Adult ADHD (Attentional Deficit/Hyperactivity Disorder) as a Specific Learning Difficulty

Guide to documenting a history of attentional and/or hyperactivity/impulsivity difficulties (2nd Edition: January 2014)

David Grant

'…..ADHD is …. *best evaluated by clinical diagnostic interview of the individual* with supporting evidence from informants'. P. Asherson, 2005, p529. Professor in Molecular Psychiatry, King's College, London. (My italics).

The guidance notes offered below, which are primarily about the life-history interview, are drawn from my experience of carrying out diagnostic assessments for Specific Learning Differences/ Difficulties. I would encourage specialist assessors to use them flexibly and to modify them in the light of their own experience.

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A. OUTCOME OF THE MAY 29TH 2013 SASC-CONVENED ADHD CONSENSUS MEETING

In September, 2013, SASC (SpLD Assessment Standards Committee) advised that 'practitioner psychologists and specialist teacher assessors **who have relevant training** can identify specific learning difficulties and patterns of behaviour that together would strongly *suggest* a student has ADHD; and in this situation they can make relevant recommendations for support at Further and Higher Education institutions'.

Background

For some years students with ADHD experienced significant difficulties in qualifying for the Disabled Students' Allowances if their diagnosis had been arrived at by anyone other than a qualified medical practitioner. Unfortunately, obtaining a medical diagnosis was (and still is) often a long-drawn-out affair due to the paucity of NHS provision across the UK, allied with a general lack of recognition of ADHD. (ADHD was only formally recognised as a valid diagnosis in the UK in 2008.)

Given that there is ample evidence of the strong link between academic underperformance/failure and ADHD (e.g. Wolf, L.E., 2006; Pope et al, 2007), in May 2013 SASC convened a Consensus Meeting, held at Oxford University and chaired by Professor Philip Asherson, an international expert on ADHD, to discuss whether specialist assessors could undertake diagnostic assessments for ADHD, to enable FE/HE students to qualify for the DSA and SpLD support by their institution. The outcome consensus was that specialist assessors could, with relevant training, undertake such assessments and make appropriate recommendations.

It is vital to note that such an assessment is for ADHD as a Specific Learning Difficulty. It is not a medical diagnosis.

Following the positive outcome of the consensus meeting, Guidance on ADHD for specialist assessors was placed on the SASC website (www.sasc.org.uk) in September 2013. This guidance is essential reading and should be checked regularly for updates, particularly as a decision has yet to be reached on what a relevant training programme should cover.

Specialist assessors interested in developing a professional expertise in ADHD are advised to regularly check the website for UKAAN (United Kingdom Adult ADHD Network) www.ukann.org for details of training courses and conferences. The PATOSS website www.patoss-dyslexia.org is another source of information.

B. LIFE–HISTORY INTERVIEW

B.1 General considerations

When seeking to ascertain whether an individual has ADHD as a specific learning difficulty, I find it helpful to bear in mind the advice given by Lorraine Wolf (2006):

> '...the diagnostic boundaries of hidden disabilities are unclear ….. comprehensive assessment must be multi-dimensional…..the key elements of the evaluation are history and neuropsychological, psycho-educational and psychological/emotional.' (p392)

That is, there is no clear cut-off point at which you can say ADHD is present/not present. Therefore, as a specialist assessor you need to be flexible, be prepared for a variety of outcomes, and to spend time on compiling a life history which is wide-ranging. It is also necessary to build a profile of educational and psychometric abilities through testing.

One key reason for taking a multi-dimensional approach is because ADHD is a syndrome. That is, there is a set of behaviours that, collectively, are indicative of the presence of ADHD. Conceptually, these behaviours are sub-divided into three categories:

1. ADHD of the Inattentive presentation;
2. ADHD of the Hyperactivity/Impulsivity presentation;
3. ADHD of the Combined presentation.

If it is suspected that ADHD is present, it is necessary to ensure that questions about life history and everyday experiences are designed to cover all aspects of this specific learning difficulty.

