

Complex presentations of adult ADHD and its management challenges: A case series

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Abstract

Adult ADHD is increasingly recognized in clinical practice, especially in private healthcare, leading to more patient presentations. However, accurate diagnosis remains challenging due to overlapping symptoms with other mental health issues. Thorough assessments beyond self-reports are crucial to avoid both over- and underdiagnosis, which can impact patient safety and treatment outcomes.

A major challenge is the rising number of patients requesting stimulant medications, sometimes with fixed expectations. Clinicians must carefully weigh

the benefits against risks such as side effects, misuse, and dependence, balancing patient autonomy with ethical prescribing.

This case series from Australia and Sri Lanka highlights the complexities in diagnosing and managing adult ADHD, emphasizing diagnostic uncertainty, prescribing pressures, treatment risks, and the vital role of psychological support. It advocates for a multidisciplinary approach combining clinical judgment, structured assessments, and psychological input for responsible, effective care.

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Introduction

ADHD is a neurodevelopmental disorder that often persists into adulthood, affecting approximately 2-3% of adults, with a global prevalence of 3.1% (1,2). Despite its impact on academic, occupational, and social functioning, adult ADHD remains underdiagnosed and undertreated (2,3).

Diagnosis is complicated by comorbid conditions such as anxiety, depression, and substance use, which can mask or mimic ADHD symptoms (4). Challenges also include inadequate assessment tools, overlapping symptoms, and inconsistent application of DSM or ICD criteria (5). Many clinicians report low confidence in diagnosing adult ADHD (6).

The inattentive subtype (ADHD-I) is most common in adults, often causing impairments in organization, time management, and attention, while hyperactivity tends to diminish with age (2,6). Adults may also develop compensatory strategies that obscure symptoms (6). Although treatment combines medication and psychosocial interventions, access remains limited (4,6).

This case series illustrates the heterogeneity of adult ADHD, highlights diagnostic challenges, and underscores the need for comprehensive, individualized, and multidisciplinary care.

Case 1

A woman in her early 30s was referred by her GP for suspected Bipolar Affective Disorder (BPAD). She worked in a customer-facing role and reported difficulties with organisation, focus, and task completion.

Assessment revealed no symptoms of BPAD. She denied mood elevation, depression, grandiosity, reduced need for sleep, or psychosis. Mental state examination showed fidgeting, poor concentration, distractibility, and restlessness.

Collateral history from her mother and school reports confirmed longstanding attention, impulsivity, and hyperactivity issues since childhood. The DIVA-11 (7) assessment supported a diagnosis of ADHD, combined type. Family history included ADHD in a paternal uncle, niece, and nephew. She used cannabis and alcohol

occasionally and was a heavy daily smoker. UDS and other investigations, including ECG, were normal.

She had previously trialed a friend's Vyvanse (lisdexamfetamine) and found it helpful. After diagnosis, she was started on Vyvanse 20mg daily. It improved focus in the morning, but symptoms returned later. Twice-daily dosing improved this but led to appetite suppression and 5kg weight loss over two months, prompting discontinuation. Atomoxetine 18mg twice daily was started, leading to improved functioning without side effects. Appetite and weight normalised, and she remained adherent with sustained benefit.

Case 2

A 19-year-old female awaiting tertiary education was referred for psychological assessment after being diagnosed with depressive disorder by a physician. Although no medication was prescribed for depression, she was started on Ritalin (methylphenidate) due to her complaints of poor concentration. However, the ADHD diagnosis lacked a comprehensive evaluation – no standardized tools, collateral history, academic records, or medical investigations were used.

A thorough psychological assessment was initiated at first contact, including clinical interviews and behavioural observations, which did not support ADHD. Instead, findings indicated low self-esteem and difficulty adjusting to academic and social demands. Mindfulness-based therapy was initiated, focusing on self-esteem, emotional regulation, social skills, academic support, and family involvement. The patient showed significant improvement in emotional well-being and functioning. She and her family were advised to consult the physician to review the ADHD diagnosis and reconsider the need for medication.

Case 3

A middle-aged, single, unemployed male was referred by his GP for ADHD assessment, insisting from the outset on stimulant medication. He claimed a childhood history of ADHD and asserted that no other treatment would be effective.

During the MSE, attention, concentration, and behaviour appeared normal. While the DIVA assessment was reportedly positive for both childhood and adult symptoms, he refused consent for collateral history from family and claimed no school records were available. Safe Script review showed a history of seeking Pregabalin and codeine from multiple GPs, with multiple alerts. He denied illicit drug use but refused a urine drug screen and declined standard pre-treatment investigations.

Due to inconsistencies, lack of corroborative evidence, and limited cooperation, an ADHD diagnosis could not be confirmed, and stimulants were not prescribed. He was advised that reassessment could be considered if supporting documentation became available. He expressed dissatisfaction and declined further follow-up.

Case 4

A man in his 60s, retired and living independently, was referred by his GP for an ADHD assessment at his own request. He manages daily life well but has poorly controlled hypertension due to inconsistent medication use. He reported long-standing attention issues and was curious about ADHD after hearing a friend's positive experience with Ritalin. He has a remote history of drug and alcohol use, no past psychiatric history, and a family history of ADHD (nephew) and dementia (father). He hoped an ADHD diagnosis might help him access NDIS support.

Despite his openness, a full assessment, including the DIVA, did not support an ADHD diagnosis. There were no school records, no collateral history, and no clear functional impairment. His mental state exam was normal. Stimulants were ruled out due to his uncontrolled blood pressure and unclear benefit.

He was advised to consider psychological support for his attention concerns. Due to his age, family history, and cognitive complaints, a cognitive assessment was recommended. He agreed to this plan.

Discussion

The four clinical cases highlight key aspects in assessing and managing adult ADHD. They stress the value of detailed patient history, accurate diagnosis, awareness of treatment side effects, and the psychosocial context.

Case 1 shows the importance of monitoring medication side effects. Adverse effects can reduce adherence, especially if distressing. A thorough, multi-dimensional assessment – medical, psychiatric, and psychosocial – is vital for diagnosis and treatment planning (8).

Case 2 emphasizes interdisciplinary collaboration, especially with clinical psychologists. It warns against overdiagnosis, often due to over-reliance on checklists and limited assessments. A structured diagnostic process should include psychological testing, behavioral observations, and collateral information (8,9).

Case 3 highlights risks of stimulant misuse. Clinicians must balance patient-centred care with ethical prescribing, avoiding pressure from patients that may lead to inappropriate treatment (9,10).

Case 4 underscores the need for detailed history-taking to clarify diagnosis. It also stresses evaluating other psychiatric or medical conditions before starting medication (9,10).

Conclusions

Together, these cases illuminate the multifaceted challenges inherent in diagnosis and treatment of adult ADHD. They advocate for a holistic and evidence-based approach that incorporates interdisciplinary collaboration, careful monitoring of treatment effects, and a commitment to understanding the broader context of each patient's life. Adherence to such principles is crucial in improving diagnostic accuracy, enhancing treatment outcomes, and minimizing the risks of misdiagnosis, medication noncompliance, or misuse.

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