

ASSESSMENT OF ADHD IN ADULTS

Dr Tom Mole

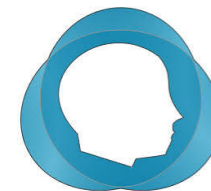
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Self Reflected (2016), Dr Greg Dunn and Dr Brian Edwards
— a 22-karat gold-leaf reflective microetching of a sagittal brain slice at 22× magnification.
Image © the artists, gregadunn.com



NovoPsych



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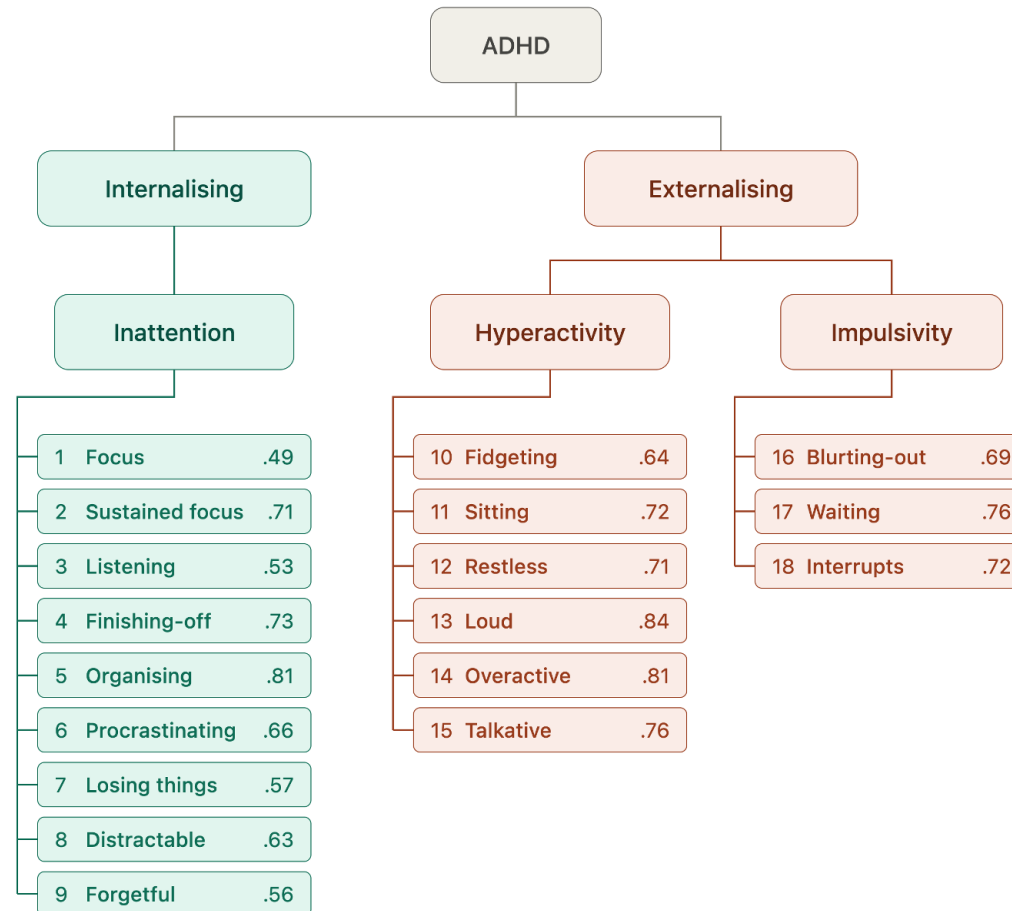
OVERVIEW

- 1 Defining ADHD
- 2 Aetiology & Neurobiology
- 3 Screening
- 4 Diagnostics
- 5 Neuroaffirmative Practice
- 6 Discussion

DEFINING ADHD

A brain style with differences from the average brain in terms of inattention, and or hyperactivity/impulsivity.