1. The presence of Inattentive ADHD is reflected in a range of experiences including poor time management, procrastination, distractibility, low boredom threshold, forgetfulness, daydreaming and poor concentration. However, there are occasions when a general difficulty with staying focused is replaced by an ability to become hyper-focused. If these behaviours are predominant and impact negatively on everyday life as well as on academic performance – and have done so for some years – it can be concluded that ADHD, primarily of the Inattentive type, is present.

2. ADHD of the Hyperactivity/Impulsivity presentation is reflected in such behaviours as restlessness, an excess of energy, risk-taking behaviours, and speaking out of turn. Once again, these need to be present at a level where they impact negatively on academic performance and everyday life.

3. ADHD of the Combined type will have features of both (1) and (2) above.

1 and 3 occur with about the same frequency, but ADHD (primarily of the Inattentive type) is the more difficult form to recognise.

The frequency of ADHD (primarily of the Hyperactivity/ Impulsive type) is quite low. Irrespective of which type is present, the symptoms occur along a spectrum. There is no clear categorical boundary.

Other aspects:

While attentional difficulties and/or hyperactivity/impulsiveness are the key defining features of ADHD, there is evidence (e.g. Brown, 2005) that *emotional lability* (sudden changes in mood) is another central feature of ADHD.

There is also substantial evidence that the incidence of *mental health issues*, such as anxiety attacks, depression or OCD (obsessive compulsive disorder), is much greater in individuals with ADHD than in the general population.

The same is true of *specific learning difficulties*. For example, I have found that about 35% of individuals I have diagnosed as having ADHD are also dyspraxic; another 15% approximately have ADHD combined with dyslexia; and approximately another 10% have ADHD combined with both dyslexia and dyspraxia or with another specific learning difficulty such as dysgraphia.

It is very clear that Wolf's advice – that a diagnostic assessment needs to cover emotional and neuropsychological aspects – has to be taken very seriously. These are additional dimensions to the core features of inattention, hyperactivity, and impulsivity.

B.2
David Grant's pre-assessment questionnaire

About two weeks before the assessment date I send a set of questions about early years experiences for the individual to go through with his/her parents/carer/ guardian. These questions are important in that most people know little about key details of their first couple of years.

Birth details, for example, are important, for when there is a history of birthing difficulties (such as a long, difficult labour and/or forceps delivery) or prematurity (particularly early prematurity before 32 weeks), the probability of a specific learning difficulty being present is significantly increased.

Secondly, it is helpful to obtain an independent answer to some questions (particularly about clumsiness, forgetfulness, poor concentration, and daydreaming).

The questionnaire I send is given below. (NB When an appointment is first made, I ascertain who is best placed to provide details about their early history and then tailor the email request based their answer.)

At the start of the assessment I cover early history. It would be helpful, if you have the chance, to cover the following questions with your mother prior to the assessment.

Was your birth on time, early or late? Were there any complications, such as a long and difficult labour? What was your birth weight?

Were there any health issues in your early years? For example, ear infections?

Did you begin walking and talking on time? If talking or walking was delayed, was speech therapy and/or occupational therapy provided?

Were you clumsy or well co-ordinated as a child? If clumsy, please provide examples?

Did you have any difficulties in infant/junior school with learning to read, spell, handwriting, maths? Please specify.

Did any of your school reports mention difficulties with concentration or poor attention span? If so, please provide examples?

Were you forgetful as a child?

Did you day-dream a lot as a child?

Were you always 'on the go' as a child?

How did you get on with other children?

B.3 Conducting the interview: areas to be explored.

In this section I have provided illustrative examples for each question. These are taken from reports I have written. (All names have been changed.)

Mental health issues

When asking questions about health I ask about *both physical and mental health* (specifically whether there is a history of depression). If a history of depression is reported I then ask when the first bout was, and if there was a trigger. For example, when an individual replies that it was triggered by the death of a close family member this is very different from a reply that the cause is unknown, or appears to be related to exam times. I also ask about medication. When an individual replies they are still on medication I then ask about side effects (in case their medication might impact on test performance, specifically tests that measure speed of responding). About 50% of the individuals I see with ADHD report a history of one or more bouts of depression.

