The experience of Psychologists and Psychiatrists providing services to adults living with Attention Deficit Hyperactivity Disorder

by

Rozanne Gowar

Submitted in partial fulfilment of the requirements for the degree of Master of Arts in Counselling Psychology in the Faculty of Health Sciences at the Nelson Mandela Metropolitan University

2017

Supervisor: Mr Vernon Sack
Declaration

I, Rozanne Gowar, s205041825, hereby declare that this treatise for the degree of Master of Arts in Counselling Psychology to be awarded is my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another University or for another qualification.

Rozanne Gowar
Abstract

There is widespread international interest in Attention Deficit Hyperactivity Disorder (ADHD). ADHD was considered to be a childhood onset neurodevelopmental disorder with few presenting symptoms in adulthood. Current research disputes this belief and there are a significant number of adults that meet the diagnostic criteria for ADHD in adulthood. This study explored the experience of selected Psychiatrists and Psychologists providing mental health services to adults living with ADHD. The awareness and presenting patterns of ADHD among adults as well as the intervention strategies used by these practitioners was explored. Furthermore, an exploration of the differential diagnoses associated with ADHD was undertaken, as well as whether the disorder was considered to be the primary or a co-morbid diagnosis in the treatment process. An explorative, descriptive- research design, utilizing a semi-structured interview format and a short survey of participants to provide descriptive statistics was used. Non-probability purposive snowballing sampling was used to gain access to psychiatrists and psychologists in both public or hospital service and independent private practice who met the inclusion criteria and who were willing to participate in the study. Interviews were conducted in English by the researcher. The major findings of the present study were categorized in three over-arching themes namely (1) views regarding the diagnosis of adults with ADHD, (2) experiences regarding the effects of impairment related to ADHD in adults, and (3) treatment and current care options for Adult ADHD. Sub-Themes were used to further explore the results. This study provides for a more in-depth understanding of Adult ADHD.

Keywords: Adult Attention Deficit Hyperactivity Disorder (ADHD); Psychologists; Psychiatrists; Awareness; Presenting Clinical Patterns; Differential Diagnosis; Intervention Strategies.
Acknowledgements

I hereby wish to express my gratitude to the following people who made this treatise possible.

Mr Vernon Sack, without your encouragement, thoroughness and guidance over the last two years this treatise would not have been possible. I appreciate that you accommodated me when I needed help with editing and had patience with my inexperience.

My husband, Gert van Wyk, for encouraging me when I felt demotivated and being patient with me throughout this process.

My parents who have supported me unconditionally. Your encouragement and love is dearly valued.

Dr. Maggie Williams, who helped with the analysis of my data.

My participants, who were willing to share your knowledge and experience. Without you this research would not have been possible.

My heavenly Father, who I believe put me on this path and enabled me to come this far.
Contents

Declaration .........................................................................................................................2
Abstract .............................................................................................................................3
Acknowledgements ........................................................................................................4
List of Tables ......................................................................................................................7
List of Figures ....................................................................................................................8

Chapter 1: Introduction and Motivation for the Study .........................................................9
  Introduction .....................................................................................................................9
  Defining Attention Deficit Hyperactivity Disorder .........................................................9
  Concomitant Psychiatric Disorders ..............................................................................10
  Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder in Adults .........10
  Motivation for the Study ..............................................................................................11
  Conclusion ....................................................................................................................12

Chapter 2: Literature Review ...........................................................................................13
  Introduction ....................................................................................................................13
  Attention Deficit Hyperactivity Disorder in Adults .......................................................13
    Evolution of the Diagnostic Criteria of ADHD ..........................................................16
    Primary and Differential Diagnosis ..........................................................................19
  Psychology and Psychiatry in South Africa ..................................................................21
  Intervention Strategies ...............................................................................................24
  Mixed Method Research ..............................................................................................28
  Conclusion ....................................................................................................................29

Chapter 3: Research Design and Methodology ..................................................................31
  Introduction ....................................................................................................................31
Aims of Study ........................................................................................................31
Research Design ....................................................................................................33
Participants and Sample .......................................................................................34
Data Collection ......................................................................................................35
Research Procedure ..............................................................................................36
Data Analysis ..........................................................................................................37
Thematic Analysis ..................................................................................................37
Trustworthiness ......................................................................................................38
Ethical Considerations ...........................................................................................38
Informed Consent ..................................................................................................39
Privacy and Confidentiality .....................................................................................39
Maintenance, Dissemination of Results and Keeping of records .........................40
Conclusion .............................................................................................................40

Chapter 4: Results ..................................................................................................41
Introduction ............................................................................................................41
Results from Data Analysis ....................................................................................41
Sub-Theme 1: Adult ADHD is chronically misunderstood and under-diagnosed .....43
Sub-Theme 2: Difficulties experienced with diagnosing adults with ADHD ........45
Sub-Theme 3: ADHD-related impairments chaotic impact on patients’ functional
areas of their lives .....................................................................................................49
Sub-Theme 4: Patients struggle with inattention and time management due to
ADHD .......................................................................................................................52
Sub-Theme 5: The diagnosis of ADHD in adults would be of a primary nature ......53
Sub-Theme 6: Psychotherapy and medication concurrently is the best treatment
option………………………………………………………………………………54

Sub-Theme 7: Education of patients and the public is vital …………………56

Sub-Theme 8: Destigmatisation of ADHD is an essential factor in treatment……58

Sub-Theme 9: Support groups would assist adults with ADHD ………………59

Sub-Theme 10: Financial aspects of diagnosis and treatment ………………...60

Conclusion ………………………………………………………………………..60

Chapter 5: Conclusions, Limitations and Recommendations ……………………61

Introduction ………………………………………………………………………61

Conclusions from this Study …………………………………………………61

Conclusions in relation to the objectives guiding the study …………………61

The awareness, perceptions and understanding of psychologists and psychiatrists
with regards to Adult ADHD …………………………………………………62

Practice patterns of psychologists and psychiatrists with regards to the diagnosis
and treatment of adults living with ADHD …………………………………63

Presenting clinical symptom patterns of adults living with ADHD …………64

The impact of ADHD on adults living with the disorder …………………….65

Limitations of the Study ………………………………………………………..66

Value of the Study ………………………………………………………………67

Recommendations of the Study ……………………………………………..68

References ………………………………………………………………………70

Appendix A: Information Letter to Participants ………………………………79

Appendix B: Consent Form ……………………………………………………..80

Appendix C: ADHD: Diagnostic Criteria …………………………………….82
Appendix D: Survey Questionnaire .................................................................85
Appendix E: Interview Questions .................................................................87
List of Tables

Table 1 Biographical Information of Participants 35

Table 2 Summary of Themes 42
List of Figures

Figure 1 Data Collection Procedure applied in this study 33

Figure 2 Selection by participants of Functional Areas affected by ADHD 49

Figure 3 Level of Insight into Patients ADHD diagnosis 57
Chapter 1: Introduction and Motivation for the Study

Introduction

This chapter will define Attention Deficit Hyperactivity Disorder (ADHD), specifically Adult ADHD as well as any concomitant psychiatric disorders. The challenges facing clinicians with diagnosis and treatment of Adult ADHD will be introduced. Motivation for the relevance of the study will also be discussed.

Defining Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) is defined by the American Psychiatric Association (APA) in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition as constituting “persistent hyperactive, impulsive and inattentive symptoms and behaviours that affect the functioning or development of the individual” (American Psychiatric Association; 2013 p. 59).

The body of evidence about ADHD as a neuro-developmental disorder with demonstrable deficiencies in the brain circuits and brain structure is well known. ADHD presents with a persistent pattern of excessive hyperactivity- impulsivity and/or inattentive symptoms that interfere with functioning or development. This pattern has to be persistent for at least 6 months, be observed in more than one setting, and occur before the age of 12 years. The diagnostic and Statistical Manual of Mental Disorders (DSM 5) specifies nine symptoms of inattention and nine hyperactive-impulsive symptoms. Associated features include low frustration tolerance, irritability and mood dysregulation. Inattentive symptoms are listed as wandering off tasks, lacking persistence, having difficulty sustaining focus, being disorganised; not occurring due to defiance or lack of comprehension.
Hyperactivity symptoms are listed as excessive motor activity, excessive fidgeting, tapping, or talkativeness. Lastly, Impulsivity refers to hasty actions that occur in a moment without forethought which may manifest as social intrusiveness and may result in harm to the individual or compromised relationships with family and in other social settings (American Psychiatric Association, 2013).

**Concomitant Psychiatric Disorders**

According to a prominent survey conducted by the World Health Organisation in 2007, the average worldwide prevalence of adult ADHD is estimated at 3.5% (de Graaf, Kessler, Fayyad, ten Have, Alonso, Angermeyer, Borges, Demyttenaere, Gasquet, de Girolamo, Haro, Jin, Karam, Ormel & Posada-Villa, 2008). The overall risk of any concomitant psychiatric disorder is increased by 80% in adults diagnosed with ADHD. The comorbidity rate of ADHD and internalising disorders (Anxiety and Depression) is high. The prevalence of co-morbid anxiety spectrum disorders in ADHD has been found to be between 13 and 60% (Sykes, 2016). The spectrum of Anxiety disorders include: Generalised Anxiety Disorder (GAD), Social Phobia, Specific Phobia, Panic Disorder, Social Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD) and Hoarding.

**Diagnosis and treatment of ADHD in Adults**

According to Westmore (2016) making the diagnosis of ADHD in adults after referral remains challenging. However, patients in South Africa, may still experience resistance from psychiatrists and other healthcare workers who are of the opinion that this disorder only occurs in children and adolescents. The high rate of comorbidities associated with adult ADHD complicates diagnosis at times, and could delay effective treatment.
Psychostimulants are one of the recommended treatments for ADHD. Enhancement of dopaminergic and noradrenergic neurotransmission in the prefrontal cortex (PFC) is critical to the therapeutic efficacy of drugs used to treat ADHD. Stimulants, which produce very large and profound increases in the extracellular concentrations of dopamine and nonadrenaline in the PFC and dopamine in the striatum are the most effective medications that are available to physicians to treat ADHD. Psychostimulants are first-choice pharmacological treatment both in adults and children (Westmore, 2016). Psychological techniques can be used to improve acceptance of a diagnosis, and treat comorbidities and residual symptoms that do not require pharmacological treatment. (Westmore, 2016)

Motivation for the study

There is a wealth of knowledge with regards to children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and prior thinking was that children diagnosed with this disorder would outgrow the disorder, its symptoms and deficits. However, studies have shown that ADHD continues to affect between 30 to 50 percent of adults who were diagnosed with the disorder during childhood (Searight, Burke, & Rottnek 2000). Accurate diagnosis in adults can be challenging as there are no standardised South African screening measures that are frequently used by practitioners. Another challenge is the presence of an overlap between the clinical signs and symptoms of Adult Attention Deficit Hyperactivity Disorder and those of other common psychiatric conditions such as Major Depression, Generalized Anxiety Disorder and Substance Abuse.
This study aims to explore the following objectives: (1) There is currently limited research available in South Africa regarding the experience of Psychologists and Psychiatrists working with adults diagnosed with ADHD. It is for this reason that the current study aims to explore the experience of Psychologists and Psychiatrists practising in the field of ADHD. (2) The study will explore the awareness of the condition and the intervention strategies used by practitioners. (3) The presenting patterns of the disorder, as well as the differential diagnosis associated with ADHD will be explored. (4) Whether the disorder is considered as the primary diagnosis or as a co-morbid diagnosis will be explored.

By identifying and understanding these practitioner’s experiences, the research may highlight potential opportunities to improve the diagnostic process and treatment of ADHD. The research will be conducted with the aim of providing information that can contribute to adults living with ADHD having better access to relevant psychological mental health services.