SYMPTOMS



Standardised loadings, two-factor CFA — Ghanizadeh 2012, n = 106, parent-rated

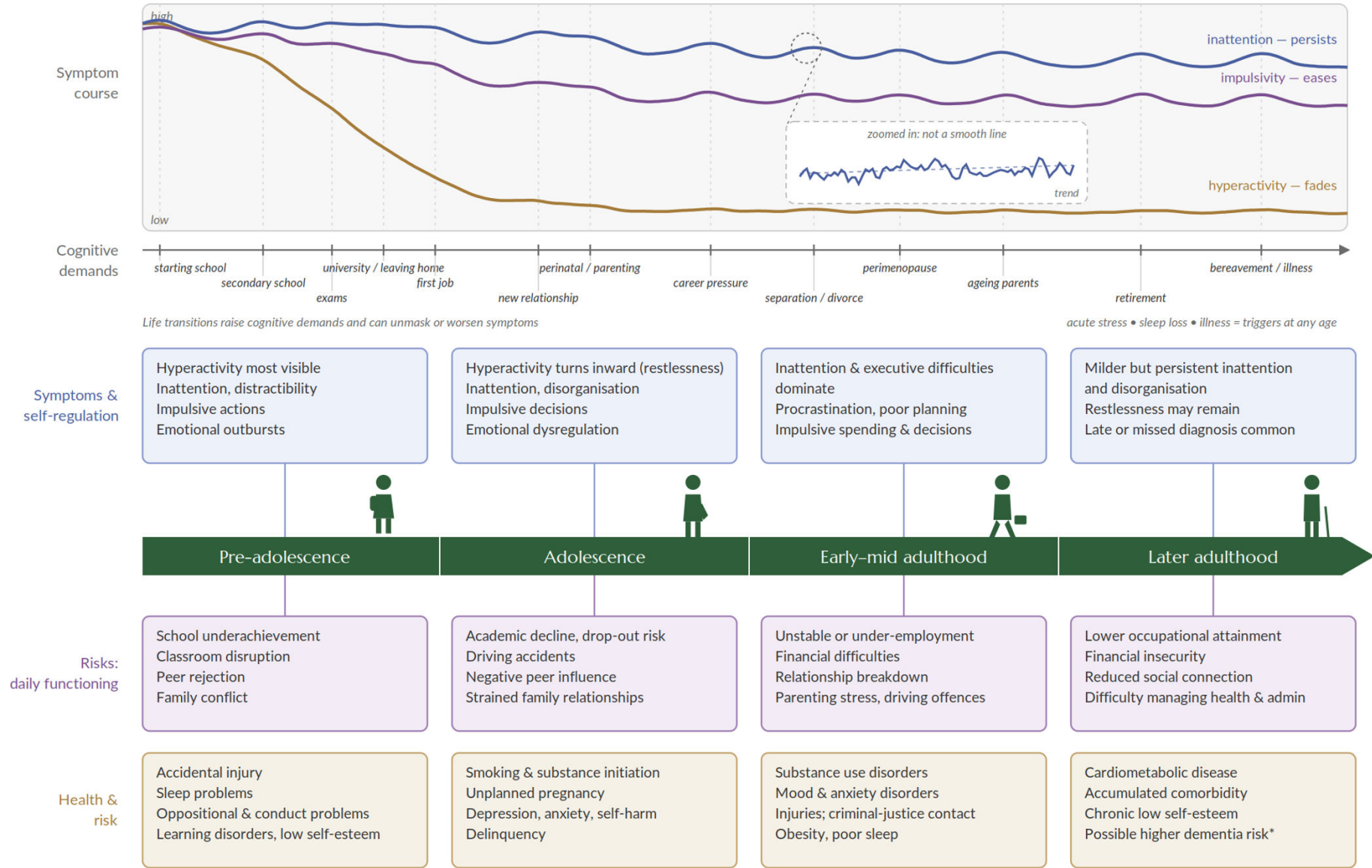
Predominantly inattentive

Predominantly hyperactive-impulsive

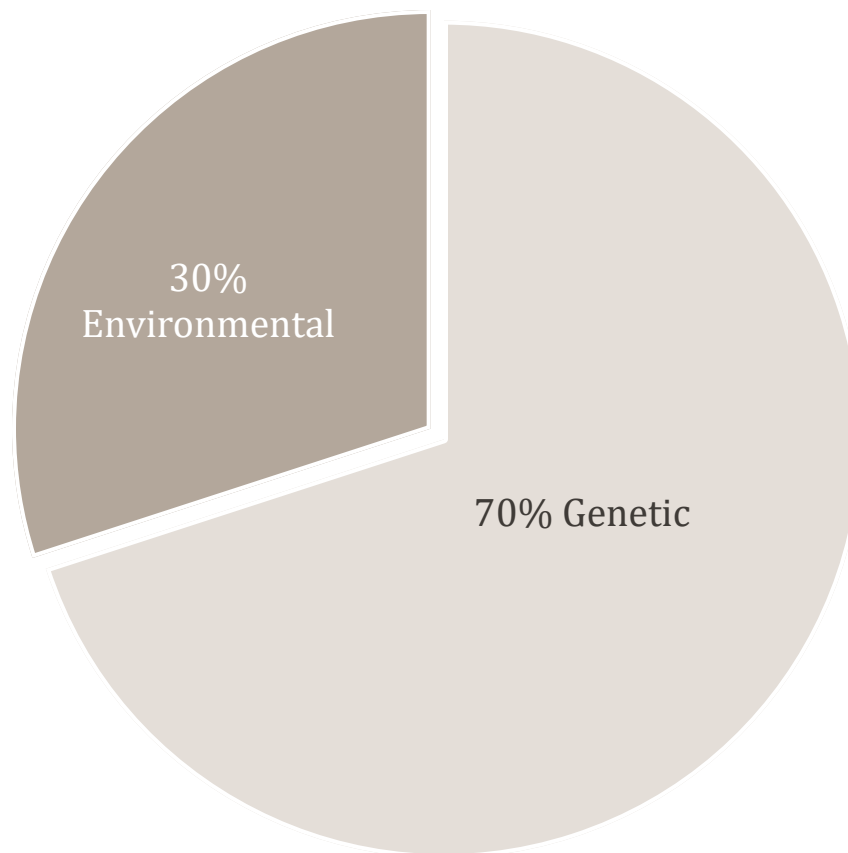
LIFECOURSE IMPACT

- **Prevalence** — from 5% in childhood to 2.5% in adulthood approx., however, even when full DSM-5 criteria is not met, data indicates that impairment persists.
- **Clinical implication** — a single cross-sectional assessment can misread where someone sits on a fluctuating trajectory. Guidelines suggest re-assessment in service transition from childhood to adulthood for this reason and to ensure comorbidity treatment.

*Image is illustrative only



AETIOLOGY



(Faraone & Larsson, 2019; Isaksson et al., 2022).

MATURATION

Delayed Maturation Theory- Hoogman et al (2017)

Differences in volume of key brain areas between ADHD & Neurotypical groups significant and reduced with age.

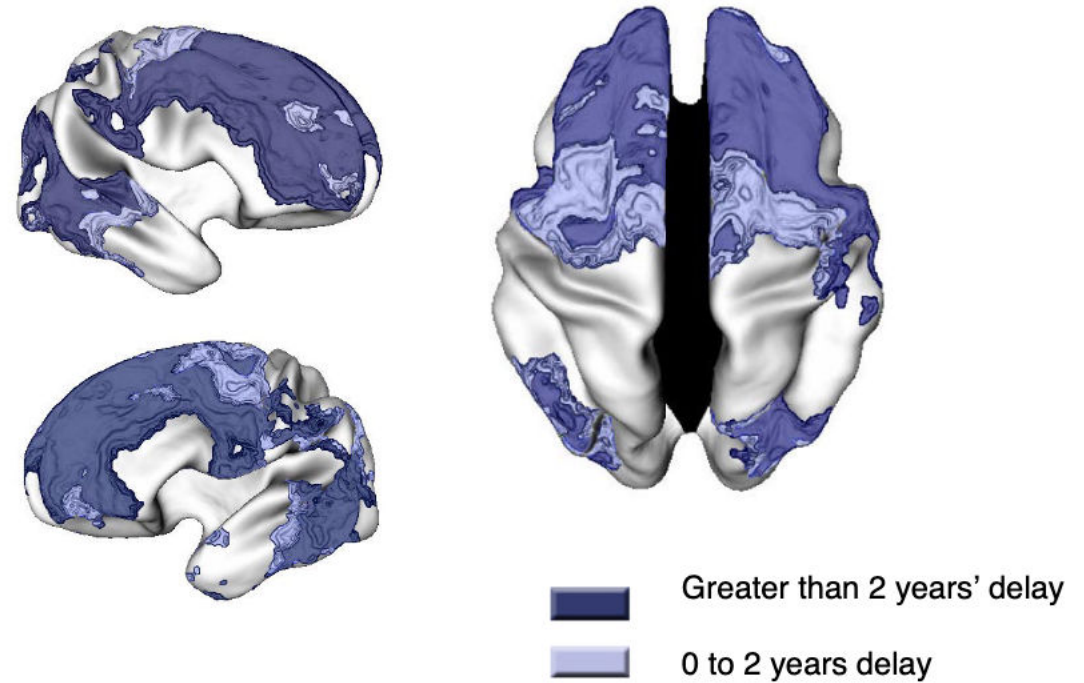


Fig. 2. Regions where the ADHD group had delayed cortical maturation, as indicated by an older age of attaining peak cortical thickness.

Image from Shaw et al (2007).

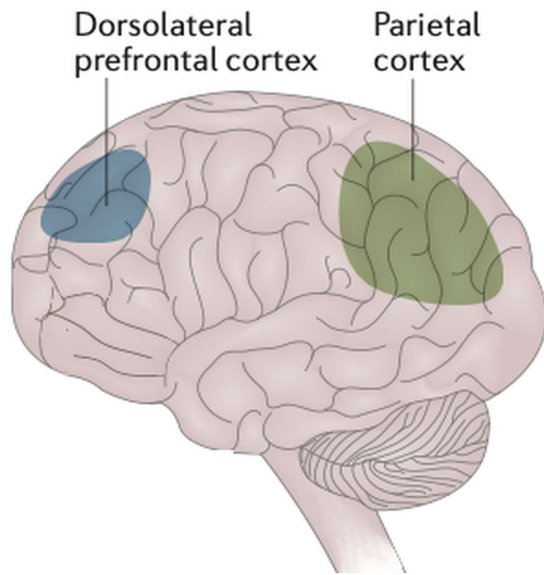
CIRCUITS

Task-positive and executive control networks under-fire, while the default mode fails to switch off