Although Joe reported no history of broken bones or bouts of depression, he said he has suffered from generalised anxiety (a formal medical diagnosis) 'ever since I was little'.

Mary has experienced bouts of depression, the first when she was seventeen. The next was when she was nineteen-and-a-half and then when she was about twenty-five. Mary was prescribed medication but no longer needs to take it.

David has experienced several bouts of depression, the first when he was fifteen and the second when he was about 19. He has 'quite severe OCD' and has been provided with therapy.

Occasionally an individual will express concern over the reporting of mental health issues (including medication) in their diagnostic report. During the de-briefing stage I point out that when I send them a draft of their report for checking for accuracy they have the option of asking for details they consider sensitive to be deleted. I also advise that if they seek the advice of a medical practitioner and/or counsellor as a follow-up to their assessment then such details are important. I also point out I will provide a summary report (clearly titled as a summary report) on request. For individuals in work this can be sufficient to establish they have a specific learning difficulty. The summary still includes recommendations for support but does not cover the details of the assessment process.

It is important to remember that *you are not engaged in diagnosing mental health issues or their causes.* In documenting mental health issues you are creating a fuller profile of an individual, which contributes to the process of arriving at a conclusion that ADHD is/is not present. Importantly, it also aids the process of securing appropriate support.

In my experience it is not unusual to assess an individual who has been provided with medication for depression but whose ADHD has not been identified. In such a case there is a duty of care to advise that individual to discuss the outcome of their diagnostic assessment with a medical practitioner.

Broken bones, excess energy, restlessness

When asking questions about health I also ask whether there is a history of broken bones. A history of broken bones may reflect a number of factors, including clumsiness, risk-taking, a high level of sports activities, and inattention. I also ask whether the individual would consider themselves to be a restless type of person. Restlessness and excess energy are classic signs of hyperactivity and are reflected in a range of activities, including sports. On occasions physical exercise is deliberately undertaken to run off excess energy.

As restlessness, impulsivity and lapses of inattention can give rise to clumsiness, such as bumping into things, knocking things over and dropping objects, it is not always easy to differentiate clumsy behaviours due to these factors and clumsiness resulting from poor motor coordination and/or poor spatial awareness.

When asked whether she has broken any bones Zoe replied 'several fingers and toes and left arm'. She broke her arm through falling out of a tree and some of her other breaks came from falling over. She felt it would be appropriate to describe her as being accident prone when she was younger. Zoe described herself as being 'very restless' and enjoying sport at school because it was a means of running off excess energy.

On being asked about his behaviour at school, Ruari said his short attention span 'got me into a bit of trouble at school. I would often disrupt the class. I was constantly fidgeting and I couldn't sit still most of the time.' Although he was often sent out of class he got on well with his teachers because his misbehaviour was not aggressive. Since leaving school he has taken up ice-skating and boxing, but only for a few months in each case. Ruari described himself as being 'very restless' as a child, 'I had lots of energy' and he still gets restless.

When the different forms that clumsiness can take were discussed with Samantha, she said she sometimes bumps into things (especially with her hips and shoulders), knocks things over and 'drops things a lot'. Samantha disliked team sports at school but enjoyed gymnastics, dance and acrobatics. She was 'always good at PE and gymnastics' but had problems remembering dance routines. She has always been restless and recalled spending several hours each day as a teenager dancing at home. She found that doing this calmed her down.

When her clumsiness was discussed with Samantha she attributed this to impulsivity and lapses of attention rather than to poor motor coordination.

Reading behaviours

When ADHD is present distractibility is a significant issue and is reflected in a wide variety of activities, including reading.

I ask individuals to estimate how many books they have read for pleasure from cover to cover in their life, how many they have started but never finished, and why they find reading difficult when reading difficulties are reported. The number of books never finished when ADHD is present can be high, even when reading skills are very good. As both dyslexics and a number of dyspraxics also report a range of reading difficulties, the key feature to look for when asking these questions is the degree to which concentration slips away quickly.

