Self-reported childhood attention-deficit/hyperactivity disorder symptoms are not specific to the disorder

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Abstract

Objective: The present study examined the specificity of self-reported childhood attention-deficit/hyperactivity disorder (ADHD) symptoms using the Wender Utah Rating Scale (WURS) in young adults with (1) a previous diagnosis of ADHD, (2) comorbid ADHD and psychological symptoms or diagnoses, (3) psychological diagnoses or symptoms without comorbid ADHD, and (4) controls.

Method: One thousand four hundred thirty-one non–treatment-seeking individuals (508 males), aged 18 to 25 years, were assigned to 1 of 4 groups (psychological controls, controls, ADHD, ADHD comorbid), based on responses to psychological, demographic, and health history questionnaires completed as part of a larger study. Responses to the WURS were analyzed at the individual item and subtest levels for their specificity to ADHD using area under the curve analyses.

Results: The standard WURS cutoff score of 46 was neither sensitive nor specific to ADHD, with a high rate of false positives in psychological controls. Factor analyses supported a 5-factor model (conduct problems, impulsivity problems, mood difficulties, inattention/anxiety symptoms, poor academic functioning) that accounted for 62% of the total variance; these factors were used to generate factor-based WURS subscales. Three subscales (impulsivity, poor academic functioning, and inattention/anxiety symptoms) showed potential for discriminating ADHD from controls among females. No subscales showed adequate sensitivity or specificity for discriminating ADHD from psychological controls among the males.

Conclusions: Results provide further evidence that retrospective self-report of childhood ADHD symptoms is not specific to ADHD and highlight concerns about the reliance on self-report of childhood ADHD symptoms for diagnostic purposes. Results suggest consideration of specific types of symptoms, and sex differences might increase diagnostic use of self-reported childhood symptoms.

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1. Introduction

In the assessment of adult attention-deficit/hyperactivity disorder (ADHD), clinicians must assess not only current symptoms but also for presence of the disorder in childhood because of the neurodevelopmental course of the disorder. In practice, the presence of and impairment associated with childhood ADHD symptoms are often assessed solely via retrospective self-report [1-2], despite considerable controversy surrounding the validity of this assessment [3]. Self-reported symptoms can be assessed via clinical interview or by using checklists and other self-report instruments. The Wender Utah Rating Scale (WURS) [4] is one of the most commonly used scales for adults to retrospectively report ADHD symptoms and behaviors in childhood [3]. In the initial presentation of the scale, Ward et al [4] provided validity data for both a long form and a short form of the scale. The short-form score correlated well with mothers’ ratings of childhood ADHD symptoms, and individuals who responded positively to methylphenidate in a placebo-controlled intervention study had significantly higher scores on the short form relative to nonresponders. Both the short form and the long form showed good 1-month test-retest reliability and adequate internal consistency in a nonclinical sample of undergraduate and graduate students aged 19 to 50 years [5]. A cutoff of 46 on the short form was reasonably sensitive to ADHD, as well as having minimal false positives in a psychological control group; this cutoff remains the one most frequently used in clinical work and research to date.

One major problem with adult report of childhood ADHD symptoms is that ADHD-like symptoms occur with high base rate in the general population. To illustrate, Murphy and
Barkley [6] surveyed 720 adults aged 17 to 84 years applying for or renewing their driver’s licenses. All were asked to complete current and childhood scales assessing Diagnostic and Statistical Manual of Mental Disorders–based ADHD symptoms. At least 20% or more of participants endorsed 10 of the 18 items as occurring “often or very often” during their childhood, including failure to give close attention to tasks, difficulty sustaining attention, difficulty organizing tasks, blurt out answers, difficulty waiting one’s turn, avoiding work with mental effort, being easily distracted, being fidgety, feeling “on the go,” and talking excessively. Although some of these adults may have had diagnoses of ADHD, given the base rates of the disorder (3%-7% in childhood), this level of childhood symptom report is high.

