Chapter 2
Clinical Assessment of ADHD in Adults

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Abstract Initial evaluation of an adult presenting with possible ADHD should determine if the diagnosis is present, identify traits commonly associated with ADHD, and establish a basis for treatment decisions. This chapter offers a practical guide to screening for ADHD, as well as step-by-step diagnosis of ADHD in adults. The approach detailed here is based on Diagnostic and Statistical Manual criteria, extensive experience operationalizing those criteria and is consistent with expert consensus guidelines. The chapter includes how to differentiate ADHD from other conditions, and conditions that are important not to miss because they may pose a contraindication to some forms of ADHD treatment. It has long been recognized that a subset of individuals with ADHD have more extreme difficulty with organization. This chapter offers a guide to identifying these "self-regulation" challenges that are not defined as core symptoms of ADHD, but are a common burden in this population.

Introduction

The manifestations of ADHD may be quite clear, or, in some adults, hidden by avoidance of challenges and compensatory efforts. ADHD impacts each patient differently, depending on their characteristic strengths and challenges. It can be helpful to appreciate that at the core, ADHD symptoms describe problems controlling what a person engages in—the moment-by-moment selection of mental and physical activities. In ADHD, it often appears that mental and physical activity are under less native control—more at the whim of what does and does not naturally engage the person. It may be useful to consider ADHD as a condition marked by limited control over what

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a person engages while developing a personalized treatment plan, as discussed further in the next chapter. Thus, identification of ADHD requires careful evaluation of the effort it takes an individual to control their mental and physical activity.

ADHD diagnosis, by definition, requires a comprehensive clinical interview covering both ADHD criteria and alternative explanations for symptoms. While some screening tools and tests correlate with a diagnosis of ADHD, current clinical understandings of the condition do not require performance of any screen or test. Screening does offer a chance to efficiently determine the whether full diagnostic assessment should occur. Although a full assessment may be a lengthy process, it can be adapted to different clinical settings by spreading evaluation out over time, or across a team of clinicians.

This chapter addresses both efficient screening for ADHD in adults, and a guide to in-depth assessment. It is organized around high-yield questions and time-saving inventories that have proven useful in clinical care. An abbreviated guide to use of the inventories, and blank copies of inventories, are found in the Appendix.

When to Evaluate a Patient for ADHD

ADHD impacts approximately 4% of adults [1], can have profound impact (as detailed in the previous chapter), and is accompanied by high rates of other mental health conditions [2]. This supports the argument that all patients presenting with functional impairment or mental health conditions should be screened for ADHD. While many patients with ADHD present in states such as depression or anxiety that deserve prioritization over ADHD, identification of ADHD may clarify traits that can be supported subsequently, and offer hope for a better level of long-term function.

It is high-yield early in a clinical discussion to inquire what particular struggles or problems bring them to the assessment. It is important to identifying if there is impairment in function that merits an evaluation—traits without impairment are usually insufficient to warrant intervention.

Even if a patient presents with documentation of ADHD or a longstanding "diagnosis" of ADHD, it should not be assumed that it remains a source of impairment worthy of treatment. Prior clinicians may not have performed a comprehensive evaluation, and, as discussed further in the next chapter, manifestation of ADHD can change with time and context.

Diagnosis Depends on Quality of Information

ADHD cannot be evaluated well without good information about the patient's mental health and function. Because individuals may have "blind spots" or distort their report of challenges, it is important to gather information from third parties where useful. Consider, for example, gathering information from any third party who initiated

the evaluation—in some cases, the referring party (such as a spouse or parent) may be better able to articulate struggles of concern. Third-party symptom history can be gathered on a self-report form such as that offered in the Appendix. School records, early school assessments, and old clinical records also offer useful perspectives on the historic presence of ADHD. In some cases, mismatch between self and other observations is very informative, identifying differences in perspective or values with key people in their environment. Thus involving a third party offers a chance to evaluate self-observation capacity, and to characterize the interpersonal context in which their concerns arise. For example, some individuals begin to have concerns about their function when they begin to live with a person who values cleanliness and lack of clutter more than they do, or who can highlight struggles that they don't share. However, information should be gathered in ways that do not compromise privacy. While it is commonplace to get teacher perspectives on symptoms of younger patients with ADHD, there may be repercussions of sharing the ADHD diagnosis with an employer as an adult.

The fact that medications for ADHD can be abused or misused also raises appropriate concern that patients may present as having ADHD to meet unhealthy goals. There is no objective way to completely eliminate concern that individuals are misrepresenting themselves as having ADHD, because there is no "test" for ADHD. It is also inappropriate to deny assessment or treatment to patients with bona fide ADHD due to such concern. Particular clinical contexts that merit more extensive procedures to ensure good information from patients include substance abuse populations, forensic populations, and individuals in highly competitive environments—all places where either misuse or abuse may be more prevalent.

As with any disorder, a clinician ideally will only make the diagnosis where they are confident the criteria are met. It will require different kinds of evaluation to achieve this confidence in different patients. Individuals vary in their ability to notice and to report symptoms of ADHD, and in what they consider impairing. While some patients can vividly describe their challenges, it may take obtaining third party reports to carefully inventory ADHD traits in many. Where one is unsure whether to make the diagnosis, obtaining the perspective of other clinicians, or pursuing other therapeutic avenues may facilitate both comprehensive support of the patient and understanding of their commitment to healthy therapeutic goals.

