strengths, or favorable socioeconomic circumstances which provide appropriate structure and support. Children who have obvious learning disabilities or behavior problems are more readily recognized than those children who struggle through and appear only as underachievers or unruly kids (Mann and Greenspan 1976). Furthermore, the shy, quiet, inhibited, inattentive "daydreamer" may not be detected as readily as the loud, disruptive, disinhibited "troublemaker." Thus, shyness and social awkwardness, typically considered far-removed from the symptoms of ADHD, may also overshadow any suggestion of attentional problems (Huessy 1973).

The structure provided in school and within the protective framework of the family unit often provide a sufficient but temporary degree of organization and support, allowing some individuals with ADHD to function adequately. However, as the cases presented here illustrate, people whose ADHD is not detected in childhood may become adolescents who set achievable goals but who cannot maintain the organization or motivation to achieve them or who can do so only with unusually high expenditure of time and effort, so that they perceive themselves as incompetent, underachieving or defective.

The transition into adult life is particularly challenging for individuals with ADHD, especially if it is unrecognized. Living independently tests their ability to function on a daily basis, exposing organizational and motivational deficits that are not apparent in a structured family life (Mann and Greenspan 1976). Mitigating strategies, developed to offset underlying neurological deficits, are often themselves a major problem. Furthermore, the impact of accumulated failures generates its own constellation of symptoms. Little attention has been paid to the variety and impact of compensatory maneuvers that adults with ADHD devise in their attempt to adjust to the demands of adult life and to the emotional baggage that accompanies their repeated failures.

METHOD

Sixty representative adult patients were selected from the total case loads of three practitioners of diverse orientation and distinct referral populations: evaluation of patients for medication (J.R.); evaluation of patients refractory to long-term psychotherapy (J.B.); and neurodiagnostic assessment (M.G.). These patients had not been diagnosed with ADHD as children and were unaware of the existence of this condition, although review of their childhood history identified symptomatology consistent with ADHD. There were 45 males and 15 females in our sample with an age range of 22 to 65, with the median age being 34.

A current diagnosis of ADHD was made if: the patient currently exhibited symptoms which met *DSM-III-R* criteria, had a longstanding history of symptoms consistent with ADHD throughout their adult life, and had a childhood history of ADHD symptoms. These criteria are consistent with the DSM-III criteria for ADD, residual type. Since this was a retrospective sample from our clinical practice, diagnoses were made clinically, and no structured or standardized interview was used in establishing the diagnosis. School records were not routinely obtained. In many cases neuropsychological testing was performed for the purpose of clarifying the diagnosis.

A retrospective diagnosis of ADHD in childhood was made if the evaluating clinician could endorse at least 8 of 14 criteria for ADHD in *DSM-III-R*.

All patients were tried on low doses of desipramine (10–30 mg daily) over a one-month period. If the response was not adequate, then patients were tried on increasing doses of methylphenidate.

CASE EXAMPLES

Case 1

LT is a 28-year-old male stockbroker who had been in treatment for a chronic mixed anxiety/depressive disorder with severe temper outbursts. He was frustrated by his inability to realize his career dreams of

becoming an economics professor because he could not easily be still enough to read. He was very successful at work and was recently appointed head of his office; however, he could not concentrate. On examination, he described a lifelong history of distractibility, restlessness, and impulsivity. He had been in weekly psychotherapy for two years and had been on a number of different drug regimens, including alprazolam and imipramine (175 mg/day), with some relief of his symptoms. Although he had graduated with honors from a prestigious college, he had found it difficult to study during the semester even though his motivation was high. By his junior and senior year, he had developed a pattern of waiting until the two-week period before finals to do the work required of him for the semester because he could superfocus under this intense pressure. He was demoralized and furious with himself for not being able to initiate or to finish projects (e.g., he was three years behind on filing his income taxes) and felt that he was and always had been a failure. Full exploration of his ADHD symptoms coupled with neuropsychological tests helped clarify the diagnosis and led to treatment with desipramine 20 mg daily. Within a week, he felt more calm and able to sit to complete tasks, his mood was more stable, and he was able to read more easily. Long-term follow up at three years finds him in graduate school and doing well, with most of his issues resolved.