1

Task-Positive Network

↓ UNDERACTIVE



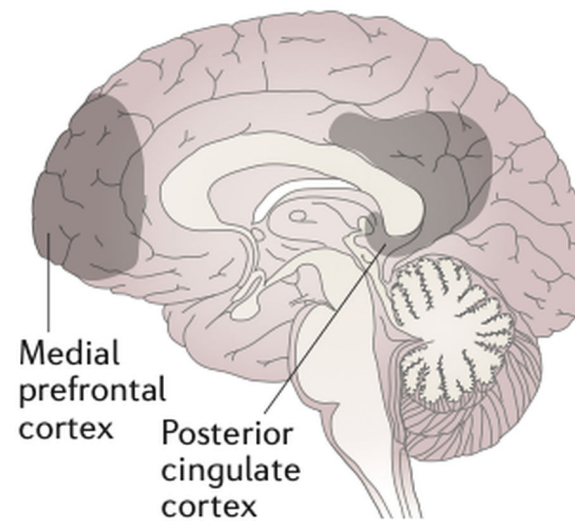
Weak task engagement

2

Task-Negative Network

↑ OVERACTIVE

Default Mode

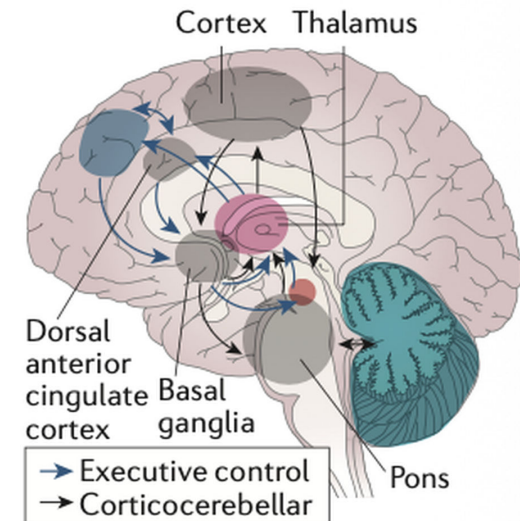


Fails to switch off: mind-wandering, lapses

3

Executive Control

↓ UNDERACTIVE

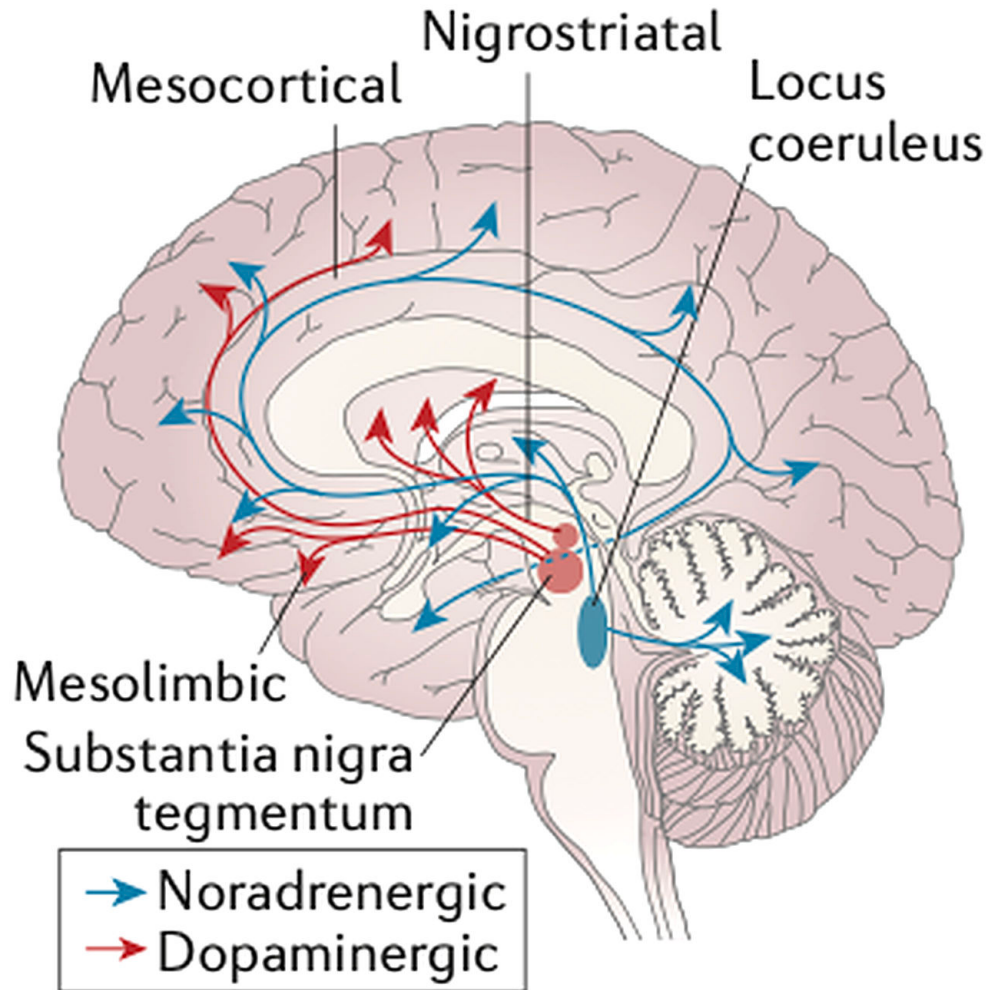


Weak inhibition, working memory, planning

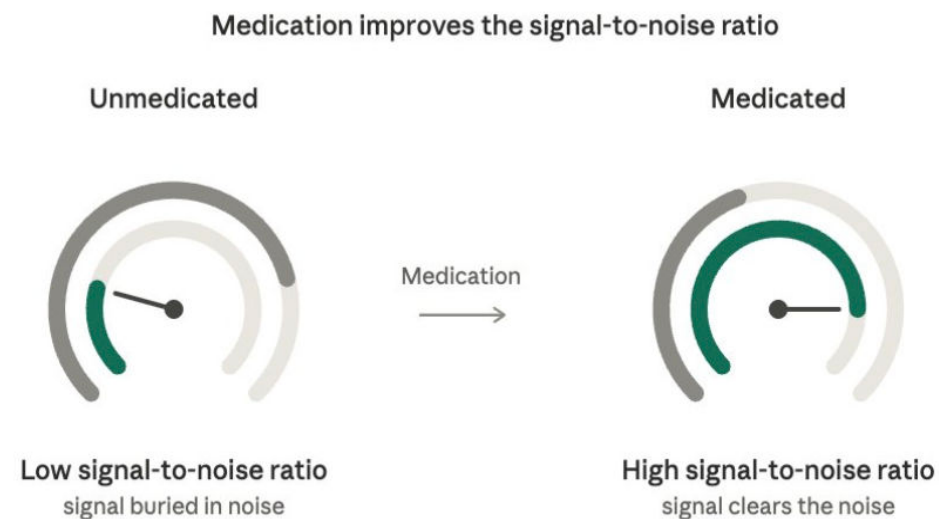
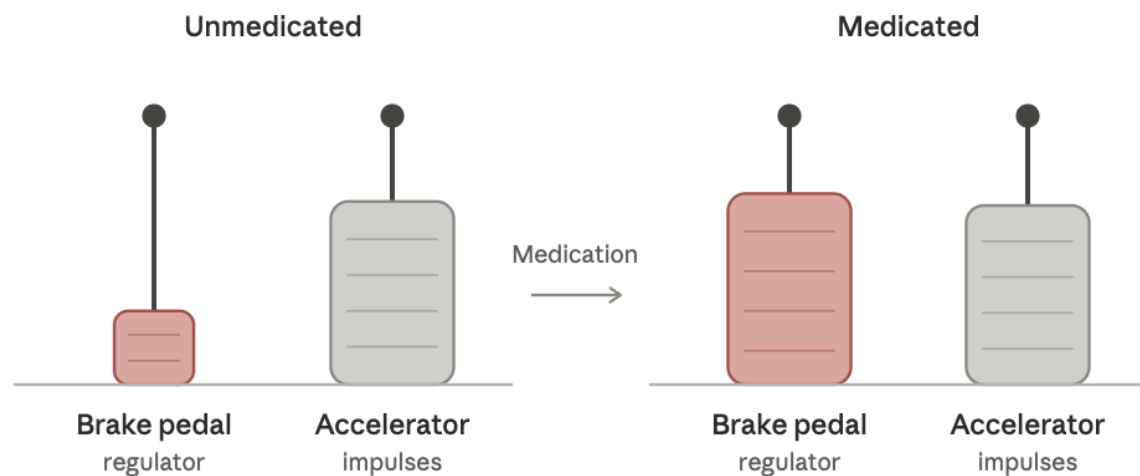
Also dysfunctional: **Salience Network** (underactive, 'unfiltered') · **Alerting Network** (underactive, reduced alertness) · **Reward Network** (underactive for distant rewards)