> Athena recalled experiencing some difficulties with learning to read in the first year, but no problems after that. She has always read for pleasure and estimated she has read 'at least 100 books' from cover to cover. She has also started another 20 to 50 books that she has never finished. Athena struggles with remembering what she has just read and her concentration often drifts when reading - 'I read a sentence. Then my mind flies away'.

> His mother said Richard was very quick at learning to read and has always been a good reader. As a child Richard enjoyed reading but stopped at the age of eleven or twelve. Richard estimated he has probably read about ten books (excluding textbooks) from cover to cover, and has started about another twenty that he has never finished. He explained that if he finds a book 'not interesting' he stops reading it. He finds it difficult to maintain focus when reading as his 'mind drifts'.

Visualisation (including synaesthesia)

I initially began asking questions about visualisation some years ago after encountering individuals who achieved a high score on the Digit Span test through visualising numbers. *This is important for the effective use of visualisation on tests of Working Memory can mask a significant Working Memory weakness.* This is the case for about 10% of the individuals I see with ADHD, and to a lesser extent for other specific learning difficulties. There are occasions when an individual makes effective use of visualisation on one, or more than one of the three WAIS-IV tests of Working Memory. When this happens I record their test score/s as being unreliable and explain why.

A series of numbers (4, 9, 7, 3, 2) was read out and Neil said he memorised them by repeating and 'seeing them'. Many of the numbers were coloured: (*2* red; *4* pink; *7* black; *8* brown; *9* lime/apple green.) Neil said his colour combinations might reflect time he spent playing snooker. When asked to add 27 and 8 he reported being able to 'see it as an equation'. The numbers this time lacked colour. ……Neil reported using visualisation on both the Digit Span and Letter-Number Sequencing tests so it is necessary to treat his Index figure for Working Memory with considerable caution, since it is highly likely it has been enhanced through his use of visualisation.

Since beginning to routinely ask questions about visualisation it is my experience that, for some individuals with ADHD, visualisation is crucial to understanding how they experience their world, for it provides them with a means for understanding and remembering. *While for many it can be seen as a bonus for some it can also be a distraction.* Ease of distractibility is a key ADHD feature. This can happen when a word triggers an image, which then changes the direction of attention from what is being said to the evoked image.

As words often trigger layers of associations (images and emotions), Josephine frequently experiences sensory overload: 'it happens when reading quite a bit'. Even the thought of having to read a text can give rise to an impending sense of overload.

I have also observed that about 25% of individuals with ADHD also report synaesthesia (that is, the binding of one item with another from a different sense, e.g. *Tuesday* is royal blue, *Wednesday* is lime green). This figure of about 25% compares with a figure of 4.4% for an undergraduate population (Simner *et al,* 2006). Occasionally synaesthesia creates such a complex experience it gives rise to sensory overload. Sensory overload has been reported for some individuals with ADHD. When this mental overload becomes too much the individual will take time out to enable their mind, as it were, 'to cool down'.

I now routinely explore imagery (including synaesthesia) for reading, words, music and numbers. An example of complex synaesthesia is given below.

When Alisha is thinking about music, B Flat is crimson and E bright orange. She experiences different combinations of colours when listening to music. Her imagery for words is very strong.

Giraffe triggered an image of 'a block of the neck' and *panda* a mental picture of the animal. *Medieval* conjured up an image of the Flemish painting of the Madonna and Child and *Catherine* evoked an image of Catherine of Aragon. When given the word *Tuesday,* Alisha reported a flash of colour (lavender/indigo) and she then 'saw' the word in the same colour, but with a black and red edge to the letters *u* and *t*.

There are times when Alisha's very strong visualisation impedes her ability to arrive at a verbal response and her complex synaesthesia sometimes gives rise to a sensation of sensory overload.

NB A strong visualisation ability is not a unique ADHD feature. However, for some its positive features (e.g. excellent visual memory) can be cancelled out by negative features (distractibility and sensory overload).

Attitude towards practice, coursework and revision

A low boredom threshold and procrastination are characteristic ADHD experiences. These are revealed in a dislike of practising a skill, switching from one activity to another after a short time, and putting off homework/coursework until the last minute. While these behaviours are also reported by many individuals without ADHD, it is the degree of severity allied with constancy over time that characterises ADHD.