Case 2

TC is a 28-year-old women referred with a diagnosis of chronic dysthymic mood disorder. She was restless, impulsive, and moody. She was given to self-loathing, had no close friends as she found people boring over time, and she would end her many dating relationships as soon as the man showed genuine interest. She was employed at a well-paying but undemanding job. The patient had been in twice weekly psychotherapy for four years and had therapeutic trials of tricyclic antidepressants, phenelzine, and lithium without any sustained improvement. She had a superb school record but had no direction toward a career when she finished college. The patient had a history of an unhappy childhood and began seeing a therapist at the age of nine for speech problems and general social problems fitting in with her peers. She was socially and physically clumsy and had difficulty following rules. Throughout her early grades, she got As in everything except in conduct and comportment. She was a shy, withdrawn child who would nevertheless blurt out answers to questions in class as she could not wait for the rest of the class to respond. She was a dreamer and was fortunate to have an excellent memory and good logic skills. Adolescence was marked by early promiscuity and abuse of marijuana. Neuropsychological testing corroborated a longitudinal clinical picture of ADHD. When a trial of desipramine was unsuccessful, methylphenidate was tried at 30 mg daily with great effect. Her moods became positive and stable, and she was more focused and assertive. Her interpersonal relationships improved and at long-term follow up she was engaged to be married.

RESULTS

Presenting problems and reasons for referral

Problems that emerge in adolescence and adulthood include poor job performance, chaotic interpersonal relationships, affective disorders, low self-esteem, obsessive-compulsive traits, stimulus-seeking behavior, antisocial behaviors, and drug abuse (Gittelman-Klein et al. 1985, Weiss et al. 1985). Many patients self-medicated their anxiety and mood lability with alcohol, while others used amphetamines and cocaine—paradoxically, as calming agents (Cocores et al. 1987, Horton et al. 1987, Huessy and Howell 1982, Khantzian 1985, Schuckit et al. 1987). Moreover, social relations were frequently marked by confusion, misunderstanding, and failure, which further eroded self-esteem. Often treatment was sought to manage these subsequent problems. However, because the neurological basis of their disorder was not identified, many symptoms remained recalcitrant to psychotherapeutic interpretation.

The majority of patients in our sample were referred as treatment failures by experienced psychotherapists who recognized the difficulty of treating their patient's symptoms through traditional psychotherapeutic means. The significance of this report lies in the fact that these individuals had not been aware of their

childhood ADHD and had been treated unsuccessfully for subsequent difficulties by numerous therapeutic strategies. Previous therapists attempted to analyze presenting symptoms as defenses against forbidden wishes or as lowered self-esteem. This approach had a decidedly negative effect, increasing the patient's sense of frustration, futility, and ultimately self-hatred. Eventually, treatment reached a stalemate which the therapist often perceived as excessive resistance or a negative therapeutic reaction. Structured short-term therapies were often ineffective, typically due to difficulty maintaining the focused commitment required for such work. Often such failures exacerbated the patient's sense of ineptitude and shame. Past psychopharmacologic intervention was often a failure, as attempts to treat the purported psychogenic syndrome often exacerbated the neurologic deficit. Some patients were exquisitely sensitive to medication and had frequent paradoxical and atypical responses, leading to frustration and discontinuation of treatment. After the diagnosis of ADHD was confirmed, these individuals responded well to psychoeducation and appropriate drug treatment.

Presenting diagnoses

A summary of the primary presenting diagnoses and their incidence within this sample is provided in Figure 1. The most frequent Axis I diagnoses were mood disorders. Depression, dysthymia, and cyclothymia were the primary presenting diagnoses in 47% of the patients. Fifteen percent of the sample presented with anxiety. An additional 15% of the patients presented with diagnoses that were grouped in a category which included eating disorders, sleep disorders, or somatization. Drug abuse was the primary presenting diagnosis in 13% of the sample. Five percent of the sample presented with a primary diagnosis of obsessive-compulsive disorder. Finally, in contrast to other follow-up studies of ADHD children which report a higher incidence of antisocial behavior (Satterfield et al. 1982, Werry et al. 1987), only 5% of this sample presented with antisocial behavior as their primary diagnosis.

