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Prominent Signs of Attention Deficit/Hyperactivity in the Adult

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**SAN JOSE STATE UNIVERSITY
SCHOOL OF NURSING**

**MASTER'S PROGRAM PROJECT OPTION (PLAN B)
PROJECT SIGNATURE FORM**

STUDENT NAME Marcia Katz
SEMESTER ENROLLED Spring 2000
TITLE OF PROJECT The Prominent Symptoms of ADHD in the Adult

Nurse Practitioner

The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

Vigil Parsons
ADVISOR SIGNATURE

3/3/2000
DATE

Thelma M. Connelly
ADVISOR SIGNATURE

3/6/2000
DATE

Please submit this form to the Graduate Coordinator. Attach the abstract, two copies of the manuscript, and documentation of submission to the journal.

Prominent Signs of Attention Deficit/Hyperactivity in the Adult

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Abstract

Attention-deficit/hyperactivity disorder (ADHD) is a common neuropsychiatric syndrome which most commonly becomes apparent during the first few years of grade school. While it was previously thought that this disorder remitted before or during adolescence, it has become well established that many patients will have an illness course that persists well into adulthood. The purpose of this study was to determine the 10 most prominent symptoms of ADHD in the adult population. Using the Dunphy and Winland-Brown (1998) "Circle of Caring" conceptual framework and the Wender (1998) Utah Criteria Scale questionnaire, a convenience sample of females ($N=15$) from northern California were surveyed. The data were analyzed to determine the 10 most prominent symptoms of ADHD.

I Purpose of the Study

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Summary of Adult Behaviors from the Wender Utah Criteria Scale (N=15)

Behavior	Mean	Standard Deviation
1. Lack of attention to details	1.53	.94
2. Fidgets	2.00	1.25
3. No attention span	1.87	.83
4. Leaves seat often	1.67	1.18
5. Does not listen when spoken to	1.80	.94
6. Restless	1.73	1.03
7. Does not follow through	1.40	.83
8. Difficulty engaging in leisure	1.33	1.18
9. Difficulty organizing	1.73	1.03
10. Feels "on the go" or driven	1.73	1.22
11. Reluctant to engage in work that requires effort	1.87	.83
12. Talks excessively	1.40	1.12
13. Looses important things	1.73	1.03
14. Blurts out answers	2.00	.93
15. Easily distracted	2.07	.88
16. Difficulty awaiting turn	1.33	.90
17. Forgetful of daily activities	1.73	1.10
18. Interrupts or intrudes on others	1.47	.83

Table 2

The Ten Most Prominent Adult Symptoms of ADHD from the Wender Utah Criteria Scale (N=15)

Behavior	Mean	Standard Deviation
1. Easily distracted	2.07	.88
2. Blurts out answers	2.00	.93
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10. Difficulty engaging in leisure	1.33	1.18

The Ten Most Prominent Childhood Symptoms of ADHD from the Wender Utah Criteria Scale of Childhood Symptoms (N=15)

1. Low opinion of self	2.73	2.69
2. Inability to concentrate	2.27	.96
3. Impulsivity	2.20	.94
4. Anxious, nervous, and fidgets	2.13	.92
5. Excessively shy	2.07	.96
6. Poor speller	2.07	1.28
7. Stubborn	2.00	1.07
8. Disobedient	1.87	1.19
9. Inattention	1.80	.77
10. Irrational	1.73	1.28

Prominent Signs of Attention Deficit/Hyperactivity in the Adult

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Abstract

Attention-deficit/hyperactivity disorder (ADHD) is a common neuropsychiatric syndrome which most commonly becomes apparent during the first few years of grade school. While it was previously thought that this disorder remitted before or during adolescence, it has become well established that many patients will have an illness course that persists well into adulthood. The purpose of this study was to determine the 10 most prominent symptoms of ADHD in the adult population. Using the Dunphy and Winland-Brown (1998) "Circle of Caring" conceptual framework and the Wender (1998) Utah Criteria Scale questionnaire, a convenience sample of females ($N=15$) from northern California were surveyed. The data were analyzed to determine the 10 most prominent symptoms of ADHD.

Introduction

Attention-deficit/hyperactivity disorder (ADHD) is a common neuropsychiatric syndrome with onset in childhood. It most commonly becomes apparent and thus comes to medical attention during the first few years of grade school. ADHD may be associated with a number of comorbid psychiatric conditions as well as with impaired academic performance and with emotional distress for both patient and family. While it was previously thought that this disorder remitted before or during adolescence, it has become well established that many patients will have an illness course that persists well into adulthood.