Even more compelling data come from a 16-year follow-up of children who had either been diagnosed with ADHD using strict diagnostic criteria or who showed no evidence of ADHD in childhood [7]. The children were reinterviewed as adults by interviewers who were not aware of the childhood diagnostic status of the participants or of the study’s purpose. Interviewers rated the childhood presence of clinically significant symptoms of inattention, hyperactivity, and impulsivity based on the interview, and these data were used to formulate a diagnostic impression of the presence/absence of childhood ADHD. Notably, 7 of 22 childhood ADHD symptoms were recorded as clinically significant in at least 20% of the control participants, including distractibility, inattention, acting before thinking, disorganization, being “on the go,” fidgeting, and running about/climbing excessively. Retrospective childhood diagnosis of either probable or definite ADHD was made in 11% of the control group, who had been carefully screened for the absence of ADHD as children. With an estimated 5% base rate of ADHD in the general population, use of self-reported childhood symptom report to diagnose ADHD would have resulted in an unacceptably high 75% false-positive rate. With regard to the WURS, Retz Juninger et al [8] used receiver operating curve analyses to identify a lower cutoff (30) on a German version of the short-form WURS, but this scale was only 76% specific to ADHD (using a large nonclinical male sample as controls). Such results clearly demonstrate that self-reported childhood “ADHD” symptoms, whether assessed by interview or questionnaire, are not specific to the disorder, and reliance on self-reported childhood symptoms may result in misdiagnosis of the disorder in adults.

Childhood ADHD symptoms are also reported at high rates in samples of individuals presenting to clinics for evaluation or treatment, even for non–ADHD-related concerns. In McCann and Roy-Byrne’s [9] sample of individuals seeking treatment for psychiatric concerns, almost half of the sample fell above the clinical cutoff on the short-form WURS. Roy-Byrne et al [10] also reported a 40% to 60% false-positive rate on the short-form WURS in a sample of individuals who presented for evaluation specifically for concerns about ADHD but who did not meet diagnostic criteria for the disorder. In contrast, Rodriguez-Jimenez et al [11] found that a cutoff of 32 on a Spanish translation of the WURS was both sensitive and specific to ADHD in a sample of inpatients in treatment for substance dependence. Overall, however, these findings raise significant concerns about reliance on self-reported childhood symptoms for diagnosis and suggest a possible recall bias when individuals presenting for current evaluation are asked to retrospectively report childhood symptoms consistent with their current beliefs about their own diagnosis [9].

Given these findings, further examination of the WURS for specificity to ADHD is warranted.

Although some symptoms commonly associated with ADHD also occur at high base rate in other populations, including controls, other symptoms or symptom clusters may be relatively specific to ADHD and thus more useful in differential diagnosis. However, few studies have examined this possibility. Researchers have begun to explore whether there are subscales on the WURS that may be useful for differential diagnosis. Stein et al [12] factor analyzed the long form of the WURS in a sample of parents of children who were being seen in an ADHD clinic (the parents themselves were not seeking clinical services). In both males and females, factors were identified that were reflective of conduct difficulties, learning problems, attention problems, emotional problems, and social difficulties, although item loadings varied somewhat between sexes. Subscale scores based on the factors showed adequate internal consistency and 1-month test-retest reliability. In an analysis of the factor structure of the short form of the WURS, McCann et al [13] used data from 143 adults who had been referred to an adult ADHD specialty clinic and identified a 3-factor solution that accounted for 59.4% of the variance. The 3 factors were labeled dysthymia, oppositional behavior, and school problems. However, Retz Juninger et al [8] factor analyzed a German translation of the short form of the WURS and identified 7 factors in a sample of 63 adults diagnosed with ADHD. Therefore, there is little consistency among the findings, possibly related to differences in both the measure used (short form, long form, translated form) and the population analyzed (clinical, nonclinical), to guide future research.

Only one study has further analyzed the validity of subscales derived from WURS factor analysis. McCann et al [13] divided their sample into 2 groups (ADHD diagnosis, n = 68; no ADHD, n = 73), with both groups potentially having comorbid psychological diagnoses. The ADHD group was younger and completed less education than the no ADHD group. The ADHD group also obtained higher overall WURS scores and scored higher on the dysthymia and school problems subscales developed from their factor analytic findings described above. A discriminant function analysis controlling for age and education and including the 3 WURS subscales revealed that age and the school problems subscales were the only predictors of group placement. The resulting classification equation had a
sensitivity of 72.1% but an unacceptably high false-positive rate of 42.5%. They concluded that the WURS was a measure of depression, conduct difficulties, and academic problems that are not specific to ADHD. Because their data were obtained only from individuals seeking clinical services specifically for ADHD, retrospective report bias may have had a major influence on both the factor structure and on their results.