John's comment that school homework and university coursework was '*always last minute, rushed, late*' captures both his high level of procrastination and poor time management over a period of many years.

On being asked about her attitude towards practice (for music and dance) Esmeralda replied, 'I never practised'. In general she becomes bored quickly and swops one activity for another on a frequent basis. Esmeralda has always left doing homework until the last minute. Her school reports frequently drew attention to her poor time management in terms of not being on time, erratic attendance, and not handing in work.

Sita said she was always been prone to leaving homework until the last minute and sometimes failed to hand it in. (NB This is still the case at university.)

Sita said her school reports frequently described her as not fulfilling her potential and sometimes expressed concern about poor presentation. Her mother said Sita's reports commented that she was 'easily distracted and always talking'.

Time management

Ease of distractibility is reflected in poor time management, with the consequence that activities take longer than anticipated to complete and are often late in being completed.

Paul's second year was marred by absence and lateness, to the extent he was required to withdraw from the course. Paul explained that in his first year his hall of residence was very close to the university so it was very easy to be on time. In his second year he lived some distance from the university and his disorganisation became a significant issue.

Daniela described how, in spite of starting work on essays in plenty of time (about a month before the submission date), she then has difficulty sustaining work on an assignment in spite of her good intentions. Procrastination is a big issue for her, with the consequence that she never completes work until the last minute. She has handed in three of four assignments a day late.

NB In my experience it is issues of lateness in handing in work or for lectures and tutorials, plus procrastination over starting work on assignments and revision, that result in students with undiagnosed ADHD first seeking advice.

Concentration

Irrespective of diagnostic outcome I always ask individuals whether they have good concentration or have a mind that wanders easily. In general, most people described themselves as having a mind that wanders easily. It is essential to explore this in detail to be sure it is of a severity that is characteristic of ADHD. This means looking for examples of poor attention span (frequently expressed in terms of being easily distracted and procrastination) across a range of activities, not just educational ones. It gives rise to what I call the 'Good Intentions Syndrome', that is fully intending to do something but either putting it off until the last minute or not doing it at all.

On being asked about his ability to concentrate, David replied 'it depends'. If he is interested in an activity he can be focused, but otherwise he finds it difficult to maintain focus. He is easily distracted and very prone to procrastination. He said this impacts on all aspects of his life, 'chores, paying bills, returning text messages'. David is quite familiar with the 'good intentions syndrome' (intending to do something but never quite getting round to doing so).

On being asked whether he finds it hard to maintain concentration, Evan replied that his mind wanders 'exceptionally easily' and this gives rise to significant time management and organisational problems. Evan pointed out his ability to focus is much better when he is immersed in an activity that he is enthusiastic about. (NB An example of hyper-focusing.) In general, he feels that his problems with attention have a negative impact on his everyday life (e.g. when engaged in conversations). He said he can be 'quite impulsive' at times and he gave as an example starting to answer exam questions without sufficient consideration.

Forgetfulness

Many individuals with ADHD report being very forgetful. Sometimes this is the case even when they score well on tests of Working Memory. It is as if the presence of ADHD amplifies forgetfulness.

I always ask questions about forgetfulness, whether to-do lists are made, and whether the individual is prone to misplacing or losing items.

Nial was asked whether he has a good memory or is forgetful and he replied it varies, in that he can forget things like his keys or to go to a meeting, but can recall events he has visualised, 'as if watching a DVD'. He has tried making himself lists of things to do and using diaries, but 'it doesn't work'. He is very prone to misplacing or losing items.

C. ADHD RATING SCALES

C.1 List of rating scales

Highly recommended DIVA 2.0 (Diagnostisch Interview Voor ADHD)

Other scales include:

DSM-5

Brown Attention-Deficit Disorder Scales

Connor's Adult ADHD Rating Scales

Wender Utah Rating Scale

Copeland Symptom Rating scale for Adult ADHD

Pilot Adult Self-Report Scale (ASRS)

C.2 Description of scales and advice on administration

The DSM-IV ADHD Rating Scale is the most commonly used rating scale, (Asherson, 2005) and it is found in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. It is recognised internationally. This scale consists of a total of 18 items and covers the three subtypes.