NEUROCHEMICALS

DOPAMINE & ADRENALINE KEY
FOR ADHD



SIGNAL-TO-NOISE THEORY & ANALOGIES



IMPORTANCE OF EVIDENCE-BASED DIAGNOSTICS

Evidence for overdiagnosis

- **Kazda et al. (2021)** — systematic scoping review of 334 studies; 45 documented genuine increases in diagnosis and 83 documented increased pharmacological treatment.
- **The additional cases are milder** — 25 studies indicate the growth is concentrated at the mild end of the spectrum, not in severe presentations.
- **Factors** — direct-to-consumer and social-media influence, and diagnosis without structured assessment.

Under-recognition

- **Undiagnosed cases** — symptomatic adult ADHD is estimated at 6.76% globally, far above diagnosed rates (Song et al., 2021).
- **Underlying prevalence is stable** — population prevalence has changed little over decades; rising diagnosis may reflect better recognition.
- **Underrepresentation of Groups** — girls and women, adults, ,predominantly inattentive presentations and Aboriginal and Torres Strait Islanders often highlighted in underrepresented groups and later diagnosed groups. Commonwealth Parliament. (2023, September 26).

A structured evidence based approach to diagnostic interview with developmental history, collateral and multisource feedback protects against misdiagnosis (Ramos-Quiroga et al., 2019).

DSM-5 CRITERIA ADHD

AGE 17 AND OVER — ADULTS

A

Symptom pattern and threshold

A persistent pattern of inattention and/or hyperactivity-impulsivity

inconsistent with Developmental Level/ causing impact on social/ academic/ occupational activities

Showing 5/> inattentive features and /or 5 or more Hyperactive/ impulsive features

1. Inattention: 5/> Features, at least 6 months

- Often fails to give close attention to detail / careless mistakes
- Often difficulty sustaining attention in tasks
- Often does not seem to listen when spoken to directly
- Often does not follow through; fails to finish tasks
- Often difficulties organizing tasks and activities
- Often avoids tasks requiring sustained mental effort
- Often loses items necessary for tasks or activities
- Often easily distracted by extraneous stimuli
- Often forgetful in daily activities

2. Hyperactivity/ **Impulsivity**: 5/> at least 6 months

- Often fidgets, taps hands/feet, or squirms in seat
- Often leaves seat when remaining seated is expected
- Often runs/climbs inappropriately (age 17+ often instead observations of restlessness)
- Often unable to engage in leisure activities quietly
- Often “On the go”, as if “driven by a motor”
- Often talks excessively
- **Often blurts out answers before a question is finished**
- **Often difficulty waiting his/her turn**
- **Often interrupts or intrudes on others**

DSM-5 CRITERIA ADULTS

Onset before age 12

B

Several symptoms (inattention or hyperactivity/ impulsivity) present before age 12.

Present in two or more settings

C

Several inattentive or hyperactive–impulsive symptoms present in two or more settings — at home, at work or study, with friends or relatives, or in other activities.

Clear functional impairment

D

Clear evidence that symptoms interfere with, or reduce the quality of, social, academic or occupational functioning.

Not better explained by another disorder

E

Not occurring exclusively during schizophrenia or another psychotic disorder, and not better explained by a mood, anxiety, dissociative or personality disorder, or substance intoxication or withdrawal.

Presentation subtypes — specify presentation fitting for symptoms in preceding 6 months

Combined presentation

Both ≥5 inattention AND ≥5 hyperactivity–impulsivity symptoms.

Predominantly inattentive

≥5 inattention symptoms, fewer than 5 hyperactivity–impulsivity.