Interestingly, few studies have addressed the role that sex differences in symptom report may play in the effectiveness of self-report instruments for diagnosis of ADHD. There is evidence for differences in symptom presentation and psychiatric comorbidities between males and female children with ADHD [14,15], suggesting that sex should be considered when assessing retrospectively for childhood symptoms in an adult population. The present study further examined the use of the short-form WURS as a measure of childhood ADHD symptoms in a nonclinical young adult sample. We first examined the effectiveness of the previously established cutoff score for distinguishing ADHD from non-ADHD individuals, including those with high psychological symptoms, and with consideration for sex differences. We also used receiver operating characteristic (ROC) curve analyses to consider whether different WURS cutoff scores would be more useful in distinguishing ADHD from control groups, again with consideration for sex differences. Given prior studies, we expected that high rates of symptom endorsement among non-ADHD individuals would make the previously established cutoff score nonspecific to ADHD, and that ROC analyses would suggest much higher cutoff scores, particularly for obtaining adequate specificity. Furthermore, we examined the factor structure of the WURS to determine whether stable subscale scores could be identified (for both sexes) and whether specific subscales had use in distinguishing ADHD from non-ADHD groups, using ROC analyses.

2. Method

2.1. Participants

Participants were 1431 individuals from a large Midwestern university who were part of a much larger institutional review board–approved study of personality, affect, and neuropsychological correlates of ADHD diagnosis and ADHD symptom report in undergraduate students. The data for the present analyses were taken from participants who had completed the first phase of the larger project, involving completion of several self-report measures between November 2005 to July 2007 and for whom complete information from key study measures (WURS, demographic and diagnostic history variables) was available. Informed consent was obtained from all participants after a complete description of the study and before collection of any data reported for the present analyses. Participants ranged in age from 18 to 25 years old, with 508 male participants. Participants self-reported their racial/ethnic status as follows: 1292 white, 6 Native American, 15 Asian/Asian American, 67 black/African American, 29 Hispanic, and 22 other racial/ethnic identity.

Participants were further divided into the following groups:

The psychological control group included 181 individuals (35 male) who denied having a prior diagnosis of ADHD but who reported either that they were currently diagnosed with/receiving treatment for a psychological condition and/or had a Beck Depression Inventory-II (BDI-II) [12] score above 20, suggesting self-report of current depressive symptoms in at least the moderately severe range.

The control group included 1166 (418 males) individuals who reported no prior diagnosis of ADHD, reported no current diagnosis and/or treatment for a psychological condition, and had BDI-II scores of 13 or less.

The ADHD group included 62 individuals (38 male) who reported having received a diagnosis of ADHD in the past, who denied current diagnosis of or treatment for any other psychological condition, and who had BDI-II scores of 13 or less.

The ADHD comorbid group included 42 individuals (17 male) who reported having received a diagnosis of ADHD in the past and who also reported a current diagnosis of or treatment for another psychological condition and/or had BDI-II scores of 20 or greater.

Of note, the final analyses excluded individuals who did not meet criteria for any of the above groups (11 individuals who reported having received a diagnosis of ADHD in the past but who had BDI-II scores between 13 and 19 and 86 individuals who reported not having any prior diagnosis of ADHD but who had BDI-II scores between 13 and 19).

2.2. Measures

2.2.1. Demographic and Personal Health History Questionnaires

Participants completed questionnaires assessing basic demographic characteristics (eg, age, ethnicity, high school and college grade point average [GPA]) as well as relevant psychological and physical history. The Personal Health History Questionnaire included inquiries about ADHD diagnostic status, ADHD medication status, impairment related to the presence of ADHD symptoms, presence of alcohol and substance use difficulties, current and past psychiatric status (including history of treatment), and history of head injury.