In 2013 DSM-5 was published. DSM-5 has maintained both the DSM-IV triptych distinction and the 18 behavioural items, the latter with a minor rewriting. In addition, some examples of typical behaviours for each item are now given. Key changes include a lowering of the threshold criteria for adults (from 6 to 5 behavioural items) and age of onset of signs (raised from 7 to 12 years). ADHD is now classified as a neurodevelopmental disorder, the same category as dyslexia, dyspraxia and math impairment.

As the DSM-5 rating scale does not cover emotional lability, I have added an additional item: *Do you often experiences rapid mood changes, such as frustration or anger*.

DIVA 2.0 (Diagnostisch Interview Voor ADHD) Diagnostic Interview for ADHD in adults.

This scale is essentially a revised version of the DSM-IV but is much more structured and can take about 90 minutes to complete.

The diagnostician is advised to complete this structured interview with both the individual with suspected ADHD and an individual who knows that person well – at the same time. Each behavioural statement has been re-written for adults and a set of behavioural examples are given against each item. For example, when asked the question, 'Does it often seem as though you are not listening when spoken to directly?' the individual is then given a range of examples for both adulthood (e.g. Dreamy or preoccupied) and for childhood (e.g. Not knowing what parents/teachers have said).

As DSM-IV was perceived as being the Gold standard at the time DIVA was under development it was validated against DSM-IV. (As DSM-IV/DSM-5 are essentially the same there are no grounds for suspecting any change would be found if re-validation was undertaken.)

DIVA is available for use, free of charge, and can be downloaded from www.divacenter.eu. It is available in a variety of languages, including English.

Although DIVA 2.0 takes some time to administer and – ideally - requires the presence of an individual who knows the person being assessed for ADHD, for assessors new to undertaking ADHD assessments it is a good training tool to ensure all key behaviours are systematically covered and to gain confidence in arriving at a valid diagnosis.

As DIVA 2 was not designed specifically to capture a range of academic activities it is still necessary to ensure these are covered when taking a detailed developmental history.

Once experience has been gained, it is possible to move to using the DSM-5 self-rating scale. I start by ask individuals to write against each item whether the behavioural description is a good description of themselves, does not apply, or applies sometimes.) I then asked them to go back through the ratings they have given themselves and write down a current example of a relevant behaviour for each item they have identifying as fully applying. When possible I also ask someone who knows that individual well (usually the mother) to independently complete the scale.

The self-ratings and written comments are then included in the report as an appendix.

Several examples are given below, including one to my question on emotional lability.

> Do you often avoid, (or do you have an aversion to, or are willing to do) tasks that require sustained mental effort [such as coursework and revision]? *Yes - It's like a mental block*, *but when I do focus I do really fantastic work but it's always very late*.

> Are you often on the go or do you often act as if 'driven by a motor'? *Yes - I don't like sitting around, had 3 jobs at one point because of this*.

Do you often talk excessively? *Yes – I talk through lectures, often shushed*.

Do you often experience rapid mood changes, such as frustration or anger?'

Judy's mother said this was a good description of her daughter: '*Yes. Judy's mood can alter dramatically very quickly.'*

Under no circumstances can the use of DSM-5, DIVA, or any other rating scale, be used to arrive at a diagnosis of ADHD without the taking of a developmental history, allied with testing for educational and neurocognitive abilities.

Other Rating Scales:

There are a number of other rating scales but a number are not free to use and require a certain level of test administration and competence to be demonstrated before a scale can be purchased (e.g. The Brown Attention-Deficit Disorder Scales). Even if an individual can provide a publisher with evidence of testing competence this does not necessarily mean they have the appropriate level of expertise in the administration and diagnosis of ADHD.

Rating scales that are freely available require even more caution be exercised in the interpretation of a rating score.