Clinicians sometimes ask whether particular interviewing approaches, tests, or office practices like drug screens or frequent visits will improve identification of patients who should not receive stimulants. If a clinician is thinking this way, it should be considered a possible sign that there is insufficient comfort with diagnosing or treating the patient. Neuropsychological evaluation or other tests of brain function is sometimes viewed as a way to objectively determine cognitive abilities. However, there is no requirement in the DSM clinical diagnosis of ADHD that the patient must perform poorly on such testing. Although some clinicians highly value various measures for their correlation with a diagnosis of ADHD, even in the presence of robust test-identified attention and executive challenges, the diagnosis should not be made unless the DSM diagnostic criteria are fulfilled.

Similarly it is useful to understand that no inventory of symptoms or symptom scale is sufficient to make a diagnosis—it remains up to the clinician to determine if criteria are met no matter how information is gathered. In addition to this guide and its rating scales, there are other valuable tools for assessment of adults with ADHD available. There is a difference between an inventory of current symptoms and instruments that can be scored based on current symptoms to identify likelihood of a clinical diagnosis. The scales in this volume are meant to enrich a clinical assessment process, not to indicate how a person's symptom burden compares to the general population or individuals with confirmed ADHD disorder. Several screeners and current-symptom based instruments are available [3–8]. Guides to operationalizing assessment of ADHD in adults based on DSM-IV criteria have also been developed [9, 10].

This chapter discusses screening for ADHD using a publicly available screening tool, and clinical evaluation of the diagnosis relying on a unique inventory, the ADHD Symptoms and Role Impact Inventory (ASRI). The ASRI is found in the Appendix in clinician, self-report and third-party report versions, for capture of current impact of ADHD and its historical onset. This inventory is unique in that it emphasizes impact of symptoms on role function, which is essential for diagnosis and treatment planning. The ASRI Guide (also in the Appendix) is unique in that it presents experience-tested language for capturing symptom severity, as well as common examples of role impact, for used in interviews. The Adult ADHD Diagnostic Checklist, found in the Appendix, can be used to ensure the rest of a full diagnostic assessment occurs, as is described in this chapter.

Screening for ADHD

In some clinical settings it is practical to screen for ADHD before conducting a full evaluation, which may be a lower clinical priority and time consuming. A number of screening tools are available which have been shown to correlate with clinical diagnosis of ADHD. These screening tools are not sufficient, however, to differentiate between ADHD and other conditions which can present like ADHD.

The ASRS is suitable for screening patients in English because it is in the public domain, has been adopted by the World Health Organization, and applied in the large National Comorbidity Survey-Replication study [11]. The scale was developed to differentiate, based on DSM-IV current symptom traits, individuals with and without ADHD. It was not designed to differentiate ADHD from other disorders—this is important to understand, because false positives might occur more often in comorbid settings.

The ASRS screener is the first 6 items of a longer 18-item self-report scale that can be used to inventory ADHD symptoms in adults [12, 13]. If an individual indicates four of these six items occurring at the frequency indicated in gray in Fig. 2.1, it is highly suggestive of ADHD. In a sample of adults with and without ADHD, the instrument had 69% sensitivity and 99% specificity for ADHD. However, it should be noted that the specificity is likely to be lower in community samples with high rates of comorbid conditions that could present like ADHD. When someone endorses

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Fig. 2.1 Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist. If four or more marks appear in the *darkly shaded boxes* then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted [reprinted from [11], with permission from Cambridge University Press]. This screener is also available in the Appendix.

symptoms on the screener, the screen can be enhanced by briefly asking for related examples and to clarify their frequency in recent days to determine whether they are impairing. As this chapter explores later, in some cases ADHD traits are compensated enough that they are not a source of significant impairment. Unless there is a functional concern, a full evaluation of diagnosis may not be warranted.

Diagnostic Interviewing for ADHD in Adults

This section offers a guide to interviewing an adult with ADHD. Where useful, types of questions that may be high-yield are offered in bold items marked >>, but clinicians should come up with their own versions and tailor the interview to the patient.

Identify Current Concerns

>> "What is not going the way you would like it to day to day? What kinds of tasks take more effort than you feel they should?"

A question like this helps identify what the individual is concerned about, offering a chance to determine mutual goals for work with them. The word "tasks" is chosen because individuals are likely to be able to talk about hands-on activities, although ADHD clearly can impact patterns of non-"task" thought patterns and communication patterns. Questions like this also acknowledge concern not only for consequences of personal challenges, but also the effort it takes to manage them day to day. Style of day to day function needs to be understood in detail to identify ADHD, and where a person struggles it counts towards fulfillment of the diagnostic criteria that impairment is present.

>> How are you feeling in the past week? Are you suffering emotionally, feeling anxious, preoccupied, or under stress? Is it a typical week?

Whether one interviews to identify ADHD or other conditions first, the assessment should comprehensively identify factors impacting wellbeing and function. This chapter does not offer a guide to comprehensively identifying all mental health conditions—but later in this chapter, we discuss major features differentiating ADHD from other comorbid conditions.

Problems related to attention, memory, organization, and control of behavior are part of several disorders and can also be brought on by uncomfortable or stressful circumstances. Where extreme mental states or circumstances are present, it may be impossible to thoughtfully evaluate what problems are due to ADHD versus preoccupation or mental health compromise of brain function. If the patient can recall a recent period when they were free of major stressors or comorbidity, the interview might focus on determining if criteria were met at that time. In addition, when a patient's chief complaint is about anxiety, mood, or another comorbidity, it may be worth explaining that you want to understand whether they historically have had challenges controlling attention and behavior to see if that has added to their distress.