**Conclusion**

The above chapter defines Adult ADHD and its concomitant psychiatric disorders. It furthermore gives a brief overview of the diagnosis and treatment of ADHD in adulthood. Motivation for this study was also discussed. Chapter two aims to provide a theoretical background to Adult ADHD. Literature regarding the evolution of the diagnostic criteria of ADHD as well as primary and differential diagnosis was reviewed. Furthermore the training and registration of Psychologists and Psychiatrists in South Africa will be dealt with briefly within the context of this study. Intervention strategies and the extrapolation of a mixed methodology research method will also be discussed.
Chapter 2: Literature Review

Introduction

The previous chapter introduced the definition of Adult Attention Deficit Hyperactivity Disorder and its co-morbid psychiatric conditions. The challenges of diagnosis and treatment were also briefly explored, as well as the rationale for the study. In chapter two relevant literature will be reviewed with regard to ADHD and the evolution of diagnostic criteria of ADHD. Primary and differential diagnoses will be discussed as well as regulations pertaining to Psychology and Psychiatry in South Africa. Literature regarding intervention strategies will be highlighted and lastly an explanation of the rationale for the selection of a Mixed Methodology Research design.

Attention Deficit Hyperactivity Disorder in Adults

Attention Deficit Hyperactivity Disorder (ADHD) is defined by the American Psychiatric Association (APA) in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition as constituting “persistent hyperactive, impulsive and inattentive symptoms and behaviours that affect the functioning or development of the individual” (APA; 2013 p. 59). According to Gentile, Atiq and Gillig (2006) the presentation of ADHD in adulthood includes difficulty getting started on tasks, variable attention to details, difficulties with self-organization and with prioritization, and poor persistence in tasks that require sustained mental effort. Adults who present in primary care settings often have chaotic life-styles, associated psychiatric comorbidities, may appear to be disorganized, and may rely on drugs and alcohol to cope with daily responsibilities and stressors. Impairments in functioning are global, not selective in adults diagnosed with ADHD. The impact of ADHD is generally noticeable in all spheres of life, to a greater or lesser degree. Untreated or under-treated adult ADHD may
result in impaired occupational functioning and interpersonal and legal difficulties. ADHD in adults is associated with higher separation and divorce rates and more frequent job changes (Gentile et al., 2006). Likewise Moffit et al. (2015) reported markedly elevated impairment as a result of ADHD associated problems. According to the above mentioned research, adults living with ADHD reported to feel less satisfied with their lives and reported problems stemming from being disorganized, underachieving, exhausting or draining others and being involved in car accidents resulting from risky driving.

Although once believed to be a disorder experienced only during childhood and adolescence, it is now widely recognised that it often continues into adulthood. According to Faraone, Biederman and Mick (2006), approximately 15% of individuals diagnosed in childhood with ADHD will continue to meet the full diagnostic criteria at age 25 years, with a further 50% meeting criteria for ‘ADHD in partial remission’, and as such have impairment sufficient enough to require intervention. While ADHD often persists into adulthood, it can alter in terms of presentation. Hyperactivity becomes less overt, with inattention becoming the greater difficulty specifically when completing executive tasks (Asherson, Akehurst & Kooij; 2012). However, the latest research according to Moffitt et al. (2015), determined that the childhood ADHD and adult ADHD groups comprised virtually no overlapping sets with 90% of the Adult ADHD cases lacking a history of childhood ADHD. The same study found that the Adult ADHD group did not show tested neuropsychological deficits during childhood or adulthood, nor did they show a polygenic risk for childhood ADHD. This implies that recent longitudinal research has demonstrated that not all adult ADHD individuals have child onset symptoms.
Baron (2007) is of the opinion that the recent clinical understanding that ADHD may persist into adulthood has resulted in an increase in referrals of adults without a childhood diagnosis. This poses challenges of diagnosis as it is difficult to retrospectively obtain accurate information on childhood behaviour, and because the diagnostic criteria gives limited consideration to the heterogeneity of the disorder and its developmental course. Compared with childhood ADHD there is still limited empirical knowledge about the clinical features and neurocognitive function of adults living with ADHD. According to Barkley (2008) adults with persisting symptoms of ADHD tend to report difficulties related to executive function, including controlled attention, more often than behavioural hyperactivity and impulsivity. Furthermore, according to Barkley (2012), a well-known clinical observation is that persons with ADHD can engage sustained attentional effort when highly motivated for a task or activity. Inattention is not an invariant feature of ADHD, but changes with motivational factors and environmental requirements for cognitive control. Leading an independent and productive adult life requires rapid and flexible adaptation of behaviour according to changing external circumstances. This is typically denoted as an executive function and it demands a high degree of attentional and behavioural control which seems to be compromised in adult ADHD (Barkley, 2012).

In a study by Karam et al. (2015) which researched the persistence and remission of ADHD during adulthood, approximately one third of the sample did not meet the criteria for a full DSM-IV diagnosis at follow up, regardless if in early, middle or older adulthood. This was despite the stage of maturation in adults which would suggest stability of ADHD symptoms. It can therefore be extrapolated that although full remission is less common than in childhood, it should be considered as a possible outcome among adults.
When considering the structure and diagnosis of adult ADHD, research done by Kessler et al. (2010) has shown that adult persistence is greater for inattention than for hyperactivity/impulsivity. Furthermore, adult symptoms include executive functioning, inattention/hyperactivity and impulsivity. However, many studies have shown that impulsivity and hyperactivity symptoms decline with age, whereas deficits in attention persist and become more varied in adult cases.

**Evolution of the Diagnostic Criteria of Attention Deficit Hyperactivity Disorder.**

The clinical characterizations and underlying concepts of attentional dysfunctions have changed and evolved over the time. According to Klaus, Lange, Reich, Katharina, Lange and Tucha (2010), the first example of a disorder that appears to be similar to ADHD was given by Sir Alexander Crichton in 1798. In 1798, he published “On Attention and its Diseases” which is of special relevance to ADHD. In this short description of the first alteration of attention, Crichton gives several indications that he was depicting the same disorder as is defined in the Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR (APA 2000) criteria of ADHD. Crichton states that the disorder “generally diminished with age” (Crichton, 1798, reprint p. 203). The notion that ADHD is a disorder of childhood and that affected children “grow out” of ADHD during puberty was common until the 1990s (Barkley, 2006 (a) ; Okie, 2006).

In 1844, the German physician Heinrich Hoffmann created some illustrated children’s stories including “Fidgety Phil” (“Zappelphilipp”), who is nowadays a popular allegory for
children with ADHD. Hoffmann describes symptoms of inattention and hyperactivity with his character, Philipp (Klaus et al., 2010).

According to Holland and Higuera (2015), ADHD was first mentioned in 1902 by British paediatrician Sir George Still who described ADHD as “an abnormal defect of moral control in children.” Furthermore his works comprise of cases considered as historical descriptions of ADHD, i.e. children with a defect of moral control but without a “general impairment of intellect” (Still 1902, p. 1077).

In 1932, the German physicians Franz Kramer and Hans Pollnow reported “On a hyperkinetic disease of infancy”. The most characteristic symptom of affected children was a marked motor restlessness (Kramer & Pollnow 1932, p. 1). The main symptoms of the “hyperkinetic disease” as described by these physicians meet all three main symptoms of ADHD as well as two additional DSM-IV-TR (APA, 2000) criteria that are accepted today. The American Psychiatric Association (APA) issued the first “Diagnostic and Statistical Manual of Mental Disorders” (DSM) in 1952 and this did not recognize ADHD. A second DSM was published in 1968. This edition included Hyperkinetic Reaction of Childhood/Impulse disorder for the first time (APA, 1968). “Hyperkinetic Reaction of Childhood” was labelled and defined with two sentences: “The disorder is characterized by overactivity, restlessness, distractibility, and short attention span, especially in young children; the behaviour usually diminishes by adolescence” (APA 1968, p. 50)

The APA released a third edition of the DSM (DSM-III) in 1980. They changed the name of the disorder from Hyperkinetic Impulse Disorder to Attention Deficit Disorder (ADD). DSM-III took the position that hyperactivity was no longer an essential diagnostic criterion for the
disorder and that the syndrome occurred in two types i.e. “with or without hyperactivity. Deficit’s in attention and impulse control were, however, considered significant symptoms in establishing a diagnosis (Barkley (b), 2006). In this respect, the DSM-III departed from the “International Classification of Diseases (ICD-9)” issued by the World Health Organization, which continued to focus on hyperactivity as indicator of the disorder (ICD-9, 1979). The DSM-III developed three separate symptom lists for inattention, impulsivity, and hyperactivity, which were far more specific than previous ones. In addition, the DSM-III introduced “an explicit numerical cut-off score for symptoms, specific guidelines for age of onset and duration of symptoms, and the requirement of exclusion of other childhood psychiatric conditions” (APA, 1980 in Barkley 2006, pp. 19).

The APA released a revised version of the DSM-III-R in 1987. They removed the hyperactivity distinction and changed the name to Attention Deficit Hyperactivity Disorder (ADHD). The APA combined the three symptoms (inattentiveness, impulsivity, and hyperactivity) into a single type and did not identify subtypes of the disorder (APA, 1987).

The APA then released the fourth edition of the DSM in 2000. The fourth edition established the three subtypes which are used by healthcare professionals today: namely Combined type ADHD, Predominantly inattentive type ADHD and Predominantly hyperactive-impulsive type ADHD (APA, 2000).

In order to bridge the span between DSM-IV and DSM-V, a text revision of the fourth edition of the DSM was undertaken in 2000 (APA 2000). The main goals were to “maintain
The American Psychiatric Association (APA) in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (APA, 2013) importantly acknowledges the disorder in adulthood as well as in childhood. Adults can be diagnosed with five symptoms instead of the six required for children for each symptom cluster. It remains important that the symptoms of ADHD must have been present before the age of 12 years (previously 7 years). The symptoms must cause significant impairment (See Appendix C).

**Primary and Differential Diagnosis.**

Young adults diagnosed with ADHD are at higher risk of a range of additional psychiatric and developmental disorders, along with increased criminal convictions, and workplace and relationship problems (Taylor, Chadwick, Heptinstall & Danckaerts, 1996).

In adulthood, ADHD rarely presents without additional co-morbid illness, and this adds to the complexity of diagnosis and treatment. Due to the similarity of presenting symptoms of ADHD to many other psychiatric conditions and their high prevalence among patients with mood, anxiety, substance use, and impulse-control disorders, both psychiatrists and general practitioners may find it challenging to identify the various diagnoses (Bushe, Televantou, Belger & Watson, 2015). Mao and Findling (2015) reiterate that diagnosis and management of ADHD in adults is complex and challenging because of the frequent comorbidity of other psychiatric disorders that have symptoms overlapping with those of ADHD. For example, the ADHD in patients with Substance Use Disorder (SUD) is high. Approximately one-fifth of
patients at SUD treatment centres may also require drug therapy for ADHD, the primary treatment for adult ADHD.

Given that the symptoms of both disorders tend to overlap each other, correctly diagnosing ADHD in such cases is extremely challenging (de los Cobos, Siñol, Pérez & Trujols 2012). Likewise, Moffet et al. (2015) found that adult ADHD had a prevalence of 3% (gender balanced) and was associated with adult substance dependence, adult life impairment and treatment contact.

The overall risk of any concomitant psychiatric disorder is increased by 80% in adults diagnosed with ADHD. The comorbidity rate of ADHD and internalising disorders (anxiety and depression) is high. The prevalence of co-morbid Anxiety spectrum disorders in ADHD has been found to be between 13 and 60%. The symptoms of both ADHD and Anxiety disorder tend to fluctuate throughout one’s lifespan. The combined effect of ADHD together with an Anxiety disorder has a strong impact on the severity of the symptoms experienced by the affected individual. There are several common overlapping symptoms of Generalized Anxiety disorder (GAD) and ADHD. This can make the accurate diagnosis of cases of ADHD with co-morbid GAD difficult (Sykes, 2016).