Despite an enormous body of research into ADHD, various aspects have generated controversy over the years. Two features of ADHD in particular seem to have contributed to the controversy: (a) the diagnostic criteria involve patient history and behavioral assessment without the availability of laboratory or radiological confirmation which is true of most mental disorders and (b) it has an extended course which may require treatment of children, adolescents, and adults over many years which is true of many chronic illnesses of childhood.

To make the diagnosis of ADHD, the symptoms specified in the criteria must be present for at least 6 months, ensuring that persistent rather than transient symptoms are included. The child's age and neurodevelopment are considered in evaluating symptoms, and symptoms must be of sufficient severity to cause problems. The symptoms must be present in two or more settings, i.e., work problems alone do not meet criteria for the diagnosis. The symptoms are not better explained by another disorder, such as mood disorder, psychosis, or pervasive developmental disorder (autism). To make this diagnosis appropriately, the clinician must be familiar with normal development and behavior, gather information from several sources to evaluate the patient's

symptoms in different settings, and construct an appropriate differential diagnosis for the presenting complaints.

Purpose of the Study

The goal of the actual examination of the patient is to determine whether he or she meets diagnostic criteria and to look for conditions other than ADHD that might simulate it. A number of rating scales and psychological testing instruments may be used in the assessment of suspected ADHD, but none of these should be used in isolation to make or refute the diagnosis. The purpose of this study is to determine the 10 most prominent symptoms of ADHD in the adult population.

Literature Review

Current research supports a neurobiological foundation to ADHD. Recent clinical brain imaging at the National Institute of Mental Health (NIMH) illustrated an imbalance between neurotransmitters like dopamine in the brain of patients with ADHD (Arnold, 1997). When comparing the brain cells of ADHD adults with those of non-ADHD, the ADHD brain cells were found to be 8% less active and to have lowered glucose metabolism. These reductions were noted in the premotor cortex and the reticular activating system; both are involved in attention control and motor activity (Arnold, 1998, p. S87).

Until recently, attention deficit disorder with/without hyperactivity (ADHD) was considered a childhood disease. Children who were diagnosed with ADHD were characterized by (a) short attention span, (b) distractibility, (c) impulsivity, and (d) hyperactivity. They were thought to outgrow the disorder when they reached puberty and/or adolescence (Wender, 1998). It is now generally accepted that one third to half of all children with ADHD continue to show

signs and symptoms of the disorder into adulthood with varying degrees of severity (Weiss, 1984). Adults with ADHD have been shown to have difficulties with (a) social adjustments, (b) immaturity, (c) personality disturbances, and (d) lower social assets. They also demonstrate (a) less ego capacity to regulate drive, (b) less control of impulses, and (c) less occupational achievement (Shekim, 1990). Several follow-up studies demonstrated that 70-75% of patients continue to have difficulty concentrating and were overactive and impulsive into adulthood (Weiss, 1984). Studies of adults who were retrospectively diagnosed as having childhood hyperactivity were also found to have increased psychopathology (Weiss, 1984, p. 211).

ADHD in children was first described clinically in 1902. The high frequency of "soft" neurologic findings led to designating the condition "minimal brain dysfunction" with the expectation that a consistent neurological lesion or set of lesions would eventually be found (Goldman, 1998, p. 1101). The first empirically based and officially recognized set of diagnostic criteria for ADHD was delineated in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. The current classification (DSM-IV, 1994) of the disorder allows subtyping as predominantly (a) hyperactive type, (b) impulsive type, or (c) combined type. These successive changes in diagnostic criteria reflect a combination of empirical research findings and expert committee consensus (Goldman, 1998).

Many studies have been conducted with children and adolescents regarding the severity of their ADHD symptoms (i.e., hyperactivity, impulsiveness, and inattention), yet little research has been done in the assessment and treatment of adults with the disorder. Spencer (1998) utilized a descriptive analysis, the DSM-IV (American Psychiatric Association, 1994) criteria list, and the Utah criteria (Wender, 1998) to document adults having ADHD. He found that ADHD symptomatology described a chronic course from childhood to adulthood. Spencer's study was

conducted from a chart review of 1700 adults with a history of ADHD over a 23-year period.

This study has both high reliability and validity due to the large sample size. The study defined the prominent symptoms of ADHD in both the child and adult.

Conners (1998) assessed the use of rating scales in diagnosing adult ADHD. He performed a comprehensive review of rating scales and addressed some of the critical issues in the use of these scales. Conners described the rationale for rating scales and found they (a) assist in drawing on previous experience of the adult over long time intervals and diverse situations and circumstances, (b) permit data to be gathered on rare and infrequent behaviors likely to be missed by in vivo assessments, (c) are inexpensive to collect and extremely efficient in the time needed to gather information, (d) incorporate the opinions of significant others, and (e) permit the quantification of qualitative ratings for behavior not readily gathered by other means (Conners, 1998, p. 24). Conners believed the disadvantage of rating scales was often rater error. There can be (a) leniency error which referred to the tendency to judge the behavior too leniently with respect to its true severity or frequency and (b) severity error in which the rater judges too harshly. There was also the halo error in which the rater gave an unfair positive or negative slant to all items based upon the judgment of one or more particular behaviors. These errors have the effect of generating a certain amount of suspicion and distrust of rating scales among clinicians. It has been thought to be a perversion of their use to rely upon them solely as diagnostic or treatment outcome measures. Despite their limitations, Conners noted that rating scales are generally reliable, valid, and treatment-sensitive (Conners, 1998, p. 26).