Identification of attention deficits

Distractibility and impulsivity in school, work, and relationships were the common themes in all of the cases presented here. In addition to their presenting symptoms, such as low self-esteem, generalized anxiety, or depression, all had a coexisting disorder of distractibility, inattention, and impulsivity. The depression in this group was a chronic disaffection, a demoralized view of themselves and life rather than a true unipolar

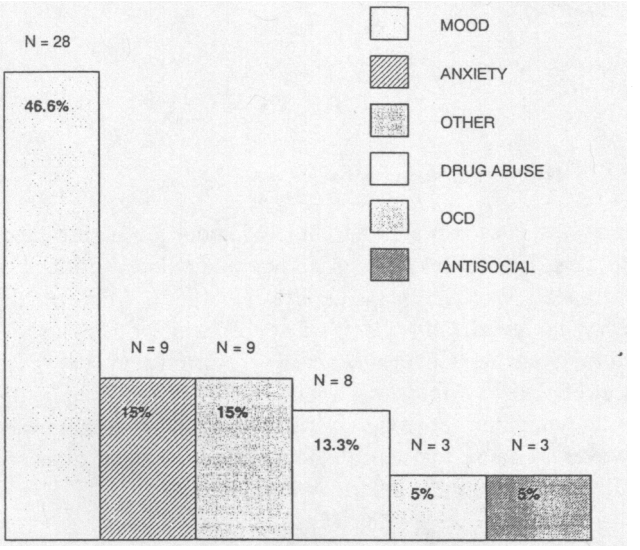

FIG. 1. Presenting diagnosis as reported by adult patients. Incidence in sample; sample size is 60 patients.

depression. All patients believed themselves to be different from other people who lacked their disorganization; thus feelings of inadequacy prevailed. Each reported his or her own personal story of idiosyncratic, nonconformistic behavior intended to overcome perceived inadequacies and inner drivenness.

Compensatory behaviors oscillated between withdrawal and high stimulus activities. In some, overcompensating for their lack of organization often resulted in obsessive-compulsive behaviors. Compulsive behaviors, used by some patients as a structured overlay to impose organization and productivity, most frequently included the generation of lists, charts, and graphs to organize daily activities. One patient, for example, compiled a system of three by five note cards which she spread out on her desk and checked daily to insure she did not neglect significant activities. Another patient devised a color coded system to further organize his list of activities. Although effort was made to increase their output, these patients were seldom able to make the next step in accomplishing their tasks. The additional time spent making, updating, and changing checklists interfered with rather than increased their productivity, and they remained disorganized and unproductive.

As a result, the majority of patients reported less than optimal performance and underachievement based upon self-perception of potential and ability. Family, employers, and colleagues reinforced the perception that their performance was less than their potential ability. In general, patients reported feeling overwhelmed by the routine demands of life. Filling out insurance forms or tax returns or simply getting a car repaired seemed like insurmountable challenges. Feelings of being overwhelmed, overburdened, or unable to meet everyday demands impeded their work and career choices. Many of the patients in this sample had not been able to make structured career goals and were working in unchallenging jobs for which they were overqualified, based on their intellect, education, and motivation.

Although many experienced failures, most patients continued to struggle to meet their expectations of themselves. In order to overcome their distractibility and impulsivity, some spent more time and energy on work or school activities than their friends, family, or peers. Quite often, they felt their ability to concentrate improved when under stress, so they worked most effectively the night before an assignment was due. All required external deadlines in order to complete projects and usually waited until the eleventh hour to begin working. Without the emotional arousal resulting from the fear of immediate failure, they were unable to work productively, despite repeated false starts.

In addition to the negative impact on work performance and daily activities, distractibility and impulsivity interfered with interpersonal relations. Most patients were easily distracted not only when working, but also when interacting with others. They had difficulty maintaining their attention on the information provided by another individual at all levels of interaction. Their spouse would complain about their not being attentive to them and that they walked away or "spaced" in the middle of the most intimate conversations. Patients frequently underreacted or overreacted to others, which negatively impacted interpersonal interactions. Distractibility and impulsivity thus led to confusion on the part of others as they interpreted their distractibility as being allergic to intimacy. These misunderstandings led to many failed relationships both personally and at work. Therefore, many patients often protected themselves by avoiding intimacy, and for some, most any social contact, because they anticipated criticism and rejection.