Women often develop Obsessive – compulsive personality disorder in order to cope as a result of their symptoms of ADHD. They make lists and check things repeatedly in an attempt to minimise the impact of their distractible nature and this can contribute to anxiety (Du Plesis, 2016).

According to Gentile, Atiq and Gillig (2006), the most common psychiatric conditions that may have overlapping symptoms with adult ADHD include Mood disorders, Anxiety
disorders, Substance use disorders, Antisocial personality disorder, Borderline personality disorder, Developmental disabilities or Mental retardation, and certain medical conditions.

Individuals with Major depressive disorder may show signs of inattention and become easily upset. Patients with Anxiety disorders may also show hyperactive behaviour, such as fidgeting and inattentive behaviours. Although there also are similarities in symptoms of Borderline personality disorder and ADHD, which include impulsivity, affective lability, and angry outbursts, the impulsivity and anger in ADHD is usually thoughtless and brief. (Gentile, Atiq & Gillig, 2006)

Biederman, Mick, Spencer, Wilens, Norman and Lapey (1993) is of the opinion that an adult with Developmental disabilities or Mental retardation may present with some of the symptoms seen in ADHD patients, but rarely will have presented for initial consultation during adulthood, and psychological testing will reveal significant neurocognitive deficits.

Lastly, adult ADHD often presents with psychiatric comorbidities, including Affective disorders, Anxiety disorders, Substance abuse disorders, Learning disabilities, and Borderline and Antisocial personality disorders (Morrison, 1980).

**Psychology and Psychiatry in South Africa**

According to the Health Professions Act 56 of 1974, only registered psychologists are permitted to perform psychological services which are defined as acts of psychological assessment, diagnosis and intervention rendered to a client. A psychologist in private practice has to be registered with the Health Professions Council of South Africa (HPCSA) which stipulates their scope of practise and professional intervention. The minimum requirements for
registration as a psychologist are five years of full-time formal education in psychology, i.e. a three year Bachelor's degree majoring in psychology or equivalent thereof, a post-graduate year in psychology (Honours degree), and a directed coursework Master's degree programme in psychology. Furthermore, a full-time approved internship of 12 months duration and the successful completion of the National Examination of the Professional Board for Psychology is required. There are various registration categories for psychologists (Sabinet, 1974).

For the purpose of this study, only registered Clinical or Counselling psychologists were interviewed. With regard to diagnosing and treating adult ADHD, the following acts fall within the scope of practice of Clinical psychologists according to the HPCSA. Clinical psychologists are able to assess, diagnose and intervene with patients dealing with life challenges, particularly those with developmental difficulties and forms of psychological distress and/or psychopathology. Furthermore they are trained in identifying and diagnosing psychopathology in psychiatric disorders, and psychological conditions namely ADHD. Lastly clinical psychologists apply evidenced-based psychological interventions to people with psychological, and psychiatric conditions and refer patients to appropriate professionals for further assessment or intervention (Sabinet, 1974).

Similarly, in addition to the scope of the profession as prescribed in the regulations, the following acts fall within the scope of practice of Counselling psychologists according to the HPCSA: Assessing, diagnosing, and intervening in patients dealing with life challenges, and developmental problems to optimise psychological wellbeing. Assessing cognitive, personality, emotional and neuropsychological functions in relation to life challenges and developmental problems falls within their scope of practice. ADHD would be categorized within this scope.
Counselling psychologists are also trained to assess developmental processes (e.g. career choice), adjustment and identifying psychopathology, and its impact on developmental processes, and adjustment. Identifying, and diagnosing disorders of adjustment and applying psychological interventions to patients with developmental challenges, and adjustment problems falls in their scope of practice. Lastly Counselling psychologists are able to perform therapeutic counselling interventions and refer patients to appropriate professionals for further assessment or intervention. Both registrations of psychologists are unable to prescribe medication.

A psychiatrist is a medical doctor, who has specialized in the field of psychiatry. To be able to practice, a psychiatrist must be registered with the Health Professions Council of South Africa (HPCSA), as a psychiatrist, under the specialist register. Psychiatrists can examine, diagnose and treat patients with medical illness related to mental problems. Psychiatrists have a medical training and as a result, they can examine, diagnose and treat patients with medical illness related to mental problems. Psychiatrists are also trained in psychotherapy and therefore are able to treat patients through psychotherapeutic interventions. Psychiatrists can prescribe medication and psychotherapy to treat mental illness. A Psychiatrist must first complete a medical degree. This is usually indicated as a MBCHB or MBChB degree. This qualification takes six years to complete. A year internship follows and South African doctors are then conscripted to do a year of Community service. Subsequent a specialization may be undertaken. Psychiatry is one of the fields of specialization and this involves a further four years. This qualification is usually indicated as a MMed Psych or a FF Psych or FC Psych.

Independent practice is a practice where a registered health professional practises without the supervision of another health practitioner. It is however of great importance that both
psychologists and psychiatrists engage in multidisciplinary collaboration in their treatment of patients with ADHD. For the purpose of this research, psychologists and psychiatrists in both private independent practice and/or public service were contacted as these specific mental health practitioners have high rates of contact with an adult ADHD population and are qualified to diagnose and treat Adult ADHD.

**Intervention strategies**

Until recently, ADHD has been neglected as a treatable condition in the adult population. The *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR) did not specifically provide any diagnostic guidance for adult ADHD, with definitions essentially only relating to diagnosis in childhood (APA, 2000). In 2013, the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) acknowledged specific facets of adult ADHD, which may differ from childhood diagnoses (APA, 2013).

It is important to note that in primary care there is relatively low use of ADHD medication, low referrals into secondary care, high rates of usage of psychiatric non-ADHD medications for different indications, and an increasing burden in terms of health care contacts in adult ADHD patients post-diagnosis (Bushe et al., 2015).

According to Moffit et al. (2015), ample evidence was found that ADHD adults are in need of treatment, treatment contact and psychological intervention. Adults living with ADHD reported that their lives tend to be marred by dissatisfaction, everyday cognitive problems and inadequate coping behaviours. They furthermore reported being disorganised and failing to fulfil their potential.
Westmore (2016) is of the opinion that making the diagnosis of ADHD in adults after referral remains challenging. Individuals with ADHD have lived with the symptoms for most of their lives and may or may not have insight into these symptoms. Patients in South Africa may still experience resistance from psychiatrists and other healthcare workers who are of the opinion that ADHD only occurs in children and adolescents. Some practitioners also believe that patients who have achieved success in some area of their lives cannot be suffering from ADHD and resist treating them. The high rate of comorbidities associated with adult ADHD complicates diagnosis and could delay effective treatment. In South Africa where resources and skills are limited, it is important that a greater awareness of ADHD in adults is established and that access to care is improved. Developing and publishing guidelines specific to the South African context and population will almost certainly have to draw on those established by The National Institute for Health and Care Excellence. Young, Murphy and Coghill (2011), is of the opinion that alongside basic training on assessment and treatment, professionals also need to keep abreast with developments in this area. According to Healey and Carlow (2015), clinicians without specialized training are often reliant upon behaviour rating scales and self-report measures completed by individual patients as there are no standardized psychological or medical tests to independently assess for or verify the diagnosis of ADHD in adults. Training can be sourced from clinicians working within established adult ADHD services, or through training from local clinicians.

While in some cases the lack of adult services for people with ADHD will have been a resource issue, this situation is exacerbated by the fact that there is little, if any, formal training for health professionals working with adults in the assessment and treatment of ADHD (Young et al., 2011). This implies that health professionals may lack the clinical skills needed to work
with this patient group, or to continue to prescribe medication that they have previously had little experience with, or training in. There are debates about whether stand-alone specialist adult ADHD services or provision for adults with ADHD within community mental health teams represent the way forward. (Ryan, 2013).

According to Truter (2014), methylphenidate remains the mainstay in the pharmacological treatment of ADHD in South Africa, with atomoxetine prescribed more often to older patients. Further studies, however, should be conducted on adult patients with ADHD to determine whether these medications are as effective in adults as in children. Furthermore, comprehensive cost studies, especially on adult ADHD, which also account for quality-of-life and productivity aspects are needed.

Sykes (2016) advises that when anxiety disorders present concurrent with ADHD, stimulant medications should be the starting point of treatment. Anxiety symptoms are not exacerbated by stimulant medication and the treatment of the anxiety disorder can be initiated as soon as the patient’s ADHD symptoms improve. The most effective treatment of co-morbid anxiety in ADHD is the combination of medication in the form of Selective Serotonin Reuptake Inhibitors (SSRI’s) and Cognitive-Behavioural therapy.

Furthermore by using family and marital counselling and involving the spouse/partner and close family of the patient with ADHD and anxiety, in his/her treatment the relationship between all participating parties is improved and strengthened. Weiss and Weiss (2004) is of the opinion that it is difficult to develop clinical skills in the management of residual adult manifestations of developmental disorders without clinical experience with their presentation in childhood. According to Westmore (2016) psychological techniques can be used to improve acceptance of
a diagnosis and to treat comorbidities and residual symptoms that do not require pharmacological treatment. The NICE guidelines recommend group or individual interventions that employ a cognitive behavioural paradigm and social skills training in adults with ADHD (NICE, 2013). According to Wilens et al. (1999) cognitive therapy was associated with significant improvement in ADHD, anxiety and depressive symptoms as well as overall global functioning. The same study showed that cognitive therapy in conjunction with medications appear to be useful for adults with ADHD. Likewise Solanto et al. (2010) are of the opinion that in dichotomous indices of therapeutic response, a significantly greater proportion of members of their study demonstrated improvement when undergoing mega- cognitive therapy (cognitive behavioural principles) which supports the efficacy of meta-cognitive therapy as a viable psychosocial intervention for adults with ADHD. According to Rostain and Ramsay (2006), combined treatment of pharmacotherapy and psychotherapy in the form of cognitive behavioural therapy is associated with significant improvements on all clinical measures. Du Plessis (2016) is of the opinion that ADHD affects multiple aspects of functioning and effective treatment may involve a multimodal approach that includes medication, psychotherapy, stress management as well as ADHD professional organising. Mindfulness is a programme that helps adults with ADHD to engage their attention and to refocus. Mindfulness may play a part in the future because it is inexpensive and could be mastered by the majority of patients. Preliminary research appears to show that Mindfulness can make an important difference in the lives of adult ADHD patients (Nel, 2016). It needs to be borne in mind that adult ADHD is often co-morbid with other disorders such as anxiety and mood disorders. The effective treatment of all conditions will enhance the prognosis of the patient in the long term and should always form part of the treatment plan.
Mixed Methodology Research

With the increased popularity of qualitative research, researchers in counselling psychology are expanding their methodologies to include mixed methods designs. These designs involve the collection, analysis, and integration of quantitative and qualitative data in a single or multiphase study (Hanson, Creswell, Clark, Petska, & Creswell, 2005).

Mixed methodology has become increasingly popular and may be considered a legitimate, stand-alone research design. It may be defined as “the collection or analysis of both qualitative and quantitative data in a single study in which the data is collected concurrently or sequentially. Mixed methodology research also includes priority of the data being established and the integration of the data at one or more stages in the process of research” (Creswell, Plano Clark, Gutman, & Hanson, 2003, p. 212).