2.2.2. Wender Utah Rating Scale [4]

The 25-item version of the WURS was administered as a self-report measure of childhood ADHD symptoms. On the WURS, participants are instructed to rate each item on a 0 (“not at all or very slightly”) to 4 (“very much”) scale, and items are summed to compute a total score ranging from 0 to 100. A score of 46 or greater has been suggested as the cutoff score for identifying adults with ADHD [2].
2.2.3. Beck Depression Inventory-II [16]

Participants completed the BDI-II to assess for the presence of current depressive symptoms. The BDI-II is a self-administered 21-item instrument that measures the presence and severity of depressive symptoms in adolescents and adults 13 years and older. Items on the BDI-II have been designed to correspond to criteria for diagnosing unipolar depressive disorders found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994). For each item, participants are asked to select 1 of 4 statements that best characterizes their mood and functioning during the past 2 weeks. Items are summed to yield a total depression score, with higher scores representing greater symptom severity.

2.3. Statistical analyses

After basic descriptive statistics and examination of standard WURS cutoff detection rates separately by sex, we used ROC analyses to compare the combined ADHD groups to the control groups, separately by sex. Because the present sample consisted of non–treatment seekers as in the Stein et al [12] study, but used a short form of the WURS, consistent with McCann et al [13], we did not feel that the factor analytic results of these prior studies could support use of confirmatory factor analysis with the present data. Instead, we conducted exploratory factor analyses for males and females separately, as well as for the whole sample, to look for factor stability within the present dataset. We used principal components analysis with varimax rotation because this method has been suggested for use when identifying factors that will be used to derive subtest scores [17]. Finally, we compared subscale scores identified by factor analysis in those with ADHD relative to relevant control groups using ROC analyses to determine whether the subscale scores could be useful in diagnosis.

3. Results

Groups were not different in age or self-reported college GPA. There were differences in distribution of sex among the groups; proportionally, more males were in the ADHD group, whereas the other 3 groups had similar sex distribution (Table 1). In the ADHD group, 31 (50%) reported current ADHD medication use (4 Ritalin, 14 Adderall, 2 Strattera, 8 Concerta, 1 Focalin, 1 other, 6 multiple medications). In the ADHD comorbid group, 18 (43%) reported currently taking medication for ADHD (6 Adderall, 1 Strattera, 3 Concerta, 1 Focalin, 1 other, 6 multiple medications).

3.1. Standard WURS cutoff analysis

Using the standard WURS cutoff of 46 resulted in a 2% false-positive rate (4% male, 1% female) in the control group and a 16% false-positive rate in the psychological control group (25% in males, 13% in females). This cutoff correctly identified only 17% of the ADHD group (24% of males, 5% of females) and 64% of the ADHD comorbid group (62% of males, 65% of females). Thus, this cutoff was not particularly sensitive to ADHD and showed high false-positives in the psychological control group, especially among males.

3.2. Receiver operating characteristic curve analyses

Receiver operating characteristic curve analyses were used to explore accuracy of detection for the WURS total score and to identify alternative cutoffs for each sex that might improve diagnostic efficiency. To make sex analyses more stable, we combined the 2 ADHD groups into one ADHD group for these analyses. When comparing the combined ADHD group to the controls, results suggested reasonable discrimination of groups, with area under the curve (AUC) = 0.78 for males (SE, 0.035; P < .001) and AUC = 0.86 for females (SE, 0.028; P < .001). However, when comparing the combined ADHD group to the psychological controls, diagnostic efficiency was lower, particularly for males, with AUC of only .50 (SE, 0.06; P = .97). For females, AUC suggested lower but still effective discrimination of groups (AUC = 0.70; SE, 0.04; P < .001). Given the importance of specificity, we used the AUC curves to identify cutoffs scores that would allow for 90% specificity in the psychological control group, which resulted in cutoff scores of 59 for males and 53 for females. These scores only successfully identified 15% of the ADHD males and 18% of ADHD females, respectively.

3.3. Factor analysis and subscales

Using data from the whole sample, we conducted a principal components analysis with Varimax rotation, which resulted in a 5-factor model that accounted for 62% of the total variance. The 5 factors were conduct problems, impulsivity problems, mood difficulties, inattention/anxiety symptoms, and poor academic functioning (Table 2). When the principal components analysis was conducted separately by sex, the same factors with the same item loadings emerged for the males, and the same factors but with slightly different item loadings emerged for females (a few impulsivity items loaded more highly on the mood difficulties factor instead of the impulsivity problems factor). The results of the factor analysis for the total sample were used to create 5 WURS subscales. Internal consistencies for each subscale were reasonable; Cronbach α for the conduct problems scale was .88 (8 items); for the impulsivity