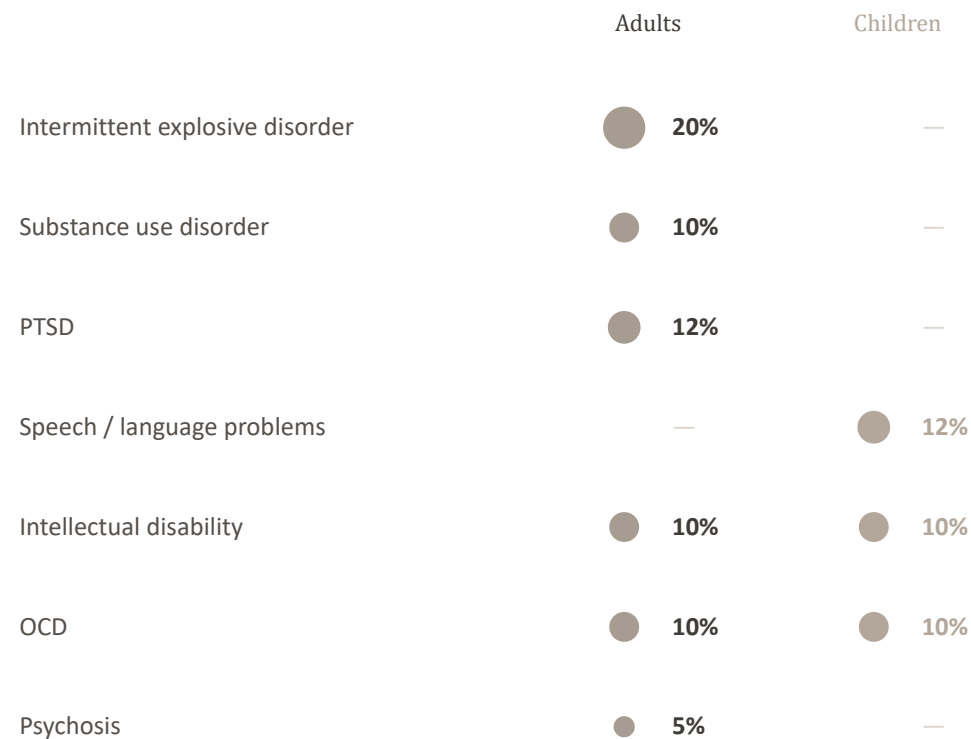
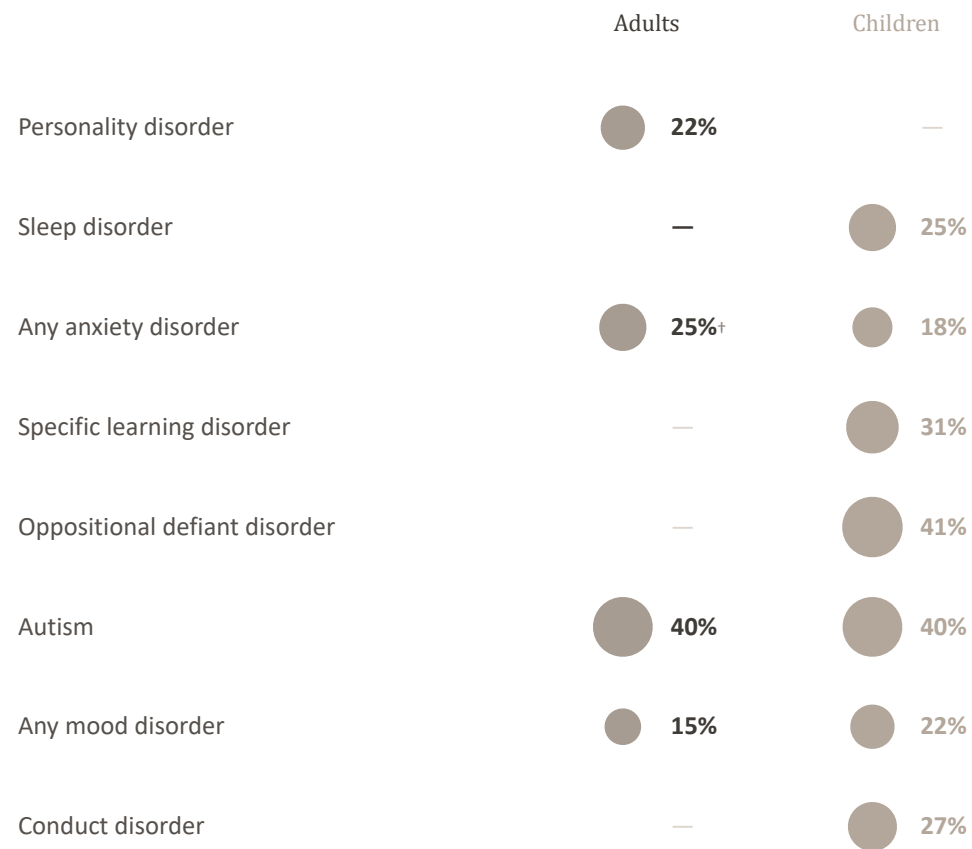
Predominantly hyperactive/impulsive

≥5 hyperactivity–impulsivity symptoms, fewer than 5 inattention.

***Specify Severity: Mild, Moderate, Severe taking into account whether there was minimal symptoms meeting threshold, or many symptoms in excess of 5/> and the functional impacts**

CO-OCCURRING CONDITIONS IN ADHD

Choi et al., PLOS ONE (2022) · Kessler et al., NCS-R (2006) · D'Agati et al. (2019) · Larson et al. (2011), NSCH · Elia et al. (2008) · DuPaul et al. (2013) · Hvolby (2015) · Antshel & Russo (2019) · Kooij et al., European Consensus Statement (2019)



SCREENING

WHEN IS AN ADHD ASSESSMENT INDICATED?

1

High-risk groups

Autism, intellectual disability, ODD, preterm birth, tic disorders, substance use, forensic populations and mood disorders.

2

Family members

First-degree relatives of a diagnosed person who show features themselves.

3

Screening instrument

ASRS as the first-line screen. A positive screen indicates assessment — it is not a diagnosis.

4

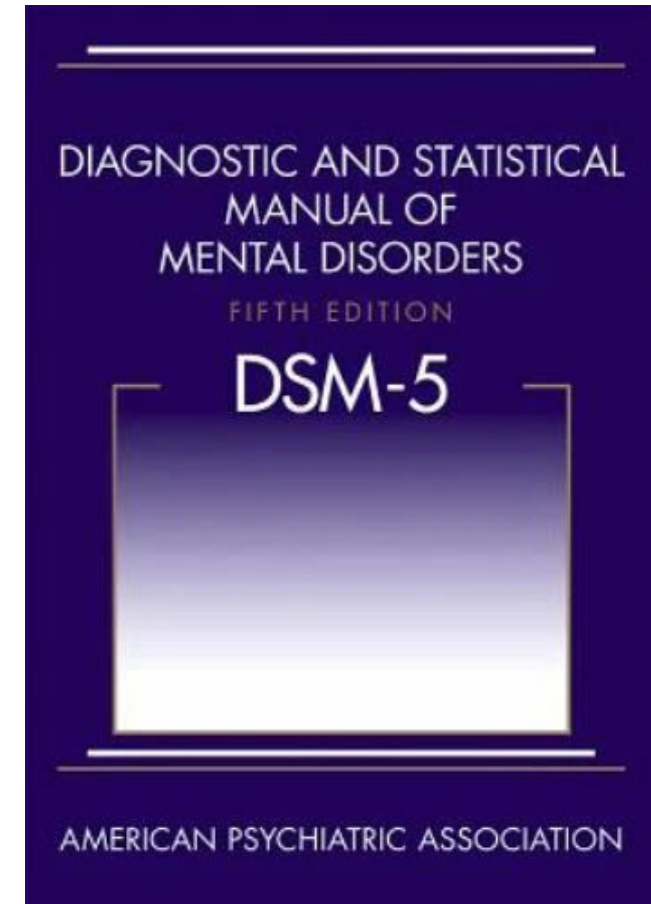
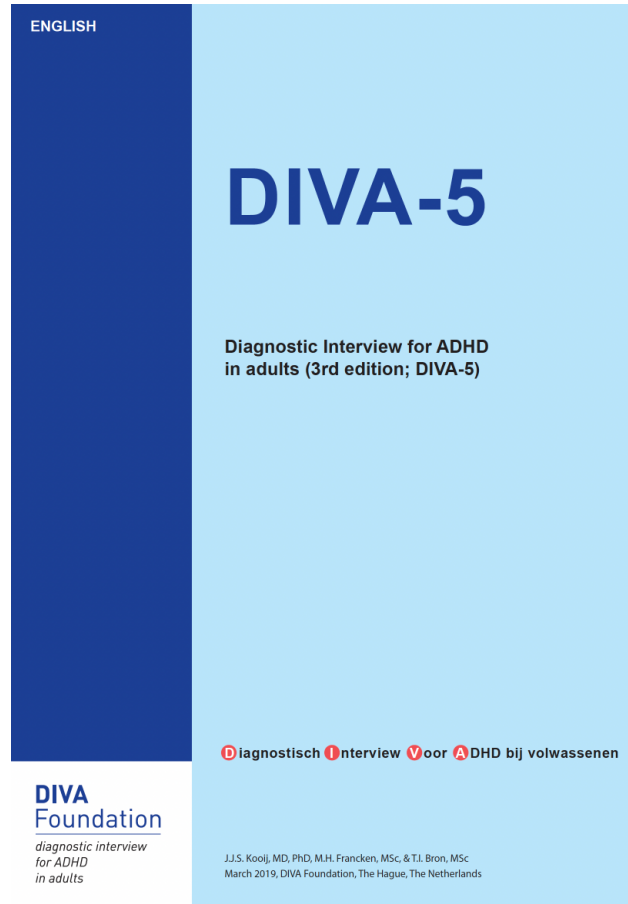
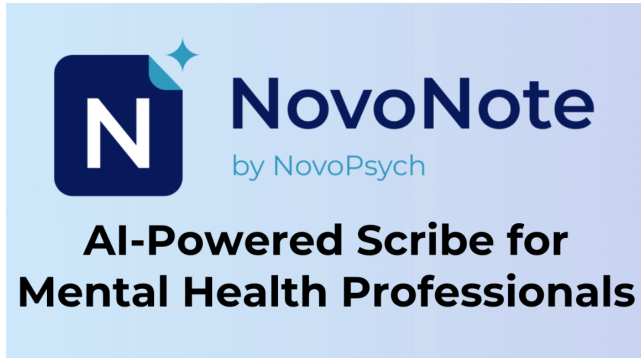
Onset and course