Researchers in the last 20 years have shown that ADHD is a disorder of adolescents and adults. The frequency of symptoms persisting into adulthood is uncertain (Harvard Medical Letter, 1995). Estimates of adult ADHD range from 1% of the population at age 18 and 0.3% at

age 25 to figures as high as 2% of all adults (Harvard Medical Letter, 1995, p.1). Adults with ADHD have been described as impatient, restless, moody, insecure, and easily bored. They have trouble setting priorities, managing their time, meeting appointments, and keeping track of their possessions. They may have brief, stormy love affairs, change jobs often, and fail to fulfill what they and others regard as their potential. The various symptoms of adult ADHD have been misdiagnosed as bipolar disorder, obsessive-compulsive disorder, posttraumatic stress reactions, and effects of drug abuse. People with borderline personality and atypical depression score particularly high on some of the behavioral rating scales used to diagnosis adult ADHD (Harvard Letter, 1995, p. 2). Another difficulty is that adult ADHD cannot exist without childhood ADHD, but documentation of childhood ADHD is often unavailable. Memories are imperfect, and people with ADHD are notoriously poor observers of their own symptoms. Most experts now agree that ADHD is a brain disorder with a biological basis. A genetic influence has been observed, especially in families with identical twins (Harvard Medical Letter, 1995, p. 4).

Conceptual Framework

Dunphy and Winland-Brown (1998) used the "Circle of Caring" to describe the essence of collaborative practice. After the linear steps of the nursing process (assessment, planning, intervention, and evaluation), nursing intervention circles back to include re-evaluation and a feedback loop. The circle of caring includes the perceptions and experiences of the patient, the physician, the nurse, and the family to collaborate on their diagnosis and health care. This model of care is unique because the clinical outcomes are evaluated based on the patient's and the family's perceptions of improvement in the patient and their understanding of the illness. Within this collaborative practice model of care, the patient is given the respect to be considered an expert on his/her own condition. The collaborative practice model, as suggested by Dunphy and

Winland-Brown (1998), would ensure both routine screening and sensitive, family support for the patients and their families. Collaboration would allow the patient to receive the benefits of treatment and care from both the perspective of medicine and nursing.

Methodology

Definition

For the purpose of the study, attention deficit/hyperactivity disorder (ADHD) was defined as a biological condition which is not caused by psychogenic factors but is influenced by family genetics (Benson, 1991). Symptoms of ADHD include: (a) attention difficulties, (b) hyperactivity and impaired coordination, (c) impulsivity, (d) disorganization, (e) altered response to social reinforcement, (f) altered interpersonal relations, (g) altered emotionality, (h) stress intolerance, and (i) response to medication or associated comorbid conditions. ADHD is said to be present if two or more symptoms are present, i.e. inattention, impulsiveness, disorganization, hyperactivity, etc. In modern terminology, this is a "polythetic" method of categorization. Classification of objects, shapes, or species can be non-reflective or monothetic definitions such as (a) man is a featherless biped or (b) an isosceles triangle is a triangle with two equal sides. However, medical practitioners unconsciously have employed polythetic definitions since the introduction and wide use of the American Psychiatric Association's DSM-III (American Psychiatric Association, 1980). A polythetic definition of a disease, or of anything else, might assert that it is present if any two symptoms are present. Thus, two patients may have the same disease and have no outward symptoms in common.

Sample and Setting/Demographics

The setting was a private psychiatric practice in northern California. The population of 100 was made up of male and female adults, over the age of 18, who had previously been diagnosed with ADHD. They were from northern California and were patients of the psychiatrist who assisted with the study. The sample consisted of the 15 questionnaires returned.

Demographic data were summarized using descriptive statistics. All participants were women, aged 35-57, with a mean age of 46.8. Medication had been prescribed for the patients; however, they chose to answer the questionnaire before medication was instituted.

Procedures

After Institutional Review Board (IRB) approval, all 100 participants received a cover letter explaining the purpose of the study, appropriate copies of the survey, and a return envelope. The surveys were anonymous, and the return of the surveys constituted informed consent to participate. The survey included brief demographic information and the Wender (1998) Utah Criteria Scale with questions about adult behaviors during the past 6 months (18 items) and recall of behaviors as a child (18 items). The Statistics Package for the Social Sciences (SPSS) was used for data analysis (Norusis, 1997). Descriptive statistics were presented as means and standard deviations.

