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Case Report **Psychiatry**

Clinical Reflection Through Her Child: Presentation of A Case of Attention Deficit Disorder in Adulthood in A 35-Year-Old Woman

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Abstract

***Introduction**:* Attention Deficit Hyperactivity Disorder (ADHD) is a common neuro-developmental disorder that persists into adulthood in nearly two-thirds of cases. In adults, particularly in women, it often remains underdiagnosed, masked by anxiety or depressive disorders. Since familial transmission is well documented, a diagnosis in a child can sometimes be revealed in a parent. ***Observation**:* We report the case of a 35-year-old single mother presenting emotional exhaustion and relational difficulties with her 7-year-old son recently diagnosed with ADHD. The patient's developmental trajectory and life course suggested adult ADHD, reassured by the positive screening on the Adult Self-Report Scale for ADHD (ASRS-v1.1). The patient presented parental exhaustion with a marked reluctance towards psycho-stimulant treatment. Psycho-education was initiated and she agreed to take symptomatic treatment with hypnotics and anxiolytics. ***Conclusion**:* This case illustrates the diagnostic complexity of adult ADHD, often masked by depressive comorbidities and anxiety-inducing emotional exhaustion. Diagnosis in children should prompt systematic exploration of the parents' developmental history. It also highlights the obstacles related to pharmacological treatment, particularly when the previous experience of psychotropic drugs is negative. The mother-child mirror effect reveals the intergenerational dimension of the disorder. Progressive support, respectful of therapeutic resistance, appears essential to encourage adherence to care, thereby improving the quality of the mother-child relationship.

Keywords: Adult ADHD, transmission, intergeneration, parental burnout.

INTRODUCTION

Attention deficit hyperactivity disorder (ADHD) is characterized by a symptomatic triad: attention deficit, hyperactivity, and impulsivity. It is a nosographic entity described among neuro-developmental disorders. Its prevalence is estimated at approximately 5% in children and 2.5 to 3% in adults [1-3].

ADHD does not disappear in adolescence, contrary to a long-held belief. It persists into adulthood in 50 to 70% of cases. At this age, the clinical picture is often dominated by attentional and organizational difficulties, and verbal or emotional impulsivity, rather than motor hyperactivity. These symptoms lead to significant impairment in psychosocial and occupational functioning [4-6].

The genetic and familial dimension of ADHD is well established. Children of affected parents are at increased risk of developing the disorder. Studies show an estimated heritability of 70-80% [7].

We report the case of a patient with maternal exhaustion and reactive depressive syndrome, whose son was diagnosed with ADHD. Her developmental history and clinical presentation suggested previously undiagnosed adult ADHD.

OBSERVATION

Ms. X, 35, was the mother of a 7-year-old child. She lived alone in an apartment with her son. She worked as a facilitator and life coach, with temporary assignments in large retail stores. She had been unemployed for 8 months before the start of the consultations.

At the age of 22, Ms X reported having undergone a voluntary termination of pregnancy at 12 weeks of amenorrhea, following the discovery of a fetal malformation. She became pregnant for a second time at the age of 27. Her ex-partner reportedly suggested she terminated the pregnancy again. Her refusal was a source of conflict, and the couple separated four months later.

Exploration of her developmental trajectory and her school career revealed that she was motorically unstable. Her mother described a troubled childhood, with a notion of impulsiveness; "*I was worse than my son, according to my mother.*" she added.

At school, she was described as talkative, disruptive to her classmates, and unable to wait for her turn.

In her personal history, she reported child psychiatric care since childhood (around the age of 5). She was diagnosed with anxiety and depression.

The treatment required a prescription for antidepressants and anxiolytics, which she struggled to wean herself off. She stopped attending appointments at the age of 17 and has not taken any medication since then. According to her, there was no evidence of addictive behavior.

Ms X's professional life was marked by frequent job changes due to recurring conflicts with her colleagues and superiors (with impatience, verbal aggression, intolerance of others' slowness).

As for family history, her mother was being treated for depression. For nearly a year, her son had been receiving treatment at the child and adolescent medical-psychological center.

Ms. X had brought him to see a neuropsychologist because he wasn't sleeping at night and was distracted. In addition, her son was oppositional at home and had difficulty following instructions. According to her, bedtimes were complicated, as her son could spend more than three hours in bed before falling asleep.

Following neuropsychological assessments, the child was diagnosed with ADHD. Academic and social adjustments were made. Academically, she reported improved grades, but at home, she still complained of difficulty controlling her son.

In this context, Mrs. X came for a consultation requesting psychosocial support. She reported feeling lost and she described a psychological exhaustion (a term she used). She complained of insomnia and anxiety attacks. Indeed, she said she had to stay up for several hours waiting for her son to sleep. She fell asleep around 2:00 a.m., woke up around 6:00 a.m., and did not take a nap.