Features present in childhood and persisting since, rather than emerging for the first time in adulthood.



Photo by Ina Ramos on Unsplash

RESOURCES: ADULT ADHD ASSESSMENT TOOLKIT



GOLD STANDARD THERAPEUTIC ASSESSMENT

EVIDENCING EACH DSM-5 CRITERION

1

Medical exclusion

Medical causes excluded; overview of current physical health conditions and history.

2

Mental state examination / observations

Appearance, behaviour, speech, affect and cognition — including restlessness, interruption and distractibility observed in the room.

3

Full clinical history

Social, educational, psychiatric, developmental and medical history.

4

Structured diagnostic interview

A DSM-5-anchored interview for ADHD — DIVA-5 or equivalent.

5

Childhood collateral

Developmental history from a parent or guardian, school reports, or WURS self-recall of childhood features.

6

Adulthood collateral

From a spouse, friend or parent who knows them well as an adult — ASRS-O can be used.

7

Functional impact

WHODAS, to evidence impairment rather than assert it.

8

Differential & comorbid screening

Consider screeners for the conditions in the differential.

9

Formulation

Strengths and protective factors, alongside the difficulties. Assessment should be therapeutic in itself and provide psychoeducation and understanding.

**If you are new to ADHD assessment, ensure you have supervision with an experienced ADHD diagnostician. It is most helpful if you can observe their practice and ask questions to gain your confidence.*

DIVA-5 IN ADULTS

STRUCTURED, CLINICIAN-ADMINISTERED, INTERVIEW MAPPED TO DSM-5

What it is

A structured, clinician-administered interview based on the DSM-5 criteria for ADHD, covering childhood and adulthood separately.

How a symptom is scored

Each criterion resolves to a single “Symptom present: Yes / No”. That Yes/No feeds the X/9 count — not the number of examples ticked.

The threshold is degree, not quantity

A behaviour counts if it occurs more frequently or more severely than in age- and IQ-matched peers, or if it is clearly associated with impairment.

Chronicity

Symptoms can change in ADHD over time, but brief episodes of symptoms which do not have a longer course should not be endorsed in DIVA-5. For example, if there was a period after bereavement where the person was not concentrating well but this resolved after a few months, this should not be endorsed in the DIVA-5 as a symptom.

Thresholds to record on the score form

Childhood — before age 12

Several symptoms (defined as three or more) of inattention and/or hyperactivity–impulsivity.

Adulthood — age 17 and over

Five or more symptoms in either domain, present over the last 6 months, with current impairment.

DIVA-5 IN ADULTS

Instructions: the symptoms in adulthood have to have been present for at least 6 months. The symptoms in childhood relate to the age of 5-12 years. For a symptom to be ascribed to ADHD it should have a chronic trait-like course and should not be episodic.

A1

Do you often fail to give close attention to details, or do you make careless mistakes in your work or during other activities? *And how was that during childhood (in schoolwork or during other activities)?*

Examples adulthood

- ☐ Makes careless mistakes
- ☒ Works slowly to avoid mistakes
- ☒ Work is inaccurate
- ☐ Does not read instructions carefully
- ☐ Overlooks or misses details
- ☒ Too much time needed to complete detailed tasks
- ☒ Gets easily bogged down by details
- ☐ Works too quickly and therefore makes mistakes
- ☐ Other:

Notes supervisor has raised issues at work due to time required to do tasks and overly detail oriented.

Symptom present? ☒ Yes / ☐ No

Examples childhood

- ☐ Careless mistakes in schoolwork
- ☐ Mistakes made by not reading questions properly
- ☐ Overlooks or misses details
- ☐ Work is inaccurate
- ☐ Leaves questions unanswered by not reading them properly
- ☐ Leaves the reverse side of a test unanswered
- ☐ Others comment about careless work
- ☐ Not checking the answers in homework
- ☒ Too much time needed to complete detailed tasks
- ☐ Other:

His mother recalled he did need extra time, to do detailed work, but he was known to be very accurate.

Symptom present? ☐ Yes / ☒ No

DIVA-5 IN ADULTS

Criterion DSM-5	Symptom	Present during adulthood	Present during childhood
A1a	A1. Often fails to give close attention to details, or makes careless mistakes in schoolwork, work or during other activities		
A1b	A2. Often has difficulty sustaining attention in tasks or play activities		
A1c	A3. Often does not seem to listen when spoken to directly		
A1d	A4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace		
A1e	A5. Often has difficulty organizing tasks and activities		
A1f	A6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort		
A1g	A7. Often loses things necessary for tasks or activities		
A1h	A8. Often easily distracted by extraneous stimuli		
A1i	A9. Often forgetful in daily activities		
Total number of criteria Attention Deficit		/ 9	/ 9
A2a	H/I 1. Often fidgets with or taps hands or feet or squirms in seat		
A2b	H/I 2. Often leaves seat in situations when remaining seated is expected		
A2c	H/I 3. Often runs about or climbs in situations where it is inappropriate (in adolescents or adults this may be limited to subjective feelings of restlessness)		
A2d	H/I 4. Often unable to play or take part in leisure activities quietly		
A2e	H/I 5. Is often "on the go" acting as if "driven by a motor"		
A2f	H/I 6. Often talks excessively		
A2g	H/I 7. Often blurts out an answer before a question has been completed		
A2h	H/I 8. Often has difficulty awaiting his or her turn		
A2i	H/I 9. Often interrupts or intrudes on others		
Total number of criteria Hyperactivity/Impulsivity		/ 9	/ 9

Score form

DSM-5 criterion A	Childhood Are several (3 or more) symptoms present of A and/or HI? ☐ Yes / ☐ No Adulthood Is the number of A characteristics ≥ 5 ? ☐ Yes / ☐ No Is the number of H/I characteristics ≥ 5 ? ☐ Yes / ☐ No	
DSM-5 criterion B	Are there signs of a lifelong pattern of symptoms, starting before the 12th year of age?	☐ Yes / ☐ No
DSM-5 criterion C and D	The symptoms and the impairment are expressed in at least two domains of functioning Adulthood ☐ Yes / ☐ No Childhood ☐ Yes / ☐ No	
DSM-5 criterion E	The symptoms cannot be (better) explained by the presence of another psychiatric disorder ☐ No ☐ Yes, by 	
	Is the diagnosis supported by collateral information? Parent(s)/brother/sister/other, i.e. * ☐ N/A ☐ 0 ☐ 1 ☐ 2 Partner/good friend/other, i.e. * ☐ N/A ☐ 0 ☐ 1 ☐ 2 School reports ☐ N/A ☐ 0 ☐ 1 ☐ 2 0 = none/little support 1 = some support 2 = clear support Explanation: 	
	Diagnosis ADHD** ☐ No Yes: ☐ 314.01 Combined presentation type ☐ 314.00 Predominantly inattentive presentation type ☐ 314.01 Predominantly hyperactive-impulsive presentation type ☐ 314.01 Other specified attention-deficit/hyperactivity disorder ☐ 314.01 Not specified attention-deficit/hyperactivity disorder ☐ Partly in remission	
	Severity ☐ mild ☐ moderate ☐ severe	

* Indicate from whom the collateral information was taken.