Table 1

<table>
<thead>
<tr>
<th>Demographic information for the 4 groups</th>
<th>ADHD mean (SD)</th>
<th>ADHD comorbid mean (SD)</th>
<th>Psychological control mean (SD)</th>
<th>Control mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>19.2 (1.1)</td>
<td>18.9 (0.9)</td>
<td>19.2 (1.2)</td>
<td>19.1 (1.1)</td>
</tr>
<tr>
<td>Self-reported GPA</td>
<td>2.2 (0.8)</td>
<td>2.3 (0.8)</td>
<td>2.4 (0.7)</td>
<td>2.4 (0.7)</td>
</tr>
<tr>
<td>% Female</td>
<td>34</td>
<td>61</td>
<td>78</td>
<td>64</td>
</tr>
</tbody>
</table>
We then compared the 4 groups on the 5 subscale scores (Table 3). Follow-up testing showed that the control group scored lower on all scales relative to the other groups (all $P < .001$). In addition, the ADHD comorbid group scored higher on all scales relative to all other groups (all $P < .001$), with the exception of academic difficulties relative to the ADHD group ($P = .006$). The ADHD group scored significantly lower than the psychological control group on the mood difficulties scale ($P < .001$) but significantly higher on the inattention/anxiety symptoms and academic problems scales (both $P < .001$). Collapsing across groups, males scored significantly higher on all subscales than females (all $P < .005$), with the exception of mood difficulties ($P = .06$).

Finally, using ROC analyses, we compared the combined ADHD groups to the controls, separately for males and females. Results for males suggested that all subscales except mood difficulties showed reasonable discrimination of groups, with AUCs ranging from 0.66 (mood difficulties) to 0.84 (inattention/anxiety symptoms) for males (all $P < .001$). For females, all subscales showed good discrimination of groups, with AUCs ranging from 0.74 (conduct problems) to 0.89 (inattention/anxiety symptoms) (all $P < .001$). As when using the WURS total score, comparing the combined ADHD group to the psychological controls resulted in lower diagnostic efficiency for the WURS subscales, particularly for males. In the males, AUCs ranged from 0.44 (conduct problems) to 0.65 (inattention/anxiety), which was the only score to obtain significance ($P < .05$). For females, the mood difficulties scale (AUC = 0.52) and the conduct problems scale (AUC = 0.60) did not significantly discriminate groups. However, AUCs for the impulsivity scale (0.70), the inattention/anxiety scale (0.80), and the academic problems scale (0.75) suggested good discrimination of groups (all $P < .001$). We then used the AUC curves to find cutoffs on the 3 subscales that would obtain close to 90% specificity in the female psychological controls (14 for impulsivity, 11 for inattention/anxiety, and 5 for academic problems). Having 2 of the 3 subscales fall at or above the cutoffs resulted in correctly identifying about 41% of the ADHD females, with 99% specificity in the controls and 89% specificity in the female psychological controls.

### Table 3

<table>
<thead>
<tr>
<th>WURS subscale</th>
<th>ADHD group, $n = 58$</th>
<th>ADHD comorbid group, $n = 33$, mean (SD)</th>
<th>Psychological control group, $n = 162$, mean (SD)</th>
<th>Control group, $n = 1058$, mean (SD)</th>
<th>$F$</th>
<th>2-tailed $P$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct problems</td>
<td>9.3 (7.5)</td>
<td>14.2 (8.0)</td>
<td>8.9 (7.1)</td>
<td>4.8 (5.2)</td>
<td>57.95</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Impulsivity problems</td>
<td>6.7 (4.6)</td>
<td>11.3 (5.6)</td>
<td>6.1 (5.5)</td>
<td>3.2 (3.6)</td>
<td>72.79</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Mood difficulties</td>
<td>2.5 (2.9)</td>
<td>5.9 (3.9)</td>
<td>3.8 (3.2)</td>
<td>1.3 (1.9)</td>
<td>98.21</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Inattention/anxiety</td>
<td>8.2 (4.3)</td>
<td>11.0 (3.5)</td>
<td>5.6 (3.9)</td>
<td>3.1 (2.9)</td>
<td>123.53</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Academic problems</td>
<td>3.2 (2.6)</td>
<td>4.4 (2.9)</td>
<td>2.1 (2.7)</td>
<td>1.2 (1.8)</td>
<td>47.44</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
4. Discussion