Using both forms of data, for example, allows researchers to simultaneously generalise results from a sample to a population and to gain a deeper understanding of the phenomenon of interest. Ponterotto, Matthew and Raughley (2013) are also of the opinion that mixed methods investigations may be used to convey the needs of individuals or groups of individuals who are marginalized or underrepresented and that the incorporation of mixed methods design in psychology research is not new. For example, the renowned research methodologists Campbell and Stanley (1966) promoted the use of mixed methods designs for topical exploration some five decades ago. Patton (1981) highlighted the value of mixed methods research in all forms of program evaluation, while Denzin (1978) advocated multiple methodologies to enhance the overall validity and credibility of research findings and interpretation. Carefully designed mixed methods studies therefore offer a valuable investigative tool to researchers studying a wide
variety of psychological topics across and within cultures (Bartholomew & Brown, 2012). The flexibility inherent in mixed methods studies can result in a more holistic and accurate understanding of the phenomena under study. Mixed methods research can also advance the counselling and psychology profession’s growing commitment to social justice research in that the use of carefully sequenced diverse methods can provide researchers with multiple windows into the lives of the less empowered and historically silenced within our society. Through these windows will emerge opportunities for social transformation and participant community empowerment. Furthermore, mixed methods research resonates with applied psychologists, particularly counselling researchers, because “combining quantitative and qualitative information also mirrors the process counsellors use in practice when they merge quantitative assessments with qualitative information about patient’s experiences and the meaning of those experiences” (Plano Clark & Wang, 2010, p. 428).

Finally, with regard to rhetorical structure, or how a summary of the study is presented to research participants and a wider audience, qualitative researchers often present the actual voices of their participants through vivid and in-depth quotes. These “voices” are presented authentically, without transformation to numerical weights. Reading the participants’ quotes and the researchers’ integration and synthesis of these quotes, provides a “thick description” of the study and allows readers to emotively connect with the participants as if they observed the lived experiences (Ponterotto, 2006).

Conclusion

The above chapter reviewed literature regarding the evolution of the diagnostic criteria of ADHD as well as primary and differential diagnosis. Furthermore the training and registration
of psychologists and psychiatrists in South Africa was briefly discussed and intervention strategies used to treat Adult ADHD. The mixed methodology research method was also discussed. Chapter three aims to describe the research methodology of the study.
Chapter 3: Research Design and Methodology

Introduction

This chapter describes the research design and method used to gather data for this study. In this chapter, an outline of the research aims is given as well as the motivation for using a mixed methodology research design. It further explains how participants were chosen to take part in the study and how data was analysed using thematic analysis. Furthermore, the applicable ethical issues are also discussed.

Aims of the Study

The main aim of this study was to explore the experience of South African psychologists and psychiatrists in the Nelson Mandela Bay Metropolitan in the Eastern Cape with regards to their exposure to and their provision of a range of professional services for adults living with Attention Deficit Hyperactivity Disorder (ADHD). The specific objectives of the study were as follows:

- To explore and describe the awareness, perceptions and understanding of psychologists and psychiatrists with regards to Adult ADHD.
- To explore and describe the practice patterns of psychologists and psychiatrists with regards to the diagnosis and treatment of adults living with ADHD.
- To explore and describe the presenting clinical symptom patterns of adults living with ADHD.
- To explore and describe the impact of ADHD on Adults living with the disorder.
Research Design

The study explored the experience of psychologists and psychiatrists in the Eastern Cape with regards to their exposure to and their provision of a range of professional services for adults living with ADHD. A mixed methodology study was utilized since mixed methods research resonates with applied psychologists, particularly counselling researchers, because “combining quantitative and qualitative information also mirrors the process counsellors use in practice when they merge quantitative assessments with qualitative information about a patient’s experiences and the meaning of those experiences” (Plano Clark & Wang, 2010, p. 428). The qualitative data collected by the method of semi structured interviews was given priority as this study was aimed to explore the experience of participants, and qualitative researchers often present the actual voices of their participants through vivid and in-depth quotes (Ponterotto, 2006). An explorative, descriptive- research design, utilizing a semi-structured interview format and a short survey of participants to provide descriptive statistics was used. This study did not utilize a classic Mixed Methods approach as there was not inferential statistics run and the quantitative component was only used for descriptive purposes. The survey questionnaire was used as a facilitation and expansion of the qualitative data received from the semi-structured interviews. Implementation refers to the process in which the quantitative and qualitative data is collected, either concurrently or sequentially. Priority refers to the weight, or relative emphasis, given to the two types of data, equal or unequal (Creswell, 2003). Unequal priority was implemented in this study. Unequal priority occurs when a researcher emphasises one form of data more than the other, starts with one form as the major component of a study, or collects one form in more detail than the other (Morgan, 1998). The qualitative data collected by the method of semi structured interviews was given priority.
Data analysis usually involves transforming the data, and integration usually occurs during the data analysis stage. These designs are useful for gaining a broader perspective on the topic at hand and for studying different groups or levels, within a single study.

A particularly important design feature of mixed methods studies is the extent to which they include an explicit purpose statement, research question, and rationale for using both quantitative and qualitative methods and data in a study (Creswell et al., 2003).

**Figure 1.** Data Collection Procedure applied in this Study

![Diagram of Data Collection Procedures]

**Figure 1.** Above is a diagram depicting the selected options related to mixed methods data collection procedures. QUAN = quantitative data was prioritized; QUAL = qualitative data was prioritized; qual = lower priority given to qualitative data; quan = lower priority given to quantitative data.
Participants and Sample

The research utilised purposive, snowballing sampling in order to locate mental health care professionals that met the inclusion criteria. According to Atkinson and Flint (2015), snowball sampling may be defined as a technique for gathering research subjects through the identification of an initial subject who is used to provide the names of other participants. The strategy has been utilized primarily as a response to overcome the problems associated with understanding and sampling concealed populations such as the deviant and the socially isolated. Snowball sampling can be placed within a wider set of methodologies that takes advantage of the social networks of identified respondents, which can be used to provide a researcher with an escalating set of potential contacts. The researcher actively looked for research participants that met the criteria for the research. The first few participants were obtained through professional contacts that the researcher had access to in the various facilities. To allow for data saturation three psychologists and three psychiatrists were sourced from both public or hospital service and independent private practice. The inclusion criteria for participation was as follows:

a) Participants were psychologists and psychiatrists registered as such with the HPCSA who had 3 years or more of post registration experience working with adults in the public health service and/or private practice.

b) All participants were fluent in English.

Participants interviewed were sampled until data saturation occurred. The interviews were conducted individually with each participant. Data saturation was achieved once themes started to repeat themselves and no new predominant themes were generated by the interviews.
Descriptive and biographical information gathered about participants from the survey questionnaires is presented in table below.

Table 1

**Biographical Information of Participants**

<table>
<thead>
<tr>
<th>Participant Registration</th>
<th>Age</th>
<th>Gender</th>
<th>Average working years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist (Clinical)</td>
<td>41</td>
<td>Female</td>
<td>3 - 10 years</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>44</td>
<td>Male</td>
<td>11 - 20 years</td>
</tr>
<tr>
<td>Psychologist (Counselling)</td>
<td>52</td>
<td>Female</td>
<td>11 - 20 years</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>39</td>
<td>Male</td>
<td>3 - 10 years</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>51</td>
<td>Male</td>
<td>21 - 30 years</td>
</tr>
<tr>
<td>Psychologist (Clinical)</td>
<td>35</td>
<td>Female</td>
<td>3 - 10 years</td>
</tr>
</tbody>
</table>

**Data Collection**

This study made use of semi-structured interviews as well a short survey questionnaire to gain a clear, descriptive picture of the participants’ views on the research topic. The short survey questionnaire was given to participants to complete prior to conducting the interviews. This included relevant biographical details, the structure and domain of their public health or private practices as well as questions relating to the syndrome of ADHD and its manifestation in adults (See Appendix D).

Semi-structured interviews were used as a method of inquiry to gather the qualitative data required to answer the central research question. Interviews consisted of open-ended questions that are based on the literature review and focused on the central research questions. The questions asked related to the perceptions and practice patterns of psychologists and
psychiatrists working with adults living with ADHD. The questions which were posed are included in Appendix E. Interviews for this study were conducted on a face-to-face basis and only one participant was interviewed by the researcher at a time. No other parties were present during the interviews. The interviewing process allowed for elaborations and explanations of questions being asked. An uninterrupted style of collection procedure that did not only allow for the constructs being measured, but also gave the participant an opportunity to elaborate on their experiences at their own discretion was achieved. The interviews were recorded using a Digital audio recorder in order to record data verbatim. These recordings were transcribed to allow for the data analysis to take place. All interviews were conducted in English and no translators were used.

**Research Procedure**

A copy of the research proposal of this study was submitted to the Faculty Postgraduate Studies Committee (FPGSC) at the Nelson Mandela Metropolitan University to request permission to implement this study. Upon approval, psychologists and psychiatrists in public service and/or independent practice were contacted by email and telephonically. Information pertaining to the research study was provided. (See Appendix A). Once participants had indicated their willingness to participate, they were provided with a consent form which explained the aim, procedures, risks, possible benefits and confidentiality considerations (See Appendix B). Once the participants gave informed consent and it was confirmed that they met the inclusion criteria, they were provided with assurances of anonymity and confidentiality. Only then did data collection take place. A suitable interview time was scheduled which best suited each of the participants. The survey questionnaire (Appendix D) and interview questions (Appendix E) where then made available to the participants prior to the semi-structured
interviews. Interviews took place in a suitable environment that allowed for confidentiality and privacy.

**Data Analysis**

**Thematic Analysis.**

Thematic analysis was used to identify, analyse and report themes within the data. One of the benefits of thematic analysis is its flexibility. Through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data. Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail. (Braun & Clarke, 2006).

The six phases of thematic analysis, as stipulated by Braun and Clarke (2006), were followed: Firstly the researcher familiarised herself with the data. This entailed careful perusing of transcriptions of data. Secondly initial codes were generated. Relevant features of the data were coded in a systematic manner across the entire data set, organising data into each relevant code. The researcher then organised codes into possible themes. The themes identified by the researcher were subsequently collated with themes identified by an independent coder to ensure reliability.

Thirdly, the researcher reviewed the themes by examining whether the themes were similar to the coded extracts and the entire data set. This process was then followed by the refining of each theme as well as the general perceptions researched. Each theme was then defined and named.
The last step entailed the production of the report. The researcher selected clear extract examples from the transcripts, conducted a final analysis relating the themes back to the research question and literature. Lastly, a scholarly report of the analysis was produced.

**Trustworthiness.**

An important consideration of qualitative research is the trustworthiness of the study. The trustworthiness constructs of Lincoln and Guba (1985) as well as Shenton (2004) were adopted in the study to meet trustworthiness criteria. The importance stressed by Lincoln and Guba (1985), of credibility, transferability, dependability and confirmability in qualitative research was acknowledged and considered. Shenton (2004) emphasises constructs of credibility, transferability, dependability and lastly achieving confirmability. In addressing credibility, investigators attempt to demonstrate that a true picture of the phenomenon under scrutiny is being presented. To allow transferability, they provide sufficient detail of the context of the fieldwork for a reader to be able to decide whether the prevailing environment is similar to another situation with which he or she is familiar and whether the findings can justifiably be applied to the other setting. The meeting of the dependability criterion is difficult in qualitative work, although researchers should at least strive to enable a future investigator to repeat the study. Finally, to achieve confirmability, researchers must take steps to demonstrate that findings emerge from the data and not their own predispositions (Shenton, 2004).

**Ethical Considerations**

This research was conducted after permission was obtained from the Faculty Postgraduate Studies Committee (FPGSC) and the NMMU Ethics Committee (Human). Using interviews as a research tool added further ethical considerations. In all research studies, informed consent is a vital part of the ethical procedure. Informed consent implies that the participant understands
the nature of the study and the risks that might result and then makes a decision to participate in
the research without being forced, deceived, or coerced into such a decision. A further issue to
be considered is confidentiality. This issue is especially pertinent when interviews are conducted
as the participant makes himself or herself known to the researcher. In this study, no names were
recorded on the audio taped versions of the interviews, the transcribed copy of the interview
data, or at any point in the write up of this research.

**Informed Consent.**

Participants were provided with information in a language that was understandable to them
when informed consent was being obtained. Participants were informed of the nature of the
research, the purpose of the study as well as of the procedure. Informed consent was
appropriately documented and participants were assured that it was voluntary participation and
therefore they could withdraw at any time.