Frequently, relationships were poor because of poor choices in partners. For example, one woman became involved with men whose own need for nurturing was high. Rather than choosing partners who needed less nurturing and could offer more to her emotionally, she chose partners who were doing poorly with their own development. Another patient avoided commitment of almost any kind as she knew from past experience that she would become intensely enthusiastic about a new idea, activity, or relationship, only to find herself disinterested a few weeks later. Some patients isolated themselves from others through high stimulus career choices and demanding workaholic schedules that limited personal accessibility. Constraints and pressures disallowed availability and prohibited the time necessary to slow down and engage in a meaningful way with others.

In contrast, many individuals in this sample used relationships to maintain their own motivation and focus. Relationships thus became directive forces. While using the other's desires, many patients neglected to establish independent careers or interests. Significant others were generally overvalued and our patients responded with submissive and at time masochistic behaviors. Not a few of the patients here were exploited by others who took advantage of the need for structure and feedback.

History of childhood symptoms

Problems in learning and performance were the most common self-reports of childhood symptoms and behavior (see Fig. 2). Seventy-five percent of the sample reported subpar school performance, and expressed a frustrated sense of not performing to their abilities. Attempts to overcome their undetected deficits commonly emerged as compensatory behaviors, such as increasing time and intensity of effort to complete work. Adaptation by "overfocusing" on tasks was common (Kinsbourne and Caplan 1979). Many of the patients presented here obtained acceptable and even superior grades due to high intellectual endowment or to the intensity with which they worked to overcome their biological handicaps. In spite of achieving adequate academic performance, the label of "underachiever" often persisted. Although grades obtained in school were good because of extra effort or cognitive superiorities, classroom performance often remained below the potential ability expected by teachers, parents, and the student. For instance, one patient was the top performer in his class throughout grade school, but his report card always carried the caveat that he was an underachiever and unruly, a description with which he readily agreed.

Forty percent of the patients endorsed significant motoric hyperactivity as children. Unable to sit still at home or in the classroom, they were considered agitated and disruptive trouble-makers. Another fifty percent of this sample were not identified as disruptive but fidgety, had difficulty with quiet periods, and had intellectual hyperactivity (i.e., constantly searching for new ideas to muse about). In contrast, a subgroup of patients were considered withdrawn and shy throughout childhood; this was particularly true for many of the female patients in this sample. Greater intellectual endowment than their peers most frequently precluded more in-depth examination for possible organic causes of their behavior. This further perpetuated the conception that their conduct was psychologically based.

Medication response

All patients were recommended to begin treatment with low doses of desipramine (range 10–30 mg/day), a practice first described in 1964 by Rapoport (1965) and later recommended by Huessy et al. (1979). If the patient did not respond, then a trial of methylphenidate (range 10–60 mg/day) was recommended. Longitudinal follow-up was possible in 31 patients who received medication. Nineteen (61%) responded well to doses of desipramine, with mean dose being 23 mg/day. Patients were typically maintained at these low dosage levels. The presence or absence of affective symptoms appeared to have no bearing on the effectiveness or ineffectiveness of desipramine. If a positive effect on attention, behavior and mood regulation was obtained at a low dose range, raising the dose often appeared to eliminate the positive effect of the desipramine. In some cases, additional focusing ability was achieved by actually lowering the dose. The eight patients who did not respond to desipramine were treated with methylphenidate (dosage range 10–60

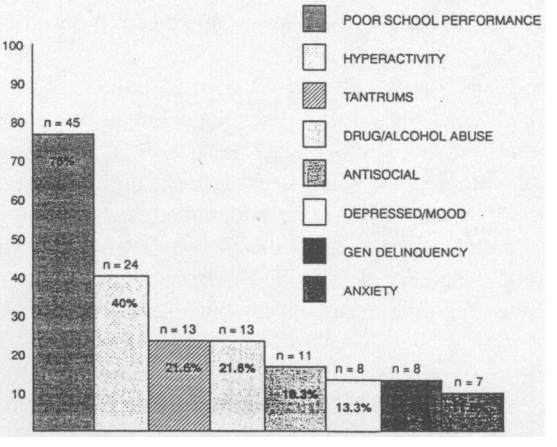

FIG. 2. Childhood symptoms as reported by adult patients. Incidence in sample; sample size is 60 patients.

mg/day). Four additional patients responded to combinations of psychostimulants and an adjunct such as nadolol (Ratey et al. 1991) or fluoxetine (Barrickman et al. 1991).

