6 Challenges in Assessing ADHD in Adult Patients
The clinical presentation and functional impacts of ADHD in adults vary greatly from their child and adolescent counterparts. DSM-5 has modified some of the qualifiers in order to facilitate the utilization of the criteria in adults.

It is often assumed that hyperactivity/impulsivity fade or resolve entirely in adults as they grow older. However, maturation results in a shift in this symptom cluster, and it evolves from behavioral to cognitive—adult patients feel restless as opposed to running around and being disruptive in school.
Inattention and hyperactivity/impulsivity are particularly evident in adults.

Inattention presents as difficulty in completing tasks, poor time management, difficulty in sustaining attention in work-related activities, distractibility and forgetfulness, and poor concentration.
Occupational performance and professional interpersonal relationships can suffer.

Ultimately, this may result in frequent job changes, unemployment, failure to live up to one’s occupational potential, and lower salaries. Moreover, deficits in global performance in the adult patient’s life role, follow-through, and memory can have pervasive effects that extend to those who depend on him or her (eg, children, spouses, employers, friends).
Objective assessment of ADHD in adults is difficult because of many factors, including the extensive degree of symptom overlap with other psychiatric diagnoses (e.g., psychiatric comorbidities, adaptive compensatory mechanisms, difficulty in assessing functional impact).

There are a host of validated rating scales for assessing adult patients with suspected ADHD, such as the Adult Self-Report Scale (ASRS) and the Conners Self-Report Scale. One of the most significant limitations of self-report scales is that they are generally not sufficient independently to establish a diagnosis in the absence of more objective data or documentation.
Major challenges include a lack of validated diagnostic criteria; psychiatric comorbidity and symptom overlap; compensatory mechanisms; evidence of significant clinical impact; underdiagnosis vs overdiagnosis; and prescription drug abuse and drug-seeking behavior.
1. Lack of validated diagnostic criteria

Because ADHD is considered a developmental disorder, the presence of current symptoms as well as a history of previous symptoms (in childhood) needs to be established. Even with DSM-5 criteria, practitioners need to make a retrospective evaluation of the presence of ADHD in childhood in order to establish a diagnosis in adulthood but many patients have problems recalling childhood symptoms or they have no documentation substantiating a childhood diagnosis. Patients with ADHD also have impaired short- and long-term memory; therefore, recall bias can affect the accuracy of assessments. The challenge is determining whether this was an established childhood diagnosis, a missed diagnosis in childhood, or a late-onset adult ADHD.
2. Psychiatric comorbidity and symptom overlap

Determining whether ADHD is present alone or whether it is comorbid with another psychiatric disorder is critical—a mood or anxiety disorder may be responsible for the ADHD-like symptoms. Compared with patients who have a depressive disorder, those with ADHD tend to have more occupational or functional impairment, organizational deficits, and impulsivity issues. The distinction between ADHD and bipolar disorder can be especially challenging, since the manic and hypomanic features of bipolar disorder are similar to the hyperactive and impulsive symptoms associated with ADHD. In patients with ADHD, these symptoms tend to be constant, but in bipolar disorder there is a waxing and waning of manic symptoms interrupted with periods of depression. Patients with bipolar disorder tend to be goal-directed and are usually productive, while patients with ADHD are less able to complete tasks. Substance use disorders are also common in patients with ADHD.
3. Compensatory mechanisms

Patients who are highly functioning with higher than average IQs tend to develop useful coping mechanisms to overcome symptoms or to hide them from others. Some patients become compulsive list makers or develop a highly structured daily routine in order to complete tasks and to minimize forgetting details or losing belongings. They may unknowingly rely on coworkers or family members to an inappropriate extent for reminders or assistance in completing tasks or fulfilling responsibilities. Although compensatory mechanisms are generally therapeutic for the patient, they may cloud the clinical picture particularly in cases where the patient does not self-suspect ADHD but rather a family member or the practitioner suspects ADHD.
Among the DSM criteria is an item that evaluates the degree of clinical impact of ADHD symptoms on life domains. For a diagnosis of ADHD, there must be clear evidence of significant clinical impact, which can be especially difficult to objectively assess. Failure to demonstrate significant clinical impact precludes a diagnosis of ADHD even if all other criteria are satisfied. Examples of true clinical impact include disciplinary action at work, risk of job loss, relationship discord, or frequent automobile accidents or accidents in the home.
5. Underdiagnosis vs overdiagnosis

Given the high degree of psychiatric symptom overlap, the realistic possibility of feigning ADHD symptoms, and a general fear of enabling drug addiction or diversion, the underdiagnosis versus overdiagnosis of ADHD in practice has been called into question. There are no available data to quantify this concern, and therefore no support can be lent to the argument of failure to recognize ADHD or misdiagnosis of ADHD. A psychiatric comorbidity and the point of entry into the health care system (primary care versus a psychiatrist) may influence whether ADHD is overdiagnosed or underdiagnosed.
The majority of adult patients who present with self-suspected ADHD are between the ages of 18 and 24; therefore, the unfortunate but realistic risk of drug seeking must be considered. A definitive statistic that quantifies the risk and rates of stimulant medication abuse is elusive owing to patient unwillingness to admit abuse or diversion.
For more information

See Adult ADHD: A Review of the Clinical Presentation, Challenges, and Treatment Options, by Jennifer A. Reinhold, PharmD, BCPS, BCPP, on which this slideshow is based.