Brown Attention-Deficit Disorder Scales

Tom Brown has an international reputation as an ADHD expert and has developed a model of ADHD that encompasses six domains. This is reflected in the scales he has developed. These take about 10 to 20 minutes to administer and there are norms for a wide range of ages. It is not restricted to psychologists. The qualification standard required is CL2R (Pearson Assessment).

The **Connor's Adult ADHD Rating Scales** is based on the DSM and is rated by the diagnostician.

The **Wender Utah Rating Scale** requires an adult to describe their childhood experiences with only about half being related to ADHD. It has a higher threshold level than the DSM-IV (Rosler et al, 2008) so could result in some cases of ADHD being missed if the diagnosis was only based on the use of this scale.

Two other scales are the **Copeland Symptom Rating scale for Adult ADHD** (which is broad-based) and the **Pilot Adult Self-Report Scale (ASRS)**, which is based on DSM-IV but has adult-specific language. However, the ASRS is designed as a screening tool. Its variant, the **ADHD Rating Scale**, is designed for use with children.

The ASRS consists of two sections. Part A consists of DSM-IV 6 behavioural statements, 4 of which are from the Inattentive list, and 2 from the Hyperactivity/Impulsivity list. These 6 are described as being the most significant ones. Part B consists of the remaining DSM-IV statements. It can be viewed at: http://m.psychiatrictimes.com/clinical-scales/ADHD/ASRSv1.html#Q1

My personal recommendation: use either DIVA-2 or DSM-5.

Administration and interpretation

If you know beforehand that an individual has been referred to you because there are signs of ADHD, or has had a previous diagnosis of ADHD, then he/she can be sent a copy of a rating scale to complete before with meeting with you. I also ask then to ask a person who knows them well to also independently complete this rating.

As many of the individuals I see have complex diagnoses, and dyslexia and dyspraxia also result in some signs of inattention (e.g. forgetfulness), I only administer a ADHD rating scale towards the conclusion of an assessment when I am reasonably certain that ADHD is present. If in doubt do so anyway. Some assessors choose to go through a rating scale with an individual early on in an assessment. My advice: do what works best for you.

Caveat

A rating scale is vital for it provides a systematic check across the key defining features of ADHD. However, at best, a rating scale is an affirming measure.

Irrespective of which rating scale is used, I know of no clinician who relies solely on a rating scale as providing a definitive answer. The advice is always place more trust in the interview data than in a rating score. For example, I have encountered occasions when an individual has scored above the ADHD threshold for Inattention but it is apparent that inattention difficulties can be better accounted for by other factors. Such a decision should be fully explained.

As the severity of Judith's working memory deficit will give rise to at least three of the DSM-IV Inattention statements fully applying, the available evidence is not strong enough to justify an additional diagnosis of ADHD (of the Inattentive kind), particularly as her mother said only two of the Inattention statements fully applied. While there is no doubt that Judith has problems with concentration, I am of the opinion that these can be accounted for by the severity of her working memory deficit. However, if issues of procrastination and disorganisation become significant issues in the future a second opinion – a medical one – should be sought.

At the end of the day the decision as to whether ADHD is present is a clinical judgement. The quality of your interview will determine the degree to which your conclusion can be trusted. In arriving at a conclusion that ADHD is present as a specific learning difficulty it is essential to have revealed *through interview* how *inattentive behaviours and/or hyperactivity/impulsivity has impacted negatively across a range of educational activities, including reading, writing and revision.* In addition, examples of inattentive and/or hyperactivity/impulsivity must also have been recorded for everyday life.

Though the process of undertaking a diagnosis for ADHD is time-consuming it is my experience that psychiatrists appreciate thoroughness in a diagnostic report for ADHD as a SpLD.

D. FURTHER ACTIONS

D.1 Explaining how you have arrived at a judgement that ADHD is present.

It is important to explain clearly how you have arrived at a diagnosis of a Specific Learning Difficulty. If you have made use of the DSM-5 rating scales you need to specify which form of ADHD is present.

The form of words I use is given below.