Ideally, however, the ADHD symptom inventory can be collected using recent contemporaneous information. ADHD symptoms may occur more in particular roles or settings—so it helps to know what the patient has been doing recently. For example, symptoms contributing to school or work-based challenges are best inventoried while the individual is in those settings.

Determining if the Individual Fulfills ADHD Criteria

DSM criteria for ADHD require presence of current symptoms of inattention, impulsivity, and/or hyperactivity. Sufficient data has accumulated to offer criteria specific to adults, and this has been reflected in the evolution of DSM ADHD criteria. Historically, application of DSM criteria to adults has required some extrapolation from the criteria for childhood symptoms. The DSM V development process reflected the desire to have adult-specific criteria. The guidelines offered here are based on assessment techniques developed with extensive clinical and research application of DSM-IV ADHD criteria. It will take some time before the utility and limitations of differences in DSM-IV and DSM-V criteria are understood.

The core question in ADHD diagnosis should be whether there is impairment due to limited control of attention and activity pattern that is not explained by another condition. There are four criteria to satisfy:

1. Presence of sufficient current symptoms
2. Pervasive presence of these symptoms since childhood
3. Symptoms cause clinically significant impairment in two or more settings
4. Symptoms are not explained by another disorder

1. *Current symptoms: Are sufficient subtype symptoms present*

DSM-IV criteria for children has required presence of six of nine listed symptoms of inattention, or six of nine current symptoms of impulsivity/hyperactivity, or both. The symptoms are described in the ADHD Symptom and Role Impact Inventory (ASRI) later in this chapter. Their pattern determines whether the diagnosis would be considered inattentive subtype, impulsive/hyperactive subtype, or, where both are met, combined subtype. However, research and clinical experience suggest that occurrence of four or more current symptoms from either category is abnormal, and is a useful threshold for discriminating adults with and without ADHD. For example, one research group found that four or more of these symptoms fell at the 93rd percentile of a sample of the general population [14], and that in a community sample 95–99% of non-ADHD individuals fell below this threshold [15, 16]. A study from our research group demonstrated that individuals who never met full DSM-IV ADHD criteria, but reported a chronic history of three or more inattentive or three or more impulsive/hyperactive symptoms, did not have the same level of clinical pathology as individuals who currently met full criteria for ADHD. A study has also suggested that requiring six hyperactive-impulsive symptoms could exclude about half of the individuals falling 1.5 standard deviations above the population mean for these traits [17]. In total, such studies suggest that four or more current symptoms from either subscale identify individuals likely to suffer from an ADHD syndrome.

While impulsivity is considered a core feature of the impulsive/hyperactive subtype of ADHD, only three of the nine impulsive/hyperactive symptoms directly reflect poor control of impulse—difficulty waiting, interrupting/intruding on others, and speaking out of turn. The DSM-V development process included exploration of adding more impulse control symptoms to the hyperactive/impulsive subtype traits. It is the opinion of this author that it will take significant experience with newer criteria to determine their utility. At present the evidence basis for treatment of adults with ADHD is more firmly rooted in the DSM-IV symptom pattern.

>> Please think about a recent, typical week. I want to know how often these things occur, or how much effort it takes to avoid or manage them. Also, I will ask how they impact your daily life.

This is a way of introducing current symptom evaluation based on a symptom inventory. It can be efficient to use a self-report or informant-report inventory, as well as conducting a symptom interview. It may be efficient to focus an interview about ADHD symptoms with items endorsed on self and informant inventories. However, it is important to make sure the ratings reflect understanding of the symptoms being reviewed, and a clinician should interview to identify how they would rate these symptoms. This chapter describes a clinical interview using the ASRI, and the clinician, self-report and informant report versions of the ASRI are found in the Appendix. Key principles for effective administration of a symptom inventory are presented below:

Focus on a Recent Time Period

Capturing a recent time period may be hard when patients want to share the worst situations they have been through. It can be useful to know about the time 3 years ago that the patient locked their car keys in their car with their car running—but day to day traits should be the focus of the rating scale, to determine how pervasive ADHD is in day to day life. It helps to repeatedly reminding the patient that you want to know about a recent, typical week.

Word Questions to Reflect Adult Experience of Symptoms

Where ADHD persists into adulthood, symptoms of inattention tend to remain prominent. However, overt impulsive and hyperactive behavior tends to diminish. Put another way, as individuals with impulsive or hyperactive traits grow up, the restlessness often remains in the form of internal impulse or urges. Children who ran in the hallways of school are not likely to run in the corridors at work, but they may get up for unnecessary and frequent breaks to just move around. Impulsive symptoms may be related to verbal communication—interrupting others, talking more than needed—but many patients describe the consequences of emails sent without thinking, decisions to leave jobs or even end relationships based on emotional reactions. Interviewing adults for symptoms of hyperactivity and impulsivity requires sensitivity to the impulses they may be actively controlling, and the contexts (like sitting, lingering with others) they avoid.