**Privacy and Confidentiality.**

Participants were provided with assurances of anonymity and confidentiality. It was ensured
that all participants were comfortable with the discussed topic. Interviews were recorded using
a Digital audio recorder in order to record data verbatim and for data analysis to take place at a
later stage. These recordings were transcribed verbatim in order to ensure honesty and accuracy
of data. Interviews took place in a suitable environment that allowed for confidentiality and
privacy.
Maintenance, Dissemination of Results and Keeping of records

The data collected and interview recordings were stored by the researcher for data analysis and verification. This data will be stored for five years after collection. The researcher will maintain confidentiality while in the process of creating, storing, transferring and disposing of data. The results of this research will be disseminated in several ways. A treatise will be handed in for partial completion of a Master’s Degree in Counselling Psychology at the Nelson Mandela Metropolitan University, Port Elizabeth. This will ensure that the research is accessible to anyone that has access to the university library system. On request, the research report will be sent to participants.

Conclusion

The focus of the above chapter included the aims of the study and the research design utilized. The process of the selection of participants and a sample was discussed. The data collection process and the research procedure were described. The various aspects of data analysis were also outlined. In chapter 4 the results obtained from both the individual interviews and from the survey questionnaires will be explored using themes.
Chapter 4: Results

Introduction

The previous chapter described the research design and the method of data collection utilized in the current study. This chapter outlines the results and provides a discussion of the data that was obtained from both the individual interviews and from the survey questionnaires. Qualitative data was gathered by means of six semi-structured interviews conducted with three psychologists and three psychiatrists. The quantitative data and descriptive statistics were extrapolated from the survey questionnaires.

The description of the results will be presented in such a manner that the objective of the study is met, namely to explore and describe the experience of psychologists and psychiatrists providing services to adults living with ADHD. Three main themes and several subthemes emerged from the above-mentioned data collection methods. These themes will be explored in-depth in this chapter.

Results from Data Analysis

Participants were initially asked to complete a survey questionnaire. After the survey questionnaire was completed, a list of interview questions was used to facilitate semi structured interviews. All participants were willing and open to sharing their knowledge and experience. Participants were probed by means of further open ended enquiry if their answers were too brief and clarifying questions were asked when necessary. The themes and subthemes that emerged from these interviews are presented in Table 2 below.
Table 2:

**Summary of Themes**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Views regarding the diagnosis of adults with ADHD</td>
<td>Sub-Theme 1: Adult ADHD is chronically misunderstood and underdiagnosed</td>
</tr>
<tr>
<td></td>
<td>Sub-Theme 2: Difficulties are experienced with diagnosing adults with ADHD</td>
</tr>
<tr>
<td>2. Experiences regarding the effects of impairment related to ADHD in adults</td>
<td>Sub-Theme 3: ADHD-related impairment has an overwhelmingly chaotic impact on many aspects of patients’ lives</td>
</tr>
<tr>
<td></td>
<td>Sub-Theme 4: Patients struggle with inattention and time management related to concentration issues</td>
</tr>
<tr>
<td></td>
<td>Sub-Theme 5: The diagnosis of ADHD in adults is considered to be of a primary nature.</td>
</tr>
<tr>
<td>3. Views regarding the treatment for Adult ADHD and suggestions for improving current care options</td>
<td>Sub-Theme 6: Combined treatment with both psychotherapy and medication provided concurrently is the best treatment option for adults with ADHD</td>
</tr>
<tr>
<td></td>
<td>Sub-Theme 7: The psycho-education of both patients and the public is vital</td>
</tr>
<tr>
<td></td>
<td>Sub-Theme 8: De-stigmatisation of ADHD is an essential factor in the treatment process, particularly with respect to the use of medication</td>
</tr>
<tr>
<td></td>
<td>Sub-Theme 9: Support groups would assist adults with ADHD</td>
</tr>
<tr>
<td></td>
<td>Sub-Theme 10: The financial aspects of diagnosis and treatment needs to be considered</td>
</tr>
</tbody>
</table>

As can be seen in Table 2, three overarching themes with their sub-themes were identified.

The first theme was regarding psychologists and psychiatrist’s views of the diagnosis of...
ADHD in adulthood. Secondly, there was a theme regarding the effects of impairment related to ADHD in adults and the final theme was that of the treatment and current care options for Adult ADHD.

**Theme 1: Views Regarding the Diagnosis of Adults with ADHD**

This study found consensus amongst the participants regarding the complexity of diagnosing ADHD in adulthood and furthermore that Adult ADHD is chronically under-diagnosed. The difficulties experienced when diagnosing Adult ADHD were also explored.

**Sub-Theme 1: Adult ADHD is chronically misunderstood and under-diagnosed.**

Until recently ADHD has been neglected as a treatable condition in the adult population. The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) did not specifically provide any diagnostic guidance for Adult ADHD, with definitions essentially only relating to diagnosis in childhood (APA, 2000). It is important to note that in primary care there is relatively low use of ADHD medication, low referrals into secondary care, high rates of usage of psychiatric non-ADHD medications for different indications, and an increasing burden in terms of health care contacts with Adult ADHD patient’s post-diagnosis (Bushe et al., 2015). Participants reiterated this sentiment as five participants said the following:

Participant one was of the opinion that “I think it (ADHD) is under-diagnosed. Some doctors are starting to see it and some people are recognizing it but it is still very much under-diagnosed and a lot of people still believe it is something you outgrow and the general population actually thinks you outgrow it”. Likewise participant two reported, “I think it (ADHD) is something that we see commonly in practice. I think it is generally still under-
diagnosed and under-treated and then the issue there is that a lot of people present with co-mobility. So, if you don’t screen specifically you will miss the diagnosis.”

Participant three stated that, “I think that it is under-diagnosed because there are lots of people out there that I think ……would be Adult ADHD which weren’t actually diagnosed as children and I think they often get misdiagnosed as just depression or something.”

Similarly, participant four expressed the opinion that, “Adult ADHD is, I think, one of the most problematic conditions in psychiatry to diagnose.......... the diagnosis in children, I find from a practical point of view, is one of the easiest diagnoses to make. Whereas, as that child ages it becomes more and more problematic.”

Participant five felt that, “we are not diagnosing the females as children because they are not hyper-active and then as adults it is even more difficult, I think, for females because they frequently just have got the inattention problems, so I do think that we are under-diagnosing a lot”.

Lastly participant six was of the opinion that, “It (ADHD) is very difficult to diagnose. It is usually maybe a patient that has been previously diagnosed as a child or somebody else maybe another specialist has diagnosed it, so it is very difficult to diagnose adult ADHD. It is easy when you do with a child and even to do it in the childhood. Also the collateral is quite easy to maintain because you’ve got a caregiver who knows and can report behaviours whereas you have got teachers and you have got a very good structure that supports the diagnosis. But with an adult you have issues regarding consent so it is very difficult in adulthood.”

Baron (2007) is of the opinion that the recent clinical understanding that ADHD may persist into adulthood has resulted in an increase in referrals of adults without a childhood
diagnosis. This poses challenges of diagnosis as it is difficult to retrospectively obtain accurate information on childhood behaviour, and because the diagnostic criteria provides limited consideration to the heterogeneity of the disorder and its developmental course.

Participant four reiterated this sentiment when he reported that “I find the diagnosis in adults very, very challenging to make and I think there are a lot of reasons for that. There is you know high co-morbidity. You know the core symptoms change from hyperactivity to tension and so on. …in midst of co-morbidity, (it is) always difficult to sass out which one is the cause of it. You know if you look at the symptoms then it is difficult to say you know its broad symptoms and you realise it is not very helpful as it’s not adult specific.” He furthermore stated that, “I think one needs a lot of expertise …..in order to diagnose it. I don’t think the treatment is sufficient, I don’t think, you know, there is enough expertise and so on to carry on the treatment of these patients even if they were diagnosed in childhood”.

Similarly, Participant one stated that, “I think there is still the perception that you outgrow it. It is not something that adults have. It’s only a thing that children have. They understand and have grown over the years to see it better in children and diagnose it there but it is more difficult to diagnose it in adults as well. I mean with children you’ve got the teachers who work along and you see them in the school and the parents but now you’ve got an adult and you see him in therapy, you don’t get feedback from the work and they are not out there to look for and say “oh well, I think this guy has got symptomology.”

**Sub-Theme 2: Difficulties experienced with diagnosing adults with ADHD.**

According to Healey & Carlow (2015), often clinicians without specialized training are reliant upon behaviour rating scales and self-report measures completed by individuals as
there are no standardized psychological or medical tests to independently assess for or verify the diagnosis of ADHD in adults. Descriptive information gathered from the research survey questionnaire about the practitioners use of standardised measures and/or questionnaires to assist with the diagnosis of Adult ADHD showed that four of the six participants used standardised measures and questionnaires to assist them in making the diagnosis. Three of the participants make use of the Conner’s 3 Self Report, one participant uses the Adult ADHD Self-Report Scale (ASRS v1.1) and another uses the Wechsler Adult Intelligence Scale (WAIS-III). Participant 6 uses the DSM-IV-TR diagnostic criteria (APA, 2000) as she mentioned, “If I do diagnose, obviously, it is looking through their DSM-IV-TR classification”. Participant three stated that she used patients self-report during consultations and noted their patterns and how they went about doing things.

Participant two reported that, “I think the psychiatrists are starting to screen for it more and more. If you just look at the numbers in terms of what is happening with prescribed medication, we do see that the adult scripts are going up. There is a little bit of a proviso with that because I am not so sure how many are being properly diagnosed ADHD and how many people are using stimulants as cognitive enhancers.”

Participant five relied on his patient’s history, the way that they communicate and “Just the interaction between us. People with ADHD tend to become difficult to follow them and bringing them back to the topic of conversation.” He acknowledged relying on them filling out a self-report scale but sometimes he wondered if patients over report their symptomology and its severity on these instruments.

From the above it is apparent that this study demonstrated that on the whole, mental health care professionals make use of various tools or standardized measures to assist in the diagnosis of Adult ADHD and that there is no single measure of choice. Participants, however, did see
the need to get collateral information from various sources to aid them in making the diagnosis of Adult ADHD.

The overall risk of any concomitant psychiatric disorder is increased by 80% in adults diagnosed with ADHD. The comorbidity rate of ADHD and internalising disorders (anxiety and depression) is high (Sykes, 2016). This study found a high level of consensus amongst participants regarding the presence of co-morbid disorders with ADHD and that these co-morbid diagnoses complicate the diagnosis and treatment of ADHD in adulthood.

Due to the similarity of the presenting symptoms of ADHD to many other psychiatric conditions and their high prevalence among patients with mood, anxiety, substance use, and impulse-control disorders, both psychiatrists and general practitioners may find it challenging to identify and differentiate between the various diagnoses (Bushe et. al, 2015). Four of the six participants had Adult ADHD patients who presented with either Anxiety, Mood disorders, Substance abuse or Depression as co-morbid disorders. Participant two reported that, “We are taught that if you have ADHD and a mood disorder you are actually supposed to treat the mood disorder first or the psychotic disorder.” This implies the presence of a Mood disorder present with ADHD. Participant six reports that, “I think ADHD is the primary diagnosis but usually they treat maybe the mood disorder and I think the mood disorder comes as a secondary diagnosis.” Participant two reported, “Substance abuse can be an issue and Adults with ADHD are prone to use both the uppers and downers.” Participant four is of the opinion that, “Comorbidities like Substance abuse, Depression, and Anxiety are prevalent with ADHD.” Likewise, Participant five reported that he would “call the Substance Use a co-mobility to the ADHD.” Participant two reported that: “We often treat the co-morbidities like Substance Use, co-morbid Anxiety and Depression.” Participant five was of the opinion that,
“People don’t present with ADHD but they present with comorbidities like Depression or Anxiety.”