Overall, the present results were consistent with prior studies showing that retrospective report of childhood ADHD symptom is generally not specific to the disorder. However, results suggest that consideration of specific types of symptoms and sex differences in presentation may improve diagnostic specificity of retrospective self-reported symptoms. The original short-form WURS cutoff score of 46 was not sensitive to ADHD in this sample. Although one reason for low sensitivity may be that it was not a sample of individuals currently seeking clinical services for ADHD, the ADHD group consisted of individuals who had been previously diagnosed and who continued to report symptoms at the present time, and about half of them were still taking medication for ADHD. In the context of low sensitivity, the false-positive rate in the psychological control group is unacceptably high and all the more notable because individuals in this group were not taken from a treatment-seeking sample, where there is presumably a higher risk for retrospective report bias to influence report of childhood symptoms. Receiver operating characteristic curve analyses suggested that much higher scores would be required to obtain 90% specificity in the psychological controls (59 for males, 53 for females), which only further lowered sensitivity of the measure to ADHD diagnosis.

Factor analysis identified 5 factors on the WURS. As in the McCann et al [13] factor analysis of the short-form WURS, factors reflecting psychological symptoms, conduct problems, and academic problems were identified; in addition, we found factors that reflected impulsivity problems and inattention/anxiety symptoms. One possible reason for the difference in findings is that, unlike the clinic sample of McCann et al, the present participants were not seeking treatment or evaluation. Unlike the McCann et al study, but consistent with the analysis of Stein et al [12] of the long-form WURS in a nonclinical sample, our factors were stable across sexes. Using subscales based on the factors derived, ROC analyses showed that no subscales effectively discriminated male ADHD from psychological controls, but that subscales reflecting impulsivity, inattention/anxiety, and the presence of poor academic functioning could still effectively discriminate ADHD from psychological controls in the female sample. The finding that academic problems in childhood may be useful to adult ADHD diagnosis, at least in females, is consistent with the findings of McCann et al [13]. However, problems remained in identifying an index of clinical impairment on the subscales that would be relatively specific to ADHD and yet also sensitive to the disorder. Obtaining scores above the cutoffs on 2 of the 3 subscales showed good specificity, although such a score only detected 41% of the female ADHD sample. Future studies should examine these subscales and cutoffs in treatment-seeking samples to further explore their usefulness in ADHD evaluation.

The present study has additional limitations that must be considered when interpreting the results. The presence/absence of prior ADHD diagnosis and current psychological diagnoses or symptoms were based on the participant’s self-report of having received these diagnoses from other health or mental health providers rather than based on clinical interview or review of medical records. Although this is a limitation of the present data, this is not an uncommon situation faced by clinicians during an initial intake session with an adult client presenting with concerns about ADHD symptoms. In addition, we did not have enough information from participant self-report to clearly determine ADHD subtype, which may have been a factor in the types of childhood symptoms reported by those diagnosed with ADHD. It is possible that some of the sex differences in our findings were related to differences in ADHD subtype, ADHD comorbidities that differ between the sexes, or even a sex bias in diagnosis (ie, the females in our sample who had ADHD diagnosis received that diagnosis only if they presented with particularly severe symptoms) [14,15]. Another limitation is that the sample consisted of young adults attending a university, suggesting that even those carrying an ADHD diagnosis were relatively high-functioning individuals. Given this, however, the high percentage of false positives in this nonclinical and high-functioning sample is perhaps of even more concern.

The main implication of the present findings is that clinicians cannot rely on self-reported retrospective childhood ADHD symptoms to be either sensitive to or specific to ADHD. Evidence for retrospective symptoms of ADHD in adults presenting for the first time with concerns about ADHD should include (1) assessment of presence of and severity of childhood symptoms, including documentation of real-world dysfunction (results suggest that records pertaining to academic performance may be of particular value); (2) information from multiple informants as well as existing records; (3) consideration of differential diagnostic issues and psychological comorbidities when assessing the clinical significance of obtained information [18]; and (4) consideration of potential sex differences in current and childhood symptom presentation.

References