** If the established presentation types differ in childhood and adulthood, the current adult presentation type prevails for the diagnosis.

COMORBIDITY & DIFFERENTIALS ASSESSMENT

As in any diagnostic assessment, you deliver a battery of questionnaires, ask screening questions for the conditions in the differential, and assess further where there is symptoms.

Suggested minimum dataset — adults

DASS-21 anxiety, depression, stress · **AUDIT** alcohol · **DUDIT** substance use · **CAT-Q** camouflaging · **AQ** autism · **ED-15** eating disorders · **ISI** Sleep

Other Assessment Tools

Bipolar	Manic features — reduced need for sleep, four days or more, elevated or expansive mood	→ MDQ
PTSD	A positive trauma screening question	→ PCL-5
OCD	Intrusive obsessions or compulsive rituals	→ OCI-R
Personality	Complex personality structure	→ PID-5
Dyslexia / SpLD	Longstanding difficulty with reading, spelling or written expression, dating from school	→ Test of Dyslexia (WPS)
Psychosis	Unusual perceptual experiences, or beliefs others find hard to follow	→ WSR-II · PRIME-5 · BPRS
Intellectual disability	Lifelong difficulty with learning, reasoning and daily independence	→ WAIS (Pearson)

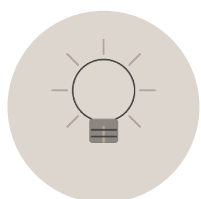
All questionnaires available on novopsych unless other source is provided in brackets

NAVIGATING INCONSISTENT MULTISOURCE REPORTS

- **Common in ADHD assessment** — self-report vs informant discord; differing views across settings (school vs home); inconsistent responses across questionnaires.
- **Sources of discrepancy** — limited self-insight, rater bias, symptom masking or compensation (particularly in women and high-functioning presentations), and differing environmental demands. Consider positive and negative impression bias for raters and weight/ de-weight sources based on this.
- **A structured approach** — weight developmental/historical evidence, gather multiple informants where possible; use structured tools (DIVA-5) to manage inconsistency systematically.
- **Essence question** — Have you had problems with focus/inattention or being hyper/impulsive throughout your life?

STRENGTHS BASED FORMULATION

NEUROAFFIRMATIVE PRACTICE



66%

Creativity



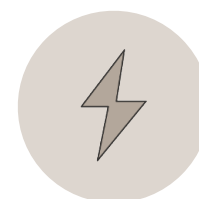
42%

Interest-based attention



31%

Prosocial attributes



26%

Elevated energy levels



15%

Adaptive risk-taking



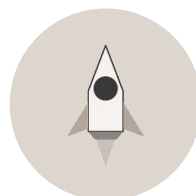
13%

Resilience



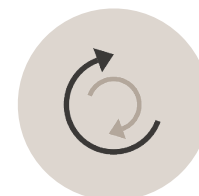
13%

Uniqueness



11%

Entrepreneurship



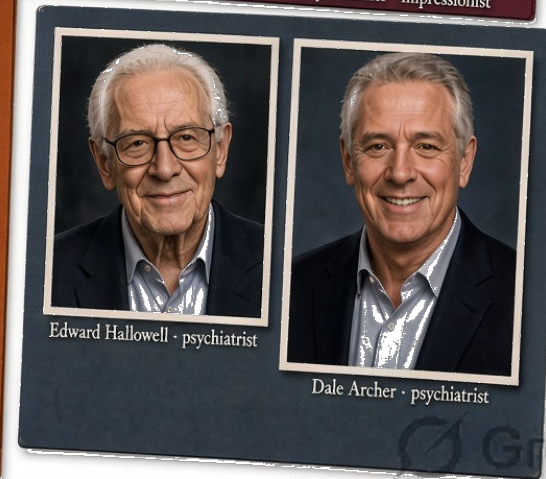
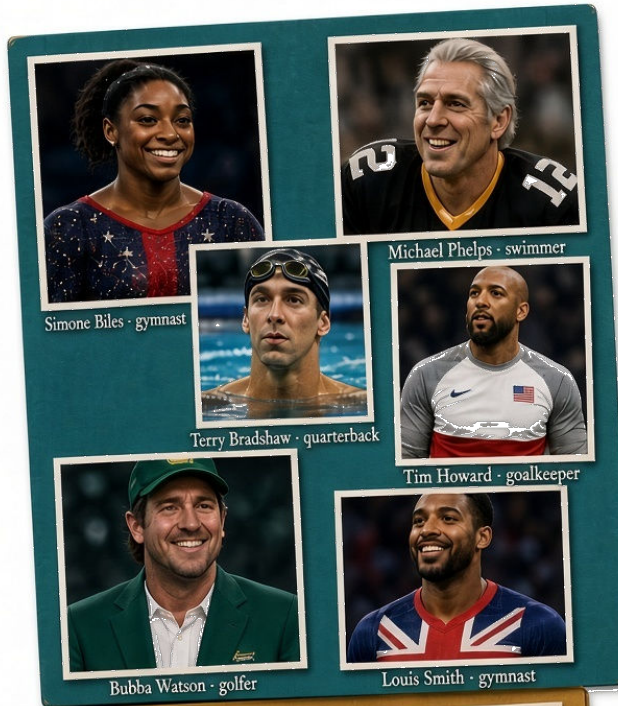
11%

Flexibility



Hyperfocus

* Whilst hyperfocus can help reach goals in areas of interest, or allow deep and pleasurable engagement in an activity, it can also result in neglect of other tasks that are less dopaminergic for the person. [pmc.ncbi.nlm.nih.gov/articles/PMC12437476](https://pubmed.ncbi.nlm.nih.gov/articles/PMC12437476) Percentages show the proportion of 125 studies documenting each strength (Rafael et al., 2026). Interest-based attention, elevated energy and adaptive risk-taking are core ADHD characteristics reframed positively, not separate traits.