Two of the six participants reported Personality disorders to be prevalent co-morbidities in their experience. Participant three stated that, “Personality disorders are often treated with ADHD and anxiety.” Likewise, Participant four was of the following opinion, “I think personality disorders are also co-occurring and distinguishing between bipolar and ADHD.” When further exploring the matter of co-morbidities, Participant two was of the view that Substance Abuse was a prevalent co-morbidity, especially amongst men. Depression and Anxiety, however, was a more common comorbidity amongst women. She reported that, “I think with regards to men, substance abuse is a big thing…..Depression and Anxiety as well as almost like a GAD type of picture with the females is often what I see.”

Theme 2: Experiences Regarding the Effects of Impairment Related to ADHD in Adults

The second theme that emerged concerned the effects of impairments related to an Adult ADHD diagnosis/disorder. Descriptive information gathered about the adult functional areas most affected by ADHD was extrapolated from the questionnaire survey of participants. The findings here are presented in a graph in the figure below.
Graph 2 shows that out of the six participants, only two considered that Work Performance and Career was the functional area to have found to be the most affected by ADHD in adults. Four of the six participants mentioned that Social and Family Relationships suffered the most due to as a result of patients living with ADHD. No other areas of impairment were described.

**Sub-Theme 3: ADHD-related impairments had an overwhelmingly chaotic impact on many aspects of patients’ functional areas of their lives.**

Despite the slight variation above, this study found general consensus amongst participants that ADHD deficits and ADHD-related impairments have an overwhelmingly chaotic impact on many aspects of patients’ functional areas of their lives. This is reiterated by literature.

According to Moffit et al. (2015) there is a markedly elevated level of impairment as a result of ADHD associated problems. Adults living with ADHD reported to feel less satisfied with their lives and reported problems stemming from being disorganized, underachieving,
exhausting or draining others and being involved in car accidents resulting from risky driving. During an interview with Participant two the following was discussed, “Something that often ...we see people that are intelligent people who will tell you that I’ve got siblings who are really performing well in their jobs and I can’t understand why I can’t do it.” This Participant went on to describe other areas of dysfunction and impairment. “Depression and anxiety as well, and then with the females often not so much, substance abuse also, but also not reaching their potential, not being able to organize myself and then anxiety.”

Participant five relayed the following experience which affirms the above statement by Moffit et al. (2015) about the impact of ADHD on the lives of adult patients, “I saw a gentleman who had a recorded IQ of 140 but had no qualification to show for his ability. He had repeatedly heard at school that he was not meeting his potential.”

When considering the structure and diagnosis of adult ADHD, research done by Kessler et al. (2010), found that adult persistence is greater for inattention than for hyperactivity/impulsivity. Interestingly, during this study, when asked what participants consider the most prominent clinical manifestation in adults diagnosed with ADHD, half of the participants considered the impulsivity and hyperactive symptoms as most prominent while the other half perceive the attentional and concentration deficits as most prominent.

According to Gentile et al. (2006) the presentation of ADHD in adulthood includes difficulty getting started on tasks, variable attention to details, difficulties with self-organization and with prioritization, and poor persistence in tasks that require sustained mental effort. Participant two was of the opinion that patients that present with impulsivity are often the patients which are the most negatively affected. She said, “I see much less hyperactivity than we see in the younger people but the impulsivity doesn’t always go away. I think for a lot of them that is actually the thing that causes a lot of social problems.” Similarly, Participant
one found that the impulsiveness symptom of ADHD was what led to patients making inappropriate decisions and it often exacerbated aggression in males. Aggression was often a causal factor in them breaking the law and, furthermore, it caused problems at work and with relationships. She reported that, “Patient impulsivity in making decisions and often with the males you get the aggressiveness that gets them into trouble with the law. Also, their aggression causes problems at work and in relationships. They also struggle to focus and I think that is what happens when they are in conversations at work and with other people as well which creates frustration.”

Participant four found that ADHD patients presented with various impairments on several aspects. He reported that ADHD patients struggle with social relationships and experience occupational difficulties. “Adults with ADHD have various impairments, they’ve got a lot of problems socially and in relationships and so on. They have many occupational difficulties. And difficulties on a social and relational level which obviously affects occupational functioning.”

Participant three reported that ADHD deficits can initiate and compound marital discord and strain. When partners are impulsive and ‘on the go’ all the time, it is hard for others to tolerate which results in arguing. She reported that, “One of my marital therapy patients wasn’t happy over many years and after diagnosis and treatment for adult ADHD her life changed and her husband was happy. So she wasn’t so impulsive, so on the go all the time and not being able to focus and stuff. They then argued less.”

Likewise, Participant five reflected on a patient who described her husband as unfeeling and presenting with narcissistic tendencies. Once he was diagnosed with ADHD and treated efficiently, the spouse realised that the partner she perceived to be not caring was unable to listen and be attentive due to his inattention and social skills deficits. He reported that, “I
remember a patient who described her husband to be unfeeling. When she eventually convinced him to come and see me and after he was diagnosed with ADHD I realised he was not listening to her or being attentive and therefore she was experiencing him to be unloving.”

**Sub-Theme 4: Patients struggle with inattention and time management due to ADHD.**

According to Asherson et al. (2012), hyperactivity becomes less overt, with inattention becoming the greater difficulty specifically when completing executive tasks. Participant two found that patients often procrastinate and struggle to complete tasks. She reported, “They also procrastinate and can’t get things done. And often with work we struggle. They are on their final warning because they haven’t been doing what they should. They start it but they don’t complete or that sort of thing.” Likewise, Participant three found similar findings with young adults completing their post graduate qualifications. They manage to pass their schooling reliant on their level of general intelligence, but with post graduate studies, due to lack of concentration they find that they are unable to cope with the quantity of work. She reported the following: “Often patients have gone through school because of their intellectual ability perhaps and they’ve coped and they get to Varsity and due to lack of concentration, they find themselves not being able to cope with the increased quantity of work. I have seen patients that have to hand in assignments and they feel that they haven’t got enough time and then they don’t want to focus on it and they procrastinate as well.”

Similarly, Participant six reported that adults living with ADHD struggle with cognitive functions such as concentration, poor memory, distractibility and they are often unable to meet their work deadlines. She reported that, “they struggle to meet targets and your patient will tell you that they can’t sit still and need to stand up often, so they are restless as well.” Participant one felt that the hyperactive and the impulsivity symptoms are the precipitating factors that often
drive patients to seek treatment. She furthermore reported that patients are “too impulsive, they get aggressive, their moods change all the time and often they get to a doctor.”

Sub-Theme 5: The diagnosis of ADHD in adults would be of a primary nature.

This study found consistent agreement amongst participants that Adult ADHD should be considered a primary diagnosis. It was noted, however, that due to the high prevalence of co-morbid diagnoses, and the debilitating impact that their symptoms had on a patient’s quality of life, that the ADHD symptomology is not always treated first.

Participant four noted the following: “Technically speaking, from an academic point of view, I would say that one should consider ADHD as a primary diagnosis because it’s a neurodevelopmental disorder. So it’s probably a condition that starts up first. So, academically speaking, that is how I suppose I should reason about it, the problem, is however, that it depends on what the patient presents with. So, if the patient presents with the symptoms of ADHD then I don’t think there is a lot of problems and I would screen the patient with co-mobility and so on. If that patient, however, presents with something else, say for instance presents with substance or with depression, bipolar or whatever then I think it becomes more challenging.

Participant two stated that: “ADHD starts first between the age of 4 and 7, usually. Sometimes anxiety will be before that but ADHD is not a co-morbid for anxiety. Yes, so I think that will be primary. Depression I would say would be a co-morbid to ADHD”. Likewise, Participant six held the opinion that while ADHD should be considered a primary diagnosis, it is often treated as a secondary diagnosis. She stated that: “I think it is the primary (diagnosis) but usually they treat the mood disorder even though the mood disorder comes as a secondary diagnosis. If you consider an example of somebody not meeting their deadline in the workplace
which results in getting into trouble with their boss, you go through disciplinary procedure and that stresses you. Now that patient presents with depression or adjustment or anxiety symptoms. We often treat the co-morbid symptoms and we miss the fact that probably it is the ADHD which initiated the problems and the reason they’ve got stress. That is why you are not meeting the deadline. So, I would say it is a primary diagnosis but most probably it’s being treated mainly as a secondary.”

**Theme 3: Views Regarding the Treatment for Adult ADHD and Suggestions for Improving Current Care Options**

With reference to Table 2, the last theme encompassed the participant’s views regarding the treatment for Adult ADHD and their suggestions for improving current care options.

*Sub-Theme 6: Psychotherapy and medication concurrently is the best treatment option.*

According to Rostain and Ramsay (2006), the combined treatment of ADHD by means of pharmacotherapy and psychotherapy in the form of Cognitive Behavioural Therapy is associated with significant improvements on all clinical measures. Likewise, Du Plesis (2016) is of the opinion that ADHD affects multiple aspects of functioning and therefore effective treatment involves a multimodal approach that includes medication, psychotherapy and stress management as well as ADHD professional organising. When participants were asked if they advocate the simultaneous treatment of pharmacotherapy in conjunction with psychological therapy for Adult ADHD, all six participants supported this position.

The participants who were registered as either Clinical or Counselling Psychologist’s said the following with regard to therapy interventions/ modalities and areas of need for intervention:
Participant one stated that: “I don’t think it (ADHD) is always efficiently treated because there is a lot of other stuff we can give adults in terms of organizational skills, ..... just organizing themselves better ........ sometimes adults will actually benefit from psychotherapy more than the kids because they have learned to a certain extent how to organize themselves. So they need extra support with that”. When asked which psychological modality, she primarily uses to treat Adult ADHD patients, Participant three said the following: “I use Cognitive Behavioural Therapy quite a bit, but I am also quite Narrative Therapy so we would look at their problems as being the problem and then we go round it. I also use a lot of Transactional Analysis but basically just looking at life skills that come out of it, like the parent/adult childhood. Offering life skills for communication helps with the relationships.

Participant six reported the following: “So basically, if I do diagnose, obviously, it is looking through their DSM classification. For treatment basically, I follow the Cognitive Behaviour modality .......... (for) improving particular symptoms. So you look at the different things like their own coping mechanisms, exercise and eating healthy, you know looking into those things and what could probably lead to the lack of concentration. Also looking into how long they can concentrate, how long can you sit at a table for. I think, more looking into the symptoms and working on it from symptom to symptom and being practical and also addressing sleep hygiene as it does have an impact on how your brain works. I also do highly advocate medication and psychotherapy to balance certain chemicals in the brain so if there is a room for that and maybe therapeutic intervention does not seem to work on its own - rather go for both of them.

Participant four whose professional registration was in Psychiatry reported the following experience: “Depending on what the co-morbidity is and then managing that before treating the ADHD. For specifically treating ADHD, my recommendation would be a combination of
pharmacotherapy and psychotherapy. I think patients have a lot of difficulties in terms of organizing and, you know and a lot of anxiety and so on and I think CBT can also be beneficial. I think, you know, they need a lot of assistance, in just getting the basic sort of life skills. So, I think psychotherapy is very important as part of the medication process” Participant two, who is also a registered Psychiatrist, felt that psychotherapy could be helpful in terms of equipping adults with organizational skills. She reported that she often referred to psychotherapists for emotional co-morbidities and executive dysfunction. With regards to the prescription of medication she provided the following position: “So we will treat the co-morbidities fully but also treat the ADHD fully and depending on what the patient has been on before, medical history, substance abuse history, co-morbid anxiety and depression, you will make a call between either stimulant or non-stimulant medication”.