Compensatory Burden Should Count Towards Symptoms Count

Adults with ADHD have learned ways to cope with ADHD symptoms, and may even avoid contexts that demand the focus and behavior control skills they lack. Simply asking about day-to-day problems may miss compensatory efforts. For example, if one asks how often a patient loses things, they may say never—but if you ask the same patient how often they have to look for things they misplaced, they may say “all the time—I find it eventually, so it’s never lost.” Often people have little basis for comparing how much effort it takes to do mundane tasks—they may not recognize that their long hours at work, need to double-check work, or reliance on advance preparation or reminders is unusual. Where compensatory efforts are effective and efficient—such as a habit of checking whether one has their keys, wallet and identification card before leaving home, they should not contribute in measurement of symptom burden. Compensation should be a burden to count towards the severity of a symptom.

Determine Severity from Frequency of Symptoms, Consequence and Compensation

It may seem efficient to ask patients whether they consider the impact of a trait "mild, moderate, or severe," but the clinician should determine if they agree. A rating scale based on frequency may be useful for quick self-report of symptom occurrence. But determining severity of a condition requires appreciation of the impact and burden of symptoms as well. Thus it is useful to capture severity of impact and burden when rating ADHD symptoms.

Symptom severity can be seen as a product of symptom frequency, efforts required to minimize impact of symptoms, and the actual impact of symptoms. It is helpful to establish guidelines for rating mild, moderate and severe, to improve the ease of this process in the moment. Here is an example of frequency or function criteria used to evaluate each level of severity:

- Severe symptom: occurs very frequently OR very compromising of function in a life role
- Moderate symptoms: occurs often OR could impair ability to fulfill an important life role
- Mild: occurs sometimes OR is not likely to impact a life role

Use Symptom Queries to Gather Unique Information

A particular day to day challenge may be seen as a product of more than one symptom on the ADHD symptom list. For example, difficulty paying attention to information presented is part of both trouble paying attention and trouble listening in one on one conversations. Difficulty finding things may be a result of poor organization—yet misplacing things and organizational skills are captured in separate symptoms. It is useful to try to see each symptom question as a chance to identify a unique dimension of the disorder. Thus, different aspects of "paying attention" might be assessed in separate items reflecting one-on-one conversations versus gathering of information such as in a meeting, while reading, or during note taking. Similarly, it is useful to use scale items to seperately identify memory challenges and organizational skills.

Establish Whether Clinical Symptom Threshold Is Met

Count up the number of traits that you rated at the moderate or severe level. Are at least four symptoms present at the level of moderate within either the inattentive or the impulsive/hyperactive subset of symptoms? Also note if there is anything informative about the pattern observed—does the person fall solidly into inattentive subtype with very little impulsive/hyperactive traits? Or is the opposite pattern evident? Clinical experience suggests that a pattern marked solely by impulsive or hyperactive

traits merits special differential diagnosis attention, as it is a rare presentation in adults with ADHD. In addition, as noted above, the three separate symptoms of impulsivity deserve special consideration. If a person met only impulsive traits, it may be particularly important to keep this in mind while exploring alternative conditions that would explain the differential diagnosis.

Discussion of Role Function Helps Ground Discussion of ADHD Impact

The inventory below also offers a chance to empathically appreciate the impact of attention and behavior control challenges, in the major settings–or roles–of a person's life—useful for appreciating whether the impairment and "two or more settings" criteria are met. Impact in a single setting merits exploration of what specific challenges are present there and nowhere else. For example, a learning disability my cause difficulty engaging school work, leaving self-care, home life and relationships intact. Explore roles that are important to the individual, that involve different dimensions of daily life.

Note Examples of Consequences

It is very helpful to make note of—and discuss—typical examples of how each symptom impacts a person. This offers a more concrete way to talk about the impact of ADHD, and track the severity of its manifestations. For example, if a person spends 20 min a day looking for things, that can be noted in the space for rating severity of misplacing things. Procrastination in a college student might be tracked by what time they get around to starting homework. To follow accuracy with details, the number of times an office worker makes "careless" mistakes might be followed.

Speaking the "Language" of ADHD: Prompts and Examples for ADHD Symptoms

To understand if someone has ADHD, one must understand their pattern of control over attention and behavior. Evaluation of ADHD symptoms is an exercise in empathy for cognitive challenges. It can help to think, "What would be hard for me to do if I was this person, and had their strengths and challenges?"

The self-report, informant report, and clinician forms of the ASRI (all found in the Appendix to be copied for clinical use) facilitate exploration of current symptom burden, related impairment in roles, and the age of symptom onset. The language in these inventories identifies common ADHD manifestations in adults.

The guidance presented in this chapter for use of the ASRI is also summarized in the Appendix. The language and examples offered below reflect the author's interpretation of the intention of DSM criteria. Many similar questions and examples of role

impairment are useful. Language should be tailored to an individual's circumstances to capture the theme of the symptoms.

The prompts that follow should be taken as one example of how one can determine whether symptoms are present in day to day function. Many similar kinds of questions could be useful (Table 2.1).

2. *Age of onset: Determining the longitudinal course*

>> What age did you first have these kinds of challenges? When did other people first talk about them? Do you remember periods of time when you didn't have these challenges? Were they part of your life during times when you felt and functioned at your best? Did you "grow out of" some of these challenges?

Systematic identification of age of onset of ADHD is central to identifying whether this developmental condition is present. The ASRI Clinician, Self, and Informant recording sheets has space to record age of onset of traits endorsed. Some clinicians prefer to start with a historical perspective, asking about childhood experiences and how challenges then persist to the present day. Whether one starts with current symptom and asks their onset, or gathers data about how childhood manifestations persist, these kinds of questions may help determine the pervasiveness of the symptoms in a person's life. Some people can note particular times when they didn't have these traits—and that can be a clue to whether an alternative diagnosis is more important (see section below on differential diagnosis). Alternatively, there may be environmental factors that meant that certain life periods were more free of problems (see discussion of age of onset criteria below). It is also important to consider how organized the childhood environment was, and whether a disorganized or struggling family could be the source of organizational challenges.