DISCUSSION

This paper demonstrates the variety of clinical presentations of ADHD in a naturalistic sample of adults who had sought out or were engaged in psychotherapy. The adults presented here were able to partially compensate for and mask their ADHD symptoms becuase they were intelligent, talented, or from socioeconomic strata which provided additional structure and opportunity. Their ADHD was not diagnosed in childhood because (1) they were above average intelligence, (2) they performed at least adequately in school, (3) they worked extremely hard, (4) they discovered compensatory strategies to deal with their symptoms, or (5) they had individual protective support systems available. Clinically our impression was that these individuals resembled Wender's group of adults with ADHD (Wender 1987).

Distinguishing ADHD from depression, panic disorder, or other illnesses remains problematic. Many questions of etiology and mechanisms (e.g., whether ADHD leads to depression, biologic panic disorder, substance abuse, or sociopathy) remains to be elucidated. The longitudinal presence of ADHD symptoms remains necessary in making the diagnosis of the disorder and helps to clarify understanding and treatment options in cases where chronic depressive symptoms are also present.

The role of arousal in attention is critical to developing an understanding of attention deficits, as both over- or underarousal can diminish performance (Hebb 1966). Patients with ADHD have a narrow window of attention for appropriate internalization and organization of information. They are often over- or under-aroused, leading to ineffective actions and unpredictable behaviors. Because information is not appropriately attended to, it may lack sufficient stimulation for the individual with ADHD. To overcome this insufficiency, the information or the perception of the information must be altered. A hypothesis consistent with attention models of information processing considers that an individual with attention deficits may obtain a "normal" level of stimulation by immersing his or herself in a greater amount or intensity of stimuli (Deutsch and Deutsch 1963). An additional hypothesis considers that an individual with attention deficits must screen out extraneous information completely and focus exclusively on one matter in order to maintain adequate attention and motivation (Kinsbourne and Caplan 1979).

A subset of 30 patients were administered a battery of neuropsychological tests. All 30 patients demonstrated significant domains of impairment and variability of testing results. The "Boston Process Approach" was employed, using standardized instruments for assessing the major realms of cognitive functioning including attention, psychomotor speed, language, academic achievement (reading, writing, and arithmetic), memory, planning and execution, motor coordination, and visuospatial ability (Kaplan 1988). Since no consensus exists specifying the necessary and sufficient criteria for diagnosing ADHD based on testing data alone, no attempt was made to define rigid rules for classifying the test performance of our patient sample. Rather, in the present study, the detection of ADHD was made clinically, based on individual patterns of test performance. The patterns compatible with adult ADHD included uneven or patchy performance across a range of tests (which could not be explained by motivational or other factors); selective impairment on tests loading high on attention (e.g., digit span, visual tracking tasks); coexisting evidence for specific learning deficits (e.g., reading, writing, arithmetic, or spelling dysfunction); signs of anomalous motoric dominance; and test results indicating focal areas of cognitive superiority.

Practitioners should be alert to the possibility of ADHD in their adult patients described above, as such patients do best with modification of the psychotherapeutic process. Traditional defense analysis in psychotherapy had little beneficial effect and worsened the patients' already damaged self-regard. The first step in treatment is the recognition and diagnosis of the defects in attention, arousal, and self-regulation. Once this has been established, the focus of treatment shifts away from uncovering defenses and altering basic but unrealistic expectations, and toward learning to live with a chronic illness which, although somewhat amenable to pharmacological intervention, is as yet incurable. This transition involves the following steps: (1) instructing the patient about the everyday symptoms that comprise ADHD as these influence each particular

individual; (2) reducing self-blame for behavior that is not psychologically motivated but is organically caused and automatically acted out; (3) reducing automatic defenses against symptoms of ADHD and enhancing a conscious awareness of these symptoms and means to willfully adjust their lives to meet expectations despite some degree of incapacitation; and (4) to build on strengths inherent in each individual and to maximize a fit between the individual's capabilities and environmental demands. The critical point for practitioners is that the requirements of treatment for patients with attentional deficits go far beyond just simple treatment of the neurological problem. One needs to consider the ramifications of the disorder in all aspects of the patient's life: vocational, educational, social, and psychological.

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