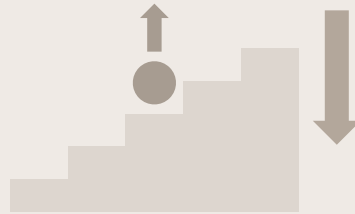
Grok

NEUROAFFIRMATIVE PRACTICE & PSYCHOEDUCATION

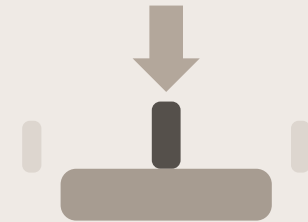
METAPHORS



Inattention
Too many tabs open



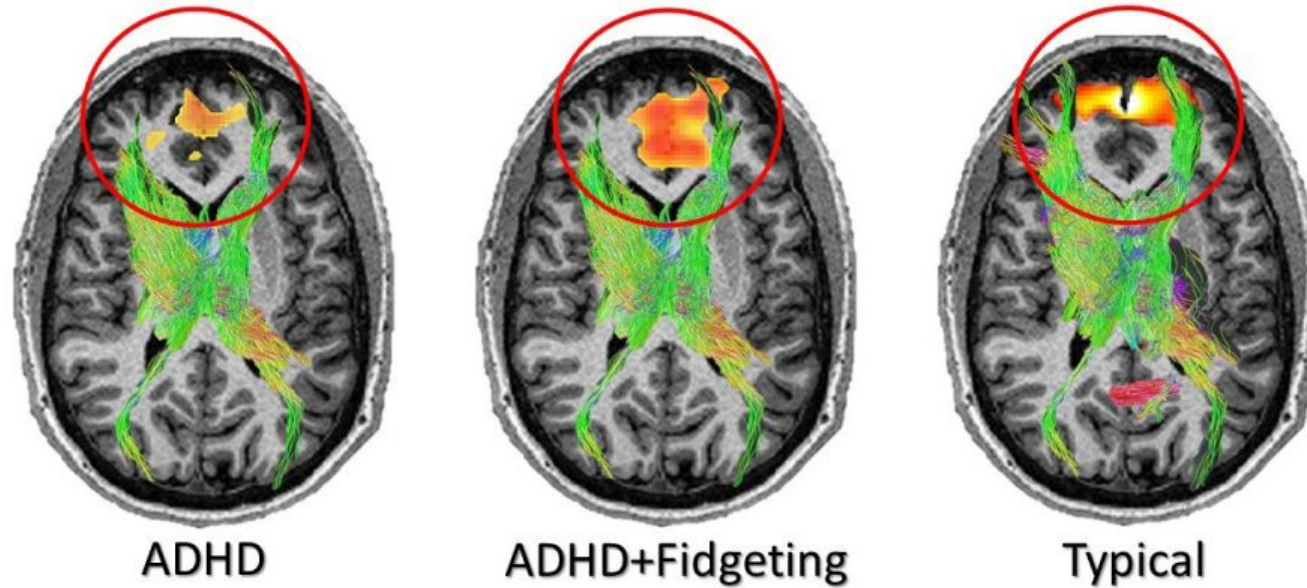
Procrastination
Running up a down escalator



Impulsivity
A stiff old brake pedal

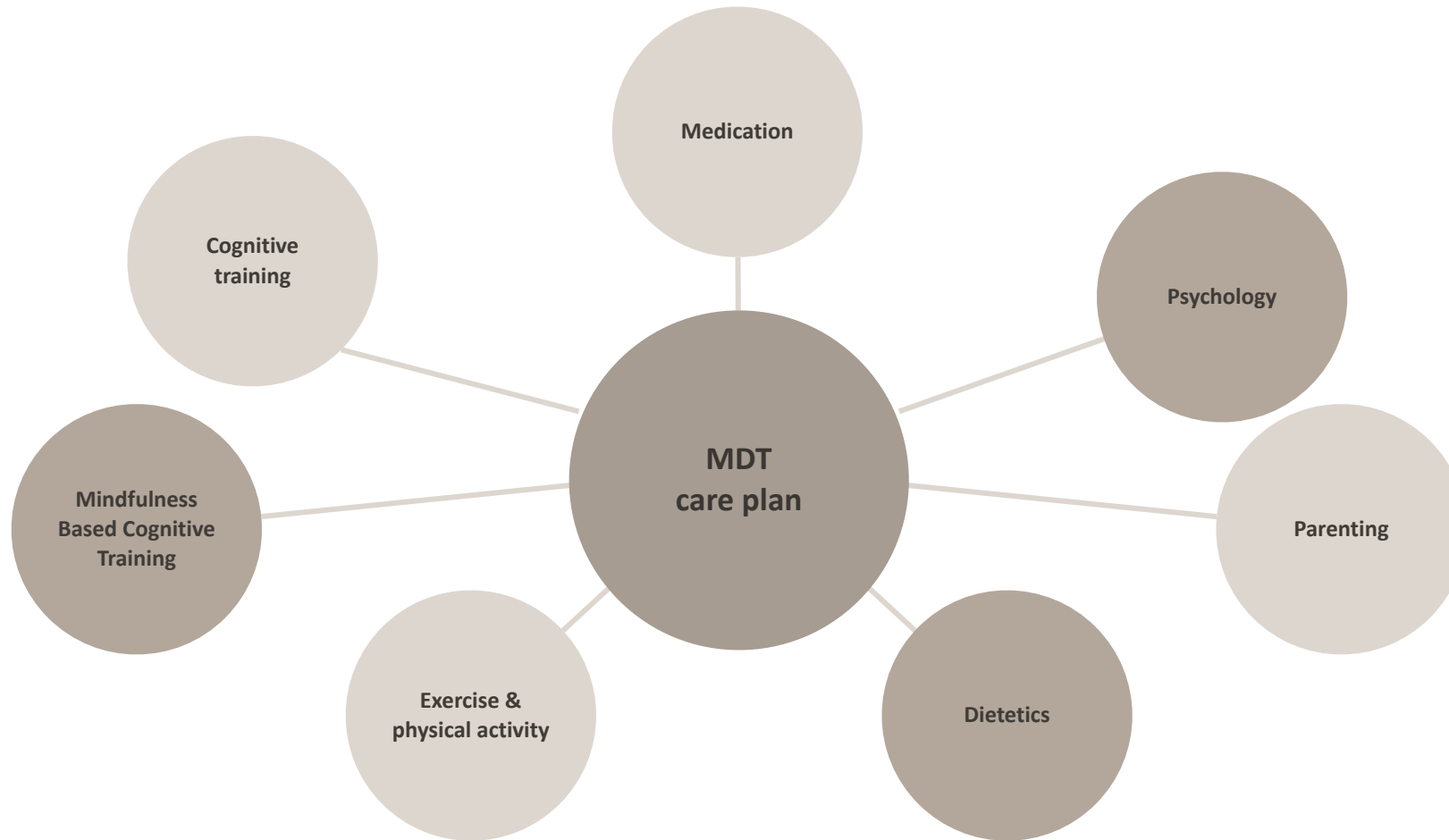
PSYCHOEDUCATION: FIDGETING & PREFRONTAL ACTIVATION

MOVEMENT AS SELF-REGULATION



Functional magnetic resonance imaging reveals fidgeting in ADHD improves prefrontal cortex activation during executive functioning. ISMRM 2023, Abstract #3343. DOI: 10.58530/2023/3343

INSTALLING HOPE MDT CARE PLANNING



Cortese et al., Lancet Psychiatry (2018) · Sonuga-Barke et al., American Journal of Psychiatry (2013) · Ostinelli et al., Lancet Psychiatry (2025) · Cochrane review of cognitive-behavioural interventions for adult ADHD (2018) · Internet Interventions (2023)



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