While it is important not to "lead the witness," it is also important to orient the patient to what kinds of examples are helpful. One might inquire: "What do you remember about your classroom experiences? Did you get in trouble in class? Can you give me examples?" Another relevant example: "Were you expected to do tasks at home? Do you recall whether and how you got them done?" Asking about a specific trait, find out how often it occurred and whether it was remarkable to others or caused problems. "You said you misplaced a lot of things as a child—did your parents comment on that or have to help you find things? How often?"

It is often hard for adults to recall enough details of their childhood, so third party reports are very useful. Giving patients homework to obtain old school records, or records from prior evaluations can be useful. It also is useful to have patients ask someone else, if they are comfortable, to fill out a rating scale with queries about onset (See Appendix for ASRI Informant inventory).

>> Did your teachers, parents, or friends comment about problems with focus or behavior when you were little? How hard was it for you to behave as expected, to get along with others, to take care of schoolwork or household chores?

While DSM-IV required onset of some ADHD symptoms by age 7, there is evidence that report of ADHD symptoms by age 12 is consistent with a clinically impairing syndrome. Individuals who met full criteria for DSM-IV ADHD but had

Table 2.1 Questions exploring symptoms of ADHD in adults

Inattentive traits
Difficulty being accurate with details
Prompt: How much effort does it take to be accurate or catch mistakes in your work? How often do you make errors that matter?
Difficulty sustaining attention
Prompt: How much effort does it take to pay attention when you should? How often do you miss presented information because of mind wandering?
Difficulty listening in conversation
Prompt: How hard is it to listen to someone who is speaking directly to you? How often do you miss what people say to you?
Difficulty sticking to and finishing actions
Prompt: How much effort does it take to stick with a task and not start a new one? How often do things go unfinished?
Difficulty organizing
Prompt: How much effort does it take to stay organized? How often do you wish things your space or activities were more organized?
Putting off tasks requiring mental effort
Prompt: How hard is it to get around to work that you need to complete? How often do you need a deadline to get things done?
Often losing important items
Prompt: Do you have to be careful not to misplace things? How often do you spend more than 10 min a day looking for things?
Forgetfulness
Prompt: Does it take special effort to remember things you need to do? How often are you upset that you forgot something?
Often distracted by things in environment
Prompt: Is it hard to tune out distractions around you? How often does distraction keep you from accomplishing tasks?
Hyperactive/impulsive traits
Hyperactivity/Impulsivity
Fidgeting
Prompt: How much effort does it take to be still when sitting? How often is your fidgeting upsetting to you or others?
Restless
Prompt: How much effort does it take for you to sit as long as you should? How often do you interrupt activities to get up?
Excessively in motion
Prompt: Is it hard to stop yourself from moving too much? How often are you more in motion than other people?
Excessively loud
Prompt: Does it take effort for you to control the "volume" of your voice or presence? How often do you wish you had controlled it better?
Excessive internal drive
Prompt: Is it hard to linger at activities? How often does the urge to stay busy cause problems?
Talking excessively
Prompt: Does it take effort not to talk longer than you need to? How often do you wish you had stopped talking sooner?

(continued)

Table 2.1 (continued)

Speaking at the wrong time in conversation *Prompt*: How hard is it not to speak before your turn? How often do other people ask you to let them finish?
Difficulty waiting *Prompt*: How hard is it to wait, such as in a line at a supermarket, or in light traffic? How often do you avoid lines or leave them?
Intruding on others *Prompt*: Is it hard not to interrupt others people when they are already in a conversation? How often do you intrude on other people?

symptom onset by age 12 appear to have similar life consequences of the condition as those with onset by age 7 [16, 18]. See the note about subthreshold presentations that follows below. Operationally, therefore, it is appropriate to count the presence of only a few symptoms within either the inattentive or impulsive/hyperactive category as enough to fulfill the onset criteria.

It is common to hear that some traits did not appear until later in life. A college students or adult entering the workforce may note, for example, forgetting things, misplacing things and having trouble organizing only recently, but problems getting around to mental effort tasks, listening, and attending to presentations back to early grade school. When particular traits did not occur until a particular point in time, it helps to understand why that might be. In some cases, it may be clear that this is related to the emergence of ADHD-sensitive roles—such as greater self-organization responsibilities. In others, concern about symptoms emerges with change in daily demands, personal priorities, or available supports.

3. *Symptom-related impairment in two or more settings*

Two or more roles of the individual's life must be impacted by the ADHD symptoms—for a period of at least 6 months. It is efficient to collect examples of role impairment during review of current symptom burden. You may want to review the examples of role impairment typically caused by ADHD symptoms that are noted in Table 2.2, and reiterated in the Guide to the ASRI in the Appendix. Symptom-related problems appear in very different patterns between individuals, and it may take exploring low-interest, effortful situations or situations requiring low activity to identify examples of role impairment. If needed, the ASRI examples of impairment can be reviewed with an individual to prompt identification of similar issues.

However, there may be roles that are difficult to evaluate—either because of lack of good information from the patient, or because they are deferred or avoided roles. Third party reports may help—whether through review of a work progress report, or direct interview of a loved one. Scales have also been developed and validated which identify kinds of impairment that are common in adults with ADHD, including the Weiss Functional Impairment Rating Scale—Self-Report [19] and ADHD Impact Module for Adults (AIM-A) [20].