She was unemployed because, according to her, she could not hold down a job while caring for and monitoring her son. He sometimes spent days at his grandmother's house, where he was taken in during vacations and holidays to relieve her daughter (Mrs. X).

Psychiatric assessments indicated good but hyper-syntonous contact. Ms. X was distracted by hallway noise during interviews and had difficulty tolerating bright lights. Her facial expressed anxiety but her speech was without content disturbance. Her words were uttered in an audible, non-monotonous voice; however, she was sub-logorrheic at times and lost track of the conversation. She described her condition as mental fatigue: "*My body no longer keeps up with my brain; I think my brain is too accelerated compared to my mouth. I want to say everything at once and nothing at the end.*"

She had insomnia with early awakening, which she struggled with during the day without daytime sleepiness. However, she also felt physically tired. She spent her days either on the couch, putting off her planned task, or moving around the house to clean when she realized she had gone more than five days without vacuuming.

She left the house less and less, only seeing one friend with whom she spent time on weekends. According to Ms. X., the others were "slowed down" compared to her pace. She said that her friends took time to understand her jokes and could not keep up with her conversations. This led to misunderstandings which she said led to her preferring to be alone. She often procrastinated, especially when it came to managing work reports, shopping, and meeting reports. At work, she needed to write down her ideas; otherwise, she would forget them, which made her moody and irritable with colleagues, she said.

During the interviews, Ms. shifted in her chair, her foot hitting the table several times. She did not hesitate to apologize for this, describing herself as clumsy. She reported having difficulty accepting authority and respecting the framework. She explained this with these words: "*The only thing that prevents me from being myself is the law and the only person who could manage me was my father, I was afraid of him, even though he wasn't violent.*" "*He told me that I was 'too' this, 'too' that! But I refused to admit it.*"

Her mood was euthymic; however, she described anxious ruminations, especially in the evenings, related to her socio-professional situation according to her. In fact, Mrs. X. was no longer able to meet her financial needs since she became unemployed and her mother helped her manage certain expenses. She had feelings of guilt, of being a bad mother and a loss of self-esteem: "*It's like I'm glitching. I regularly refocus myself, things that seem simple require a lot of concentration and I feel bad about it. I wonder if I have missed something in my son's education.*" she said.

Behaviorally, she frequently lost items and relied on a diary to remind her of tasks. She also reported difficulty driving her car long distances due to fear of running traffic lights.

Finally, the Adult Self-Report Scale for ADHD (ASRS-v1.1) screening test was administered to Ms. X. The results obtained indicated a total of 10 boxes checked in the shaded area of parts A and B.

Regarding her care plan, the patient had initially refused any medication due to a negative experience with psychotropic drugs in childhood. Indeed, she reported having been taking antidepressants for years and had great difficulty stopping them.

She gradually agreed to take a hypnotic and anxiolytic medication to improve her sleep after 8 months of follow-up. Supportive psychological therapy, including psycho-education about ADHD, was initiated at the same time. The goal was to improve her understanding and acceptance of the specific psycho-stimulant-type treatment, which she had still not started.

DISCUSSION

- Limits of the work

This is a single case, which limits generalizability. The diagnosis is based on the history, the evolution of the symptomatic picture and the supportive elements according to the ASRS-v1.1 test. Althought the diagnosis of ADHD remains clinical, the administration of standardized diagnostic tools (such as the DIVA: Diagnostic Interview for ADHD), would reduce the risk of bias. The concomitant presence of a depressive syndrome complicates the interpretation of attentional symptoms. Finally, the observation is part of a restricted temporality, not allowing to evaluate the long-term effectiveness of the treatment nor the evolution of mother-child interactions.

- Diagnosis complexity of adult ADHD

Adults with ADHD may present with common comorbidities such as anxiety disorders or borderline personality disorders complicating diagnosis [8].

The presence of anxiety-depressive symptoms, fatigue, and stress intolerance may mask underlying symptoms. In our case, maternal exhaustion and reactive depression were prominent, delaying the consideration of ADHD.

Diagnosis with bipolar disorder (or even a combination of both) can be difficult. Increased energy, distractibility, impulsivity, hyperactivity, irritability, and a tendency toward logorrhea may suggest a manic syndrome. However, the episodic nature of bipolar disorder should be considered in comparison to the persistent nature of ADHD [9].

Symptoms such as emotional dysregulation, mind wandering, and sleep-onset insomnia are commonly observed in ADHD. Studies show that this coexisting emotional disturbances improves after treatment along with the core symptoms. This suggests considering it as a clinical entity, rather than a separate comorbid disorder [10].

From a pathophysiological perspective, in people with ADHD, the nervous system would present a weak connectivity between the insula (responsible for inhibiting emotional responses) and the amygdala (managing decision-making), and this would contribute to the lack of emotional control.

The diagnosis remains to this day based on a thorough clinical evaluation and on the criteria established by the Diagnostic and Statistical Manual of Mental Disorders, revised text (DSM-5-TR), see Table I [1].

