ATTENTION DEFICIT AND HYPERACTIVITY DISORDER – A REVIEW OF COURSE AND IMPACT INTO ADULTHOOD

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Introduction: Attention Deficit and Hyperactivity Disorder (ADHD) is one of the more prevalent and studied neurodevelopmental disorders, coursing with dysfunction at three level of symptoms, hyperactivity, Impulsiveness and attention deficit. It has a heterogeneous and complex course that is based on Neurobiological theories. ADHD is a disease diagnosed usually in more precocious ages, like childhood, and with a follow up that goes beyond the reaching of adult age. Since adult age, there seems to be some difficulty in delineating the course and the impact of the disease.

Classification

The classic symptomatological triad of the syndrome is characterized by:

Attention Deficit

Hyperactivity

Impulsivity

Other types of anormalities

Executive Function Deficits

Emotional Dysregulation

Clinical presentation may vary according to the stage of development.

- Symptoms related to hyperactivity/ impulsivity are **more evident/frequently reported** than inattention symptoms in preschool children with ADHD.
- The symptoms of hyperactivity **decrease** in adolescence, remaining, in a more accentuated way, the symptoms of inattention and impulsivity.

Other changes more characteristic of adulthood

- Occupational difficulties
- Criminality
- Substance abuse
- Incidents in traffic

Epidemiology

The global prevalence of ADHD is estimated at approximately **5%**. In adulthood, between ages 18-44 years, is estimated to be **3.4 -4.4%**.

More frequent in boys than in girls of young age (3:1). In adults, prevalence is balanced in both sexes (1:1). Can vary depending on the sub-type:
Male - > Attention deficit type | **Female** - > hyperactive or combined type

Course

With the correct intervention, **most cases diagnosed, remit until adulthood**.

Still a good part remains until adulthood.

Predictive factors of persistence:
Severe initial symptomatology; Comorbidities (oppositional defiant disorder, social phobia); Mental illness in at least one of the parents.

Factors not related to persistence:
I.Q.; Socio-economic status; Parental-child relations; Parental education.

Persistence in adulthood is associated with:

- High levels of unemployment
- Workplace difficulties and reduced productivity
- Increased susceptibility to accidents
- Educational failure
- Increased crime and consumption of additive substances
- Etc.

Psychiatric comorbidity tends to increase with age.
Affective disorders, substance abuse and personality disorders (antisocial), overlap with the ADHD condition, **shifting the treatment focus** in adulthood.

It is estimated that **2/3** of cases diagnosed with ADHD in childhood **maintain dysfunction**, with or without disorder criteria.

Several obstacles are placed to the continuity of Monitoring/Treatment:

- ✓ Non-transition/articulation with adult psychiatry
- ✓ Not so obvious symptomatology with late “Onset”
- ✓ Stigma/lack of recognition
- ✓ Subdiagnosis in adulthood
- ✓ Lack of disclosure in the non-psychiatric clinical community
- ✓ Scarce resources (Psychotherapy/Occupational Intervention)

Impact

The route is guided by important changes in the various spheres of individual functioning

Most of them disguise cognitive and behavioral gaps:

- Adapt “to the circumstances of life” by choice
- Develop adaptive or compensatory skill

A large part of it maintains dysfunctionality, however, with difficulties in meeting deadlines, organizing tasks and with compromised social interaction.

The disfunctionality is associated with **decreased quality of life/satisfaction**.

- Single/divorced, fewer children, fleeting/unstable jobs

Massive economic impact for families and society.

Treatment of ADHD symptoms in substance abuse disorders.
Promotes better adherence to treatments and less relapses, but with the risk associated to the use of psychostimulants.

There seem to be benefit with treatment of ADHD in adults after stabilizing psychiatric conditions.

Conclusion: With the correct intervention, most of the cases remit, but a good part however remains beyond adult age. The persistence is associated with several risk factors, and psychiatric comorbidities in these cases tend to increase with the age. Estimates are that two thirds of the cases with a diagnosis of ADHD in the childhood maintain alterations of the disease, with or without criteria for the condition. Of those, most disguise the cognitive and behavioural gaps, but many maintaining the dysfunctionality of the disease, revealing itself a greater economic impact for families and society. It seems to exist benefit in the correct referral and follow up on the cases of ADHD when the condition remains in the adult age.

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