Sarah's personal history also revealed signs of Attention Deficit with Hyperactivity/Impulsivity Disorder (ADHD), so consideration was given to whether a diagnosis of ADHD would be appropriate. Sarah's self-reported responses to the DSM-5 rating scale of ADHD items resulted in her identifying 8 of the 9 Inattention items as well as 8 of the 9 Hyperactivity/Impulsivity ones as applying fully.

A score of 5 or more on the nine Inattention items is the trigger point for indicating that Adult ADHD is likely to be present, while a combined score of 5 across the 6 Hyperactivity and 3 Impulsivity items is the threshold for having to consider the likelihood of Hyperactivity. Sarah's score of 8 for Inattention is above this critical point as is her score of 8 for Hyperactivity/Impulsivity. She said the statement 'often experiences rapid mood changes, such as frustration or anger' fully applied.

The evidence is strongly indicative of the presence of ADHD. However, in order to reach a diagnosis of ADHD the DSM-5 guidelines state that signs should have been evident prior to the age of twelve and manifest themselves in more than one setting.

In Sarah's case no early signs were noted in childhood, but they may have been masked by what Tom Brown refers to as 'scaffolding' – that is, a very supportive family and an organised regime at school.

In arriving at a diagnosis of ADHD, care has to be taken not to confuse signs of ADHD with signs of dyspraxia or dyslexia, as there is a high degree of commonality between these three diagnoses. Neither of these other specific learning difficulties is present in Sarah's case.

The key question is whether Sarah's DSM-5 profile is reflected in her day-to-day experiences and there are a number of key indicators that this is so: her short-attention span, ease of distractibility, high level of procrastination, problems with time management, dislike of routine in everyday life and tendency to seek out challenging experiences.

The evidence, in my opinion, justifies a diagnosis of ADHD - Attention Deficit Hyperactivity Disorder (of the combined presentation). This is a diagnosis of ADHD as a Specific Learning Difficulty. *It is not a medical diagnosis*.

NB As some specialist assessors have expressed reservations over using the term diagnosis when ADHD is present, as it may be confused with a diagnosis by a medical practitioner, the following form of words are acceptable:

The evidence is strong enough to justify a conclusion that ADHD is present as a specific learning difficulty.

D.2 Referring on for medical investigation.

Without exception advice should be given on seeking a second opinion, a medical one, following an assessment outcome that ADHD is present as a specific learning difficulty. Not all individuals wish to seek a medical opinion, which is reflected in the wording of the advice I provide in a diagnostic assessment report:

> 'Sarah *may wish* to consider seeking medical confirmation of her diagnosis of ADHD. If so, she will need to provide her GP with a copy of this report and request a referral.
>
> **www.simplywellbeing.com** provides good advice on how to request a GP referral and on how to find a reputable ADHD coach.'

Obtaining a referral can often be difficult for many GP's are unfamiliar with ADHD and there is also paucity of specialist Adult ADHD Clinics. Referral may be for medication and/or cognitive behaviour therapy, and/or ADHD coaching, and I advise as such in my reports.

D.3 Accuracy check

Once I have written the first complete draft of a diagnostic report I then email it to the individual and ask him/her to read through the sections detailing their history and check them for accuracy. If they report any errors or additional items of information the relevant changes are made prior to printing the final version. This additional step takes time but it helps the individual take ownership of the report and ensures the report is an accurate record.

David Grant January 2, 2014

(NB The first edition was published in January 2013. This version has been updated to include the outcome of the SASC-convened ADHD consensus meeting and the publication of DSM-5.)

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Useful web sites

www.addis.co.uk ADDISS is a national ADHD charity run by volunteers.

www.addstudy.org was developed to provide students and staff in higher education with information about ADHD. It is also a forum for exchanging ideas and information.

www.simplywellbeing.com This site has been developed by Andrew Lewis, an ADHD coach.

www.ukaan.org has been set up by the medical profession as part of the UK's response to the NICE recommendations. UKAAN (UK Adult ADHD Network) was established in March 2009 to provide support, education, research and training for mental health professionals working with adults with Attention Deficit Hyperactivity Disorder *(ADHD)*.