It is hard to evaluate function in a role the person is not currently active in. Fortunately, patients can often explain how they functioned the last time they were

Table 2.2 Examples of Adult Role Impairment Due to ADHD Symptoms

Role impairment due to inattentive traits		
Difficulty being accurate with details		
Self/home: Filling out forms incorrectly	*School/work*: Careless mistakes, missed instructions	*Relationships*: Missing important details in emails
Difficulty sustaining attention		
Self/home: Mind wandering while reading	*School/work*: Gaps in class or meeting notes	*Relationships*: Trouble following the theme in group conversations
Difficulty listening in conversation		
Self/home: Not hearing requests from others at home	*School/work*: Not hearing instructions	*Relationships*: Other people have to repeat themselves
Difficulty sticking to and finishing actions		
Self/home: Frequently sidetracked from everyday tasks	*School/work*: Partially completed tasks pile up	*Relationships*: Difficulty staying on topic in conversations
Difficulty organizing		
Self/home: Mess makes it hard to use personal spaces (desk, closet)	*School/work*: Overwhelmed due to poor planning and prioritizing	*Relationships*: Less likely to organize social activities
Putting off tasks requiring mental effort		
Self/home: Mail left unopened, paying bills late	*School/work*: Staying up late to prepare work for the next day	*Relationships*: Lack of preparation for shared activities upsets others
Often losing important items		
Self/home: Personal time consumed by looking for items like keys or phone	*School/Work*: Takes longer to complete work because of looking for needed items	*Relationships*: Overreliance on others to keep track of personal items
Forgetfulness		
Self/home: Having to return to get things left behind	*School/work*: Forgetting assignments or instructions	*Relationships*: Forgetting to call or meet with others
Often distracted by things in environment		
Self/home: Need to isolate from reminders of other tasks to get personal tasks done	*School/work*: Inefficient at working around others	*Relationships*: Difficulty listening with conversations or activity nearby
Role impairment due to hyperactive/impulsive traits		
Fidgeting		
Self/home: Self-conscious of own fidgeting	*School/work*: Disrupting classes or meetings by tapping on a desk, bouncing legs	*Relationships*: Physical movements misinterpreted as anxiety, lack of interest
Restless		
Self/home: Hard to sit long enough to sort through mail, manage bills	*School/work*: Frequently disengaging from tasks and meetings to get up	*Relationships*: Difficulty sitting through activities, conversations upsets others

(continued)

Table 2.2 (continued)

Excessive motion		
Self/home: Requires exercise to feel physically calm	*School/work*: Poor performance at tasks requiring sitting	*Relationships*: Hard to enjoy low-action activities with others
Excessively loud		
Self/home: Excitability detracts from quality of communication with others	*School/work*: Excessive, distracting presence in class or meetings	*Relationships*: Volume or intensity makes other people uncomfortable
Excessive internal drive		
Self/home: Rarely taking time to relax	*School/work*: Taking on too many new activities or responsibilities	*Relationships*: Others find the person to be rarely "present" because of urge to move on
Talking excessively		
Self/home: Talking too much creates inefficient communication with service providers like doctors	*School/work*: Lose other's interest in classes or meetings	*Relationships*: Talking more than other people limits depth of relationships
Speaking at the wrong time in conversation		
Self/home: Interrupting limits information gathering from others	*School/work*: Hard to listen while trying to "hold the thought" and not interrupt?	*Relationships*: Annoying other people, limiting chance to build relationships
Difficulty waiting		
Self/home: Leaving or avoiding necessary lines (shopping, finding food)	*School/work*: Acting without waiting for input from others	*Relationships*: Upsetting others with impatience
Intruding on others		
Self/home: Others are less willing to assist because of impolite, intrusive behavior	*School/work*: Being bossy or "taking charge" limits collaboration.	*Relationships*: Offending others with impolite, intrusive style

in a particular role. But a 43-year-old woman who has been out of school for 22 years but thinking about taking classes may have little idea how she would function as a mature student. One might extrapolate from her ability to focus in work meetings and complete tasks for her job to imagine how school function would go—but full evaluation of her school capacities might take re-enrollment in classes. The more one has to "imagine" whether there would be impairment in a role, the less confident one should be about the diagnosis. The mental exercise of imagining how traits limit options is important for considering the potential future impact of traits also—such as thinking how a person who thrives on stimulation would handle lengthy solo desk-based projects at a job they are considering. Below find further discussion of factors to consider in determining if impairment is present.

Factors to Consider in Evaluating Impairment

Impairment is a relative term—and it may be helpful to consider which if any of the factors in the following table should be accounted for in determining whether impairment is present. Some patients will talk as if they are impaired by symptoms of ADHD, but further evaluation determines that they are overly critical of themselves, and another person would not consider them impaired. Patients who excel by social standards can still have ADHD, either manifesting in extensive efforts to compensate or not performing to their potential.

In assessing impairment, it may be helpful to consider the difference between performance enhancement and accommodation of a clinical problem. It is appropriate to facilitate a person's ability to apply their native capacities where it allows a person to overcome impairment to thriving. If ADHD traits limit ability to apply native capacities, then their reduction is an appropriate clinical goal. This purpose should be contrasted with seeking to "enhance" functional capacities where there is no impairment in ability to apply native capacities. A common example of the latter would be a student who does not have ADHD, but takes a stimulant to stay up late and study more intensely for exams (Table 2.3).

4. *Are impairing symptoms due to another condition: Explore the differential diagnosis*

Evaluating whether this criteria is fulfilled can take up much of the interview time, if patients have other forms of mental health distress. It must be emphasized again that many preoccupying or mentally compromising states, and some physical conditions such as endocrine disorders, pain, or drug withdrawal, can impair cognitive control of attention or behavior. Because ADHD is a disorder of childhood onset, time course is very useful to differentiate it from other conditions. Many other mental health conditions are episodic—so identifying if ADHD has been present between episodes is useful.

>> "Can you think of the most recent time that you were free of (feeling down, irritable, sad, anxious etc.)—did you have these focus (or restlessness or impulsivity) challenges then?" "How about when you were feeling and functioning your best—was it a struggle to pay attention (or be at rest, or control your behavior) then?"

Preoccupying states of mind compromise control of attention just as ADHD. Asking a patient to share what they think about when their mind wanders can be a very quick way to identify anxiety, mood or other distress in patients. For example, patients have revealed that it is hard to focus because they keep obsessing about a concern, or their thoughts are dark or otherwise mood related. The following are related questions to ask:

>> Is it hard to put worry or nervous thinking out of your mind? Imagine yourself in that weekly meeting (choose a relevant recent example) that you always have trouble paying attention to—what does your mind wander to? Is it to thoughts with a particular mood to them, like nervous, concerned or upset thoughts? Are distressing thoughts a burden that is hard to put out of your mind when you are doing tasks?

Table 2.3 Identifying ADHD-Related Impairment

Evaluate what else explains impairment besides ADHD
Would a different choice of role or environment eliminate burden?
Are current demands straining an area of functional weakness other than ADHD?
Consider impact of resolving symptoms
Would absence of ADHD symptoms allow the person to thrive?
Consider how beliefs and values distort patient's evaluation of impairment
Will symptoms impact the person's life as much as they think they will?
Are the patient's personal goals unhealthy?
Decide if treatment facilitates healthy native capacities or is inappropriate enhancement
Would treatment eliminate a barrier to healthy, adaptive function

It is valuable to characterize the type of internal distracted thinking that is occurring—to differentiate between mind wandering and distressed preoccupation. Where a person endorses concerned or obsessive type thinking, this may raise the importance of looking for an anxiety disorder; if down or depressed, a depressive etiology should be sought. For example, a businessman thought he had ADHD because he couldn't read reports on other companies, because he would quickly obsess over why his company wasn't doing the things he read about. Cognitive behavioral therapy helped resolve his anxious thoughts, and he now rarely struggles to read.

The diagnostic assessment should include a screen for all major mental health disorders, *as well as major medical conditions*. It helps to have a structured way such as a checklist or a template to go through other possible diagnoses, as the list is long. However, it can be efficient to ask the following kinds of questions to identify patterns of past suffering.

>> Have you ever had a time in your life when you were unable to function as you normally do? Or where you suffered distress?

>> Are there particular ways that you struggle besides ADHD symptoms? What kinds of things are hard for you to do?

>> Are you worried or concerned more than you should be? Is it hard to get worry or concerns off your mind even when you are busy?

>> Are your moods and feelings unpredictable?

>> Are there things that you spend time doing that you wish you didn't? Or that upset other people?

These kinds of questions may engage the patient in discussion of other dimensions of personal struggle beyond ADHD. They do not replace systematic assessment of other Axis I, II or III DSM conditions.

It may be very appropriate to defer evaluation of ADHD where another major syndrome is present. Discussion of how to manage ADHD in the setting of comorbidity can be found in chapters on common comorbidity and adolescent ADHD in this text.

To determine all the potential conditions in a person's life—and the relative impact of ADHD traits among them—it is useful to identify all the conditions that

Table 2.4 Distinguishing Between ADHD and Other Conditions Compromising Cognition[a]

Type of condition	Differential features	Differential measures
Other mental health condition	Onset and pattern of symptoms, absence of criteria for other disorders	Clinical interview
Other learning or "processing" disorder, e.g., dyslexia	Impairment specific to learning, communicating, or manipulating information	Neuropsychological testing
Executive function deficits (beyond ADHD)	Disorganization not due to focus, restlessness, or impulsivity; poor planning, judgement, sense of time, or routines	Neuropsychological testing
Pervasive developmental/ autistic spectrum	Social skills deficits; lack of mutual relationships	Clinical interview
Developmental encephalopathies [genetic (e.g., mitochondrial) or acquired (e.g., fetal alcohol) syndromes]	History of neurologic insult; family history; developmental delay; severity of mental status impairment; broad mental function deficits; physical deficits	Neuropsychological testing; genetic testing
Brain trauma (e.g., post concussive syndrome)	Onset following trauma; broad mental function impairment	Brain imaging
Acute delirium/encephalopathy	Fluctuating attention; organ system impairment; poisoning; alcohol, substance use; peripheral neurologic symptoms	Laboratory testing; toxicology screen; workup for occult illness (e.g., urinary tract infection, chest infection)
Dementia	Pattern of onset (decline later in life); new memory, executive function or behavior impairment	Neuropsychological testing; brain imaging
Endocrine disorder	Physical symptoms (e.g., fatigue, weight change in thyroid dysfunction); broad decline in mental function	Laboratory testing
Seizure disorder	Pattern and late onset of symptoms	Sleep-deprived EEG
Sleep disorder	Pattern and onset of symptoms; presence of snoring, restlessness, ease of napping despite full sleep. Iron deficiency	Sleep study; actigraphy; sleep-related habit inventory; laboratory studies
Dietary intolerance (e.g., food allergy; gluten sensitivity)	Gastrointestinal symptoms; confirmed association with a food	Food allergy testing; elimination diets
Neurotoxicity	Toxin exposure; neurologic or other physical symptoms of toxic exposure	Laboratory testing (e.g., lead)

[a]This is not a comprehensive list. Any condition impacting brain function could share ADHD symptoms

Table 2.5 Some Medical Conditions that may Contraindicate ADHD Treatments[a,b]

Type of contraindication	Relevant agents
Arrhythmia, structural or other cardiac defect	Tricyclic antidepressants prolong QT interval; most ADHD medications impact heart rate, contractility, blood pressure
Agents with sympathomimetic properties	Agents (e.g., caffeine, theophylline, pseudoephedrine) with sympathomimetic properties may compound sympathetic side effects of ADHD medication
Monoamine oxidase inhibitors (antidepressants, linezolide), other drugs	ADHD medication combined with MAOI may promote hypertensive reaction, serotonin syndrome; ADHD medications may impact effect of other agents[b]
Past or current psychosis (e.g., hallucinations, paranoia); past or current states of agitation (e.g., hypomania/mania)	ADHD medications could exacerbate or cause recurrence
Elevated intraocular pressure (e.g., narrow angle glaucoma)	ADHD medications could exacerbate
Substance misuse or abuse	Stimulants may be abused
Tic disorder	Some ADHD medications could exacerbate
Untreated hyperthyroidism	Some ADHD medications could exacerbate
Untreated hypertension	Some ADHD medication could exacerbate

[a]Specialty consultation or management, including careful education, manages some risks
[b]Drug–drug interactions are not detailed on this list because of their variety, and it is important to check for updated interactions whenever prescribing

may be present. It can help to mentally suspend for the purposes of full assessment, any DSM requirements stating that some conditions cannot exist in the presence of others.

There are many causes of mild encephalopathy that can look like ADHD. Neuropsychiatric conditions, such as learning disabilities, are often comorbid with ADHD. Many conditions that compromise ability to focus or create restlessness can be differentiated from ADHD by presence of ADHD symptoms when the conditions were not present, symptoms unique to the conditions, or medical findings associated with them. Table 2.4 offers a list of typical conditions worth considering, with possible ways of differentiating them from ADHD. An adapted version of this table is in the Appendix for use in both differential diagnosis and identifying comorbid conditions that compromise cognitive ability.

Special attention should be given to any condition that ADHD medication treatment might exacerbate, many of which are summarized in Table 2.5. A version of this table is adapted for clinical use in the Appendix. Stimulants, for example, may be abused, and all sympathomimetics may exacerbate agitation or psychosis. Cardiovascular risk, and screening for cardiovascular risk, is discussed in detail in the chapter on stimulant treatment. As emphasized in the next chapter, other conditions causing cognitive compromise can impact adherence to treatment recommendations.

Identify Traits and Comorbidity that May Influence Treatment Plan

The process of differential diagnosis is also an opportunity to inventory conditions and traits that compound impairment or complicate management. These include conditions or traits that strain the cognitive, physical or emotional wellbeing of a patient. Conceptually, it is important to understand that anything that compromises ability to compensate for ADHD, produces symptoms similar to those of ADHD, or creates mental distraction will exacerbate symptom severity. Comprehensive evaluation of such conditions and circumstances is important to holistic support of the patient.

Because ADHD is a cognitive disorder that strains adaptive function, it is useful to use the initial history-taking as a chance to identify patterns of strengths and challenges relevant to adaptation. It may be efficient to directly ask an individual where they have struggled and where they have thrived in the past. It can also be useful to think about mismatches between the person's abilities or opportunities and their achievements. A common sign that organizational challenges beyond core ADHD traits are present includes onset of new or greater struggle once individuals are more independent—for example, on arrival to college. This transition point often brings out difficulties with organization and self-structure as the scaffolding provided to children falls away. Another important indicator of strengths and challenges might be struggles occurring in particular job environments or social roles—try to discern if there is a pattern suggesting that struggles are due to a learning style, or challenges with interpersonal, communication or other skills.

The following chapter offers more perspective on how to identify factors which exacerbate an individual's ADHD-related struggles.

Note on Subthreshold Cases

The sine qua non of clinical diagnosis is impairment related to the condition. It is appropriate to diagnoses subthreshold ADHD—or ADHD not otherwise specified (NOS) in DSM language—where the overlap with ADHD full diagnosis is large, impairment related to the traits are present, and there is no better explanation of the traits. It is worth noting, however, that research data suggests that less than three current symptoms in an ADHD subcategory, and onset after age 12, information is less likely to correlate with full ADHD type impairment. This has led to incorporation of later onset and lower current symptom burden requirements in the DSM-V adult criteria.

Treatment as a Method of "Assessment"

Medications for ADHD, particularly stimulants, may enhance aspects of cognitive function such as vigilance, sustained attention, or alertness in individuals without ADHD. Therefore, a trial of stimulant treatment is not a good "test" of whether the

diagnosis is present. However, it may take a treatment trial to understand the potential benefit of a treatment trial. This may seem like an obvious statement, but it is important to see such trials as a part of the exploration of appropriate clinical intervention