Table I: DSM 5 criteria for attention-deficit/hyperactivity disorder (ADHD) [1]

A. Presence of either 1) or 2): 1) Six (or more) of the following symptoms of inattention have persisted for at least six months to a degree that is maladaptive and inconsistent with the child's developmental level. **Inattention:** a. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities b. Often has difficulty sustaining attention in tasks or play activities c. Often does not seem to listen when spoken to directly	e. Is often "on the go" or acts as if "driven by a motor" f. Often talks excessively Impulsivity: g. Often blurts out answers before questions have been completed h. Often has difficulty waiting for his or her turn i. Often interrupts or intrudes on others (e.g., butts into conversations or games)
	B. Some hyperactive/impulsive or inattentive symptoms that caused functional impairment were present before age seven.

d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions) e. Often has difficulty organizing tasks and activities f. Often avoids, dislikes, or is reluctant to engage in tasks requiring sustained mental effort (e.g., schoolwork or homework) g. Often loses items necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools) h. Is often easily distracted by extraneous stimuli i. Is often forgetful in daily activities	**C.** There is evidence of some functional impairment from the symptoms in two or more settings (e.g., school, work, home).
	D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
2) Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least six months to a degree that is maladaptive and inconsistent with the child's developmental level. **Hyperactivity:** **a.** Often fidgets with hands or feet or squirms in seat **b.** Often leaves seat in situations when remaining seated is expected **c.** Often runs about or climbs in situations where it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness) **d.** Often has difficulty playing or engaging in leisure activities quietly	**E.** The symptoms do not occur exclusively during the course of pervasive developmental disorder, schizophrenia, or another psychotic disorder, and are not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).
	Clinical Subtypes: Combined type: Criteria A1 and A2 are both met for the past six months Predominantly inattentive type: Criterion A1 is met for the past six months, but not criterion A2 Predominantly hyperactive-impulsive type: Criterion A2 is met for the past six months, but not criterion A1

- Intergenerational transmission

The familial and hereditary nature of ADHD is well established. In a comparative study, Faraone showed that the group of first-degree relatives of people with ADHD are 2 to 8 times more likely than the control group to present this disorder. High heritability rates for ADHD, of approximately 71 to 90%, are described in numerous other studies [11, 12].

In our case, the recognition of ADHD in the boy led to the retrospective study of the maternal trajectory. Here, the symptomatic similarities between mother and son reinforce the hypothesis of intergenerational continuity, with a relational impact aggravated by the mirror effect. However, epidemiological data confirm the major role of the environment in addition to genetic transmission [7].

- Functional impact

Undiagnosed ADHD has significant consequences: professional instability, social isolation, parental burn-out and depressive vulnerability. For the patient, repeated conflicts in the workplace and the inability to maintain stable employment demonstrate a major impact. Parenthood is weakened, with a risk of a vicious circle reinforcing the child's disorders and maternal exhaustion [13].

Mrs. X was overcome by low self-esteem, which would explain her feeling of not being up to the task of raising her son. This also constitutes a source of psychological vulnerability conducive to the occurrence of depressive symptoms [7].

The findings that adult ADHD is associated with unemployment are broadly consistent with the findings observed in our case. The financial repercussions are compounded by the daily struggle with chronic difficulties, giving the impression of a chaotic and anxiety-inducing personal life. Furthermore, other studies have shown that mothers of children with ADHD suffer more from anxiety and depression disorders and take more antidepressants than control mothers [14].

- Management

The combination of a psychostimulant, cognitive-behavioral psychotherapy focused on organization and emotional management, and parenting support constitutes an appropriate care plan. This involves correcting the attention deficit but also improving sleep, self-esteem and mood fluctuations. This treatment would also have a direct impact on the child, by reducing conflicts and strengthening educational coherence [15].

Non-pharmacological treatment includes family and social interventions and school and professional adjustments. For example, managing the family environment would make it possible to adjust daily life for Mrs. X and her son, to defuse the situation but also to consolidate external resources (carers such as the grandmother) [16].

However, the initial reluctance observed toward the proposed drug treatment would be part of a trajectory marked by diagnostic wandering and the prolonged prescription of psychotropic medications. This previous experience, characterized by unstable of clinical benchmarks and chronic drug treatment, seems to have

generated a loss of confidence in therapeutic approaches, which partly explains the reservation expressed regarding the new direction of care.

CONCLUSION

This case illustrates the challenges of diagnosing and managing adult ADHD, particularly from an intergenerational perspective. Identifying the disorder in children should prompt a systematic exploration of the parents' developmental history, given that in women, the symptoms may manifest primarily as emotional and relational instability rather than hyperactivity.

Recognition maternal ADHD not only improves in the adult's quality of life, but also provides better support for the child, thus breaking the cycle of symptom repetition and relational conflict.

Authors have declared that no competing interests exist.

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