Data Analyses

The Wender Utah Criteria Scale (Wender, 1998) for symptoms of ADHD in adults was the questionnaire used for this survey. Frequencies were assessed by calculating the mean and standard deviation of each item. The 18 individual behaviors on the Wender Utah criteria scale were analyzed using descriptive statistics (see Table 1). Participants were asked to respond (a)

never or rarely, (b) sometimes, (c) often, or (d) very often. Mean scores were calculated for each of the behaviors cited on the tool to indicate the frequency of a particular behavior. The 10 most prominent behaviors were determined from the statistical analysis.

Limitations

This study has several limitations. The total sample size was small, 15 females (age 35-57). The return rate for the questionnaire might have been improved with a longer time frame. This study was conducted from a convenience sample of patients from one psychiatrist's office in northern California. Different outcomes may occur from a larger sample obtained from many physicians across the country. There was no control group.

Discussion

The most frequently cited behaviors in the adult survey were: (a) poor sustained attention or persistence of effort to tasks, difficulty organizing tasks, (b) easily distracted, by noise, movement, etc., (c) excessive task-irrelevant activity or activity poorly regulated to the demands of a situation, fidgeting with hands or feet, (d) blurting out answers before questions have been completed, (e) diminished problem-solving ability, ingenuity, and flexibility in pursuing long-term goals, avoiding work that requires effort, (f) difficulty sustaining attention in tasks or fun activities, (g) delayed development of internal language (the mind's voice) and rule following, not listening when spoken to directly, (h) feeling on the go or driven by a motor, (i) feeling restless and, (j) failing to give close attention to details or makes mistakes in their work (See Table 2).

The symptoms that were most prominent in their childhood were: (a) a low opinion of self, (b) inability to concentrate, (c) impulsivity, (d) anxious, nervous and fidgeting, (e) excessively shy, (f) poor speller which continued into adulthood, (g) stubborn, refusing to do things I didn't want to, (h) disobedient, (i) inattentive, (j) irrational, not thinking of consequence

before doing things (see Table 3). In comparing the scores from both scales, it can be noted that the symptoms of childhood often follow into adulthood. They are often disguised or may appear in different forms, but the behaviors are essentially the same.

Conclusion

Childhood ADHD does continue into adulthood although it is often undiagnosed, and it may lead to devastating effects. As adults, those with ADHD are likely to be under-educated relative to their intellectual ability and family background. They are also likely to experience difficulties with work adjustments and may be under employed in their occupations relative to their intelligence and education and family background. They tend to change their jobs more often than others do, sometimes out of boredom or because of interpersonal problems in the work place. They also tend to have a greater turnover of friendships and dating relationships and seem more prone to marital discord or even divorce.

The primary care provider's roles in ADHD treatment are: (a) evaluator, (b) coordinator, and (c) monitoring clinician. During the initial diagnostic process, the nurse practitioner begins and continues as an important contact person for the patient and family (i.e., the educator role). The patient and family will need information about the types of testing to be done as well as the purpose and functions of the tests. Since it is natural for both family and patients to feel anxious and confused while waiting for results of the diagnosis, an important component of the nurse practitioner role is providing guidance and reassurance. With the help of the family nurse practitioner, these patients can develop an understanding of their illness and make appropriate accommodations for their disorder. It is important for family nurse practitioners (FNP) to appropriately assess the symptoms of ADHD in the adult and to guide these patients to the proper medications, treatments, and therapies as part of the circle of caring.

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Table 1

Summary of Adult Behaviors from the Wender Utah Criteria Scale (N=15)

Behavior	Mean	Standard Deviation
1. Lack of attention to details	1.53	.94
2. Fidgets	2.00	1.25
3. No attention span	1.87	.83
4. Leaves seat often	1.67	1.18
5. Does not listen when spoken to	1.80	.94
6. Restless	1.73	1.03
7. Does not follow through	1.40	.83
8. Difficulty engaging in leisure	1.33	1.18
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Table 2

The Ten Most Prominent Adult Symptoms of ADHD from the Wender Utah Criteria Scale(N=15)

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Table 3

The Ten Most Prominent Childhood Symptoms of ADHD from the Wender Utah Criteria Scale of Childhood Symptoms (N=15)

Behavior	Mean	Standard Deviation
1.Low opinion of self	2.73	2.69
2. Inability to concentrate	2.27	.96
3. Impulsivity	2.20	.94
4. Anxious, nervous, and fidgets	2.13	.92
5. Excessively shy	2.07	.96
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