**Sub-Theme 7: Education of patients and the public is vital.**

Descriptive information gathered about participant’s insight into their ADHD diagnosis in percentages from the survey questionnaires is presented in a graph below.
Participant one felt suggested that a starting point would be to first recognize that Adult ADHD symptoms are predominant and that it is a myth that ADHD stops miraculously when you age. If ADHD symptoms appear to have dissipated it is most probably due to the fact that adults have learnt coping mechanisms to deal with them. Her following statement highlights this, “It’s important to recognize the symptoms and then teaching people
that it exists, so that they are actually more aware of it”. Participant two thought that increasing the awareness of patients and others is necessary. She furthermore believed that mental health care professionals are in need of current treatment guidelines. She was of the opinion that, “with treatment guidelines we can go to medical aids and we can say we need to reimburse people for that. As I said increasing awareness”. Participant two, three and five agreed that educating doctors, specifically General Practioners, would be beneficial as they have contact with the wider population. Participant four recommended that longitudinal research studies need to be conducted and discussions about the condition should be more frequently conducted. “Education, you know, is an important part. Especially for psychiatrists, one needs more guidelines and perhaps a specific workshop on dealing with ADHD people that works. So one needs more studies and expertise and so on in terms of the presentation of ADHD through different life stages. Education, I think is lacking”. Participant six provided the following view, “Education – knowledge is power. People who don’t know what they are dealing with, they usually have no interest in addressing it or attending to it. So I think, you know, the same thing as with other diseases like diabetes and like HIV that we have given so much attention and so much investment in educating people about it That it is why, I think, if you look at the HIV rates over the past few years and you compare them to 10 years down the line, it is because of education. So people need to be educated and really when you know something you manage it better but if you don’t know it then you don’t manage it better.

**Sub-Theme 8: Destigmatisation of ADHD is an essential factor in treatment, particularly relating to medication.**

Participant five was of the opinion that the stigma around the diagnosis and treatment of ADHD, and the role of drug therapy specifically with Methylphenidate, needs to be addressed.
“I believe the abuse potential of Methylphenidate is much lower than we postulate it to be. I have been a psychiatrist for a long time and really in my profile of patients I haven’t really seen people abuse it. So we have to do a lot for education and we need to do a lot in terms of de-stigmatization in terms of talks at schools and so on. I also think we need to educate the GP’s”. Participant four regards the biggest obstacles surround the use of medication, “Ritalin is the gold standard. I think that creates reluctance. So, if I were to treat ADHD with something that was not addictive and that didn’t have a street value, I don’t think we would’ve had this discussion. ....we would have been comfortable making the diagnosis. I think the medication is a challenge in the sense that it is abused, it is sold for a lot of money and so on So I think the medication plays a major role in all the controversies around ADHD”. Participant six also stated that “We must take the stigma out of it. Children and young adults don’t want to take medication-top ups in front of other people because of stigma.”

**Sub-Theme 9: Support groups would assist adults with ADHD.**

Support groups were also advocated by most of the participants as being a useful tool to drive education. The National Institute for Health and Care Excellence guidelines recommend group or individual interventions that employ a Cognitive Behavioural paradigm and social skills training in adults with ADHD (NICE, 2013).

Participant two felt that support groups work well. “I think that can also help a lot.” Likewise Participant five was of the view that support groups work as many patients and their families take solace and understanding from groups, especially if the support groups involve health professionals to implement psych-educational workshops. He furthermore was of the opinion that support groups also can make a difference in terms of getting information out there.

The financial aspect of treatment was highlighted during two of the semi-structured interviews. Participant two ventured that, “I think a big problem for us in practice is the fact that we know that medication does not work that well in adults as in kids and the second part is that if the medication is not reimbursed by medical aids......some people don’t want to go onto medication. They just want to see a psychologist. A lot of them are willing to do both (psychotherapy and medication) but the financial constraints I would say are the biggest reason for not having dual therapy”.

Likewise Participant two reported that, “Financially it is difficult because a lot of these people have kids already on medication, kids going for therapy, getting OT – so I think from a financial perspective it’s a huge burden. The adults can get medication from clinics but then they have to sit and wait and miss work for that.”

Conclusion

This chapter described the results that were obtained from interviews with six participants. Three main themes emerged from these interviews, namely views regarding the diagnosis of adults with ADHD, the experience regarding the effects of impairment related to ADHD in adults and the participants views regarding the treatment for Adult ADHD.
Chapter 5: Discussion, Limitations and Recommendations

Introduction

The previous chapter presented and discussed the results obtained from the study’s exploratory-descriptive research design which utilised interviews and a survey questionnaire that were completed by psychologists and psychiatrists. In this chapter conclusions, will be drawn from these results. The limitations and value of the current study, as well as recommendations for future research will also be discussed.

Conclusions from this Study

The conclusions, based on the analysis of the data obtained from interviews and the survey questionnaire completed by psychologists and psychiatrists in the Nelson Mandela Bay Metropole in the Eastern Cape area will be presented according to the objectives guiding the study, as well as in terms of the major themes which arose from data analysis. Thereafter the assumptions underpinning the study, as specified in chapter 1, will be reviewed in relation to the conclusions.

Conclusions in relation to the objectives guiding the study

The respective research objectives of the study that will be discussed are: (1) to explore and describe the awareness, perceptions and understanding of psychologists and psychiatrists with regards to Adult ADHD; (2) to explore and describe the practice patterns of psychologists and psychiatrists with regards to the diagnosis and treatment of adults living with ADHD; (3) to explore and describe the presenting clinical symptom patterns of adults living with ADHD; (4) to explore and describe the impact of ADHD on adults living with the disorder.
The awareness, perceptions and understanding of psychologists and psychiatrists with regards to Adult ADHD.

Psychologists and psychiatrists found the diagnosis of ADHD to be complex when it manifested in adulthood. Furthermore, they stated that they considered Adult ADHD to be chronically under-diagnosed and misunderstood. When reflecting on the opinions of three of the psychologist’s regarding the diagnosis, all three participants concurred that Adult ADHD is under-diagnosed. One of the psychologists indicated that the condition is under-diagnosed due to the complexity of its nature. Likewise, all three psychiatrists agreed that the condition is under-diagnosed, with one being of the opinion that it is especially under-diagnosed in women.

Participants in this study indicated that they regarded there to be a general lack in health care professionals’ awareness of how Adult ADHD presents and how it has evolved over the years. They were of the opinion that it was, and still is, neglected as a treatable condition in the adult population. Adult ADHD is often undertreated especially when any concomitant psychiatric disorder is present. Health care professionals often treat the comorbidities as these symptoms may have a more severe impact on the patients’ lives and therefore become the focus of treatment.

The lack of diagnostic guidance for Adult ADHD was highlighted which in turn made participants cautious in their process of diagnosis. The participants in the study were aware that there is still a widespread perception among the general population as well as health care practitioners that patients outgrow the disorder. The participants felt that this belief contributed to Adult ADHD remaining under-diagnosed.
Practice patterns of psychologists and psychiatrists with regards to the diagnosis and treatment of adults living with ADHD.

According to Healey and Carlow (2015), often clinicians without specialized training are reliant upon behaviour rating scales and self-report measures completed by individuals as there are no standardized psychological or medical tests to independently assess for or verify the diagnosis of ADHD in adults. Two of the psychologists indicated that they use formal rating criteria, one being the DSM IV, and the other using the Weschler Adult Intelligence Scale (WAIS). The other psychologist based her diagnosis on the patient’s presenting patterns during therapy. Although all three psychiatrists used the Conner’s 3 Self Report Scale to assist with diagnosis, the one psychiatrist also relied on clinical observations. One of the psychiatrists also utilizes the Adult ADHD Self-Report Scale (ASRS v1.1).

Du Plesis (2016) is of the opinion that ADHD affects multiple aspects of functioning and therefore effective treatment involves a multimodal approach that includes medication, psychotherapy and stress management as well as ADHD professional organising. When participants were asked if they advocate the simultaneous treatment of pharmacotherapy in conjunction with psychological therapy for Adult ADHD, both psychologists and psychiatrists supported this position. Although the psychologist’s emphasis lay within the psychological therapy aspect, they recognised that the use of pharmacotherapy can be successful if the patient is medication compliant. Two of the three psychiatrists indicated that pharmacotherapy would be their primary intervention but recognised the importance of dual therapy. One of the psychiatrists was of the opinion that although dual therapy was optimal, financial constraints often result in patients needing to choose between either psychological therapy or pharmacotherapy.
Two of the three psychiatrists indicated the need for specific treatment guidelines when treating patients with Adult ADHD.

With regards to the choice of preferred psychological modalities, one psychologist preferred working within a System’s Theory approach. The two other psychologists indicated the use of Cognitive Behavioural Therapy. One of the therapists indicated that she also uses Narrative therapy, Positive Psychology as well as a Transactional Analysis approach.

**Presenting clinical symptom patterns of adults living with ADHD.**

Due to the similarity of the presenting symptoms of ADHD to those of many other psychiatric conditions and their high prevalence among patients with mood, anxiety, substance use, and impulse-control disorders, both psychiatrists and general practitioners may find it challenging to identify and differentiate between the various diagnoses (Bushe et al., 2015).

The three psychologists reported that they had encountered Mood disorders, as well as Anxiety disorders co-morbid with Adult ADHD. Bi-Polar Mood disorder in particular was mentioned as a Mood disorder. Two of the psychiatrists noted Substance Abuse disorder, Anxiety disorders as well as Mood disorders, Tourette’s syndrome as well as Obsessive Compulsive disorder were also identified as likely comorbid psychiatric disorders by one of the psychiatrists.

Gender differentiation was made by one of the psychiatrists who reported that Substance abuse was a prevalent co-morbidity, especially amongst men. Depression and Anxiety, however, was a more common comorbidity amongst women.

This study found consistent agreement amongst participants that Adult ADHD should be considered a primary diagnosis. It was noted, however, that due to the high prevalence of co-morbid diagnoses, and the debilitating impact that their symptoms had on a patient’s quality of
life, that the ADHD symptomology is not always treated first. The three psychiatrists consider ADHD as a primary diagnosis due to its neurodevelopmental nature.

One of the psychologists indicated that although she considers ADHD as a primary diagnosis in her experience it, however, is mostly diagnosed as a secondary disorder by others. Another psychologist stated that she considered ADHD to be a co-morbid diagnosis. The third psychologist indicated that it should be considered as a primary diagnosis.

When considering the structure and diagnosis of Adult ADHD, research done by Kessler et al. (2010), found that adult persistence is greater for inattention than for hyperactivity/impulsivity. Two of the psychologist’s report impulsivity and hyperactivity to be the most prominent clinical presentation in their experience. The other psychologist reported inattention to be the prominent clinical manifestation. Two of the psychiatrists reported attention and concentration deficits as most prominent. The other psychiatrist reported that some adults with ADHD present with inattention as well as impulsivity symptoms.

**The impact of ADHD on adults living with the disorder.**

According to Moffit et al. (2015) there is a markedly elevated level of impairment as a result of ADHD associated problems. Adults living with ADHD have reported feeling less satisfied with their lives and that they had problems stemming from being disorganized, underachieving, exhausting or draining to others and of being involved in car accidents resulting from risky driving. Two of the three psychologists indicated that their Adult ADHD patient’s had not managed to reach their full potential. One psychologist however differed. All three psychiatrists reported that patients with Adult ADHD had deficits in meeting their full potential.

Two psychologists indicated that work performance and career were the functional areas that were most affected. However, the other psychologist reported that social and family
relationships suffered the most. All three psychiatrists reported social and family relationships to have been most affected by ADHD. One psychologist and a psychiatrist reported that ADHD deficits can initiate and compound marital discord and strain.

This study found general consensus amongst participants that ADHD deficits and ADHD-related impairments have an overwhelmingly chaotic impact on many aspects of patients’ functional areas of their lives.

All three psychologists reported that they had treated Adult ADHD patient’s that had been in trouble with law. One psychiatrist concurred with the above finding. One psychologist reported that it was the impulsiveness symptom of ADHD that led to patients making inappropriate decisions and this often exacerbated aggression in males. Aggression was often a causal factor in them breaking the law and, furthermore, it caused problems at work and with relationships.

According to Gentile et al. (2006) the presentation of ADHD in adulthood includes difficulty getting started on tasks, variable attention to details, difficulties with self-organization and with prioritization, and poor persistence in tasks that require sustained mental effort. Two psychologist’s reported working with patients with Adult ADHD who struggle with procrastination and an inability to complete tasks. One psychiatrist reported procrastination and an inability to meet deadlines as difficulties experienced by adults living with ADHD.

**Limitations of the study**

The major limitation of the study is the lack of the generalisability of the findings. This is primarily due to its small sample of participants (n=6) and the heavily weighted qualitative component of its methodology including the purposive sampling technique that was used. This had the disadvantage of only representing a very specific population group of mental health care
professionals. The sample of mental health practitioners that were interviewed is thus not representative of the whole population of mental health care professionals who render services to adults living with ADHD. This study was also geographically restricted to participant psychologists and psychiatrists in the Nelson Mandela Bay Metropole. While most of these limitations were foreseen it is important to take note of these in order to avoid over interpretation of the findings.

As the study canvased experiences and perceptions it is also important to recognise that these are likely to be limited as they may not fully reflect the reality of people living with Adult ADHD and their mental health care providers. The study, nevertheless, created meaningful insights drawn from a select sample of experts, adding knowledge about local psychologists and psychiatrists experience in the field of Adult ADHD.

A further possible criticism could lead to the question of whether mental health practitioners from other professional registration categories (e.g. Educational psychologists, general medical practitioners, nurses, social workers) should also have been consulted. This, however, lay outside of the scope of the study and it could be the basis for future studies.

Comprehensive literature control with other South African sources was a limitation as the researcher found no similar studies that had been conducted in the country.

**Value of the study**

The current research study, probably the first of its kind, contributed to the knowledge and provided a more in-depth understanding about the experience of psychologists and psychiatrists working with Adult ADHD. The value of the current study is that it recognised both the barriers as well as the strengths of the mental health care practitioners interviewed. This study has
highlighted the need for appropriate, consistent and specific guidelines which mental health care practitioners can use to guide both the diagnosis and the treatment of adults living with ADHD.

The consensus findings that Adult ADHD deficits and impairments are often under recognised and under treated giving rise to overwhelmingly disruptive impacts on patient’s functional lives adds urgent impetus to better professional training in and the raising of general public awareness about the condition.

The financial burden of dual pharmacological and psychotherapeutic treatment was determined as a barrier to managing Adult ADHD which is a chronic mental disorder that requires long term treatment. The need for specific multidisciplinary treatment protocols to address cost effective access to appropriate therapies is indicated by the study.

**Recommendations**

Psychology is looking to reformulate itself in terms of new professional training and educational programs by seeking to meet the changing needs of the profession to provide quality health care to the communities at large. In view of this the following recommendations are made:

- This research has highlighted that there is a vast need for specialised training for all mental health care professionals in diagnosis and treatment of Adult ADHD.
- Patients require psycho-educational input as they would benefit from increasing their understanding of their diagnosis and the disorder. These psycho-educational workshops need to be undertaken by specialists in the field. Educating psychologist and medical doctors, especially General Practitioners, would also be beneficial as they have contact with the wider population and they are often tasked with the referral process.
A further recommendation is that public awareness should similarly be raised by means of psycho-educational workshops specifically aimed at the destigmatisation of Adult ADHD and with regards to the use of any medication that may be required.

Support groups are also advocated as being a useful tool to drive education and their establishment is recommended.

Consensus needs to be taken on which standardized psychometric measures are the most effective in the diagnosis of Adult ADHD for the South African population. This study highlighted a lack of consistency in the use of standardized measures in diagnosis.

With regards to further research there is a need to canvas larger samples of participants from other areas and provinces in South Africa in order to validate the experience of Eastern Cape psychologists and psychiatrists of people living with Adult ADHD.

The financial aspects of the diagnosis and treatment of Adult ADHD has already been highlighted, and this is even more problematic in communities with limited resources. The need for the accessible provision of cost effective health care and treatment of Adult ADHD is essential and it needs to be addressed by healthcare funders.
References


Bartholomew, T. T., & Brown, J.R. (2012). Mixed methods, culture, and psychology:

A review of mixed methods in culture-specific psychological research. *International Perspectives in Psychology: Research, Practice, Consultation*. 1, 177-190.


Crichton, A. (1798). *An inquiry into the nature and origin of mental derangement: comprehending a concise system of the physiology and pathology of the human mind and a history of the passions and their effects* (Vol.2). London: Insanity Law


Appendix A: Information Letter to Participants

For attention: [Participant’s name]

INFORMATION LETTER TO PARTICIPANT

Dear [Participant’s name],

My name is Rozanne Gowar, and I am a Counselling Psychology student and intern at the Nelson Mandela Metropolitan University in Port Elizabeth. The research I wish to conduct for my Master’s treatise involves the exploration and description of the experience of Psychologists and Psychiatrists providing services to adults living with Attention Deficit Hyperactivity Disorder. A mixed method research design will be utilised for the study which will incorporate semi-structured interviews and a short survey questionnaire to gather descriptive statistics. After all data has been collected, a thematic analysis will be carried out to interpret and describe the interview findings. Throughout this process confidentiality of the participants will be maintained. This project will be conducted under the supervision of Mr V. Sack (Department of Psychology, NMMU, South Africa).

I am hereby contacting you to see whether you will be willing to be involved in this research study. I have provided you with a copy of the approval letter, which I received from the NMMU Research Ethics Committee (Human).

Upon completion of the study, if requested I undertake to provide you with a copy of the research report. If you require any further information, please do not hesitate to contact me through the following:

Telephone: (041) 504 2598
Cellular: 0833052608
Email: s205041825@nmmu.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Ms R Gowar
Researcher

Mr. V Sack
Supervisor
## Appendix B: Consent form

### CONSENT FORM

#### SECTION A:

**THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Title:</td>
<td>The experience of Psychologists and Psychiatrists providing services to adults living with Attention Deficit Hyperactivity Disorder.</td>
</tr>
<tr>
<td>2. Aim:</td>
<td>This study aims to explore and understand the experience of Psychologists and Psychiatrists providing services to adults living with Attention Deficit Hyperactivity Disorder.</td>
</tr>
<tr>
<td>3. Procedures:</td>
<td>I understand that I will participate in an individual in-depth interview that will be from 1 to 2 hours in duration and that this interview will be recorded with an audio recorder.</td>
</tr>
<tr>
<td>4. Risks:</td>
<td>There are no significant risks to me as a consequence of my participation in this study.</td>
</tr>
<tr>
<td>5. Possible benefits:</td>
<td>As a result of my participation in this study, there will be no benefits to me.</td>
</tr>
<tr>
<td>6. Confidentiality:</td>
<td>My identity will not be revealed at any stage of the research or in the dissemination of results.</td>
</tr>
<tr>
<td>7. Voluntary participation / refusal / discontinuation:</td>
<td>My participation is voluntary</td>
</tr>
<tr>
<td></td>
<td>My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle</td>
</tr>
</tbody>
</table>

#### THE INFORMATION ABOVE WAS EXPLAINED TO ME/THE PARTICIPANT BY:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rozanne Gowar in English and I am in command of this language</td>
</tr>
<tr>
<td></td>
<td>I was given the opportunity to ask questions and all these questions were answered satisfactorily.</td>
</tr>
<tr>
<td></td>
<td>No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.</td>
</tr>
</tbody>
</table>

**I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED RESEARCH PROJECT:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Signature:</td>
<td>Location:</td>
</tr>
</tbody>
</table>
**SECTION B:**

**STATEMENT BY OR ON BEHALF OF INVESTIGATOR**

I, Rozanne Gowar declare that:

I have explained the information given in this document to:

<table>
<thead>
<tr>
<th>He / she was encouraged and given ample time to ask me any questions</th>
<th>[initial]</th>
</tr>
</thead>
</table>

3. This conversation was conducted in English

4. I have detached Section C and handed it to the participant

YES NO

Name: [Signature: ] Date: Location:

**SECTION C:**

**IMPORTANT MESSAGE TO PARTICIPANT**

Dear participant

Thank you for your participation in this study. Should, at any time during the study:

- An emergency arise as a result of the research, or
- You require any further information with regard to the study

<table>
<thead>
<tr>
<th>Kindly contact</th>
<th>Rozanne Gowar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone number</td>
<td>+27 833052608</td>
</tr>
<tr>
<td>Email Address</td>
<td><a href="mailto:s205041825@nmmu.ac.za">s205041825@nmmu.ac.za</a></td>
</tr>
</tbody>
</table>
Appendix C: Attention-Deficit/Hyperactivity Disorder: DSM V Diagnostic Criteria

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

   a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).

   b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).

   c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).

   d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).

   e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).

   f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

   g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paper work, eyeglasses, mobile telephones).

   h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

2. **Hyperactivity and impulsivity:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

   **Note:** The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

   a. Often fidgets with or taps hands or feet or squirms in seat.
   b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
   c. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)
   d. Often unable to play or engage in leisure activities quietly.
   e. Is often “on the go,” acting as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
   f. Often talks excessively.
   g. Often blurts out an answer before a question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation).
   h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
   i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or
another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).
Appendix D: Survey Questionnaire

**Instructions**

1. Please complete the following by marking “X” in the appropriate block or by filling in the blank spaces provided.
2. You are encouraged to answer the questions as honestly as you can as all responses will be kept private and confidential.

<table>
<thead>
<tr>
<th>Registration:</th>
<th>Psychologist</th>
<th>Psychiatrist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>How many years have you been working with ADHD Adults in your private practice?</td>
<td>3-10 years</td>
<td>11-20 years</td>
</tr>
<tr>
<td>Were your clients/patients previously diagnosed with ADHD as children or adolescents?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, did they receive:</td>
<td>Pharmaco therapy</td>
<td>Psychological therapy</td>
</tr>
</tbody>
</table>
8. Which adult functional area have you found to be the most affected by ADHD?

☐ Social and family  ☐ Work performance  ☐ Other (Specify:__________)
relationships  and career

9. Rate your adult clients/patients insight of and awareness about their ADHD diagnosis.

☐ Poor  ☐ Fair  ☐ Good  ☐ Excellent

10. Have your Adult ADHD clients/patients managed to reach their full potential?

☐ Yes  ☐ No

11. Have your Adult ADHD clients/patients ever been in trouble with the law?

☐ Yes  ☐ No

12. In your experience, do you find that adults with ADHD frequently procrastinate?

☐ Yes  ☐ No

13. In your evaluation and assessment of adult clients/patients who present with ADHD features, do you use standardised measures or/and questionnaires to assist you with diagnosis?

☐ Yes  ☐ No

14. If you do, please specify:_________________________________________

15. Do you advocate the simultaneous treatment of pharmacotherapy in conjunction with psychological therapy?

☐ Yes  ☐ No

Thank you for completing this survey questionnaire.
Appendix E: Interview Questions

Thank you for attending today’s interview, as explained to you previously, the interview is mainly about your experience providing services to adults living with Attention Deficit Hyperactivity Disorder in your practice.

1. In general, what are your thoughts and views about the diagnosis of Adult Attention Deficit Hyperactivity Disorder?

2. In your opinion, do you think that ADHD in adults is efficiently diagnosed and treated by mental health care practitioners?

3. What are the impairments that you find to be most often associated with Adult ADHD?

4. In your experience, which of the following do you consider to be the most prominent clinical manifestations in adults diagnosed with ADHD, the impulsivity and hyperactive symptoms or the attentional and concentration deficits?

5. In your experience is Adult ADHD regarded as a primary or a secondary and co-morbid diagnosis?

6. What are the primary treatment interventions provided to adults with ADHD in your practice?

7. What do you think could improve the mental health care services provided to adults living with ADHD?

Thank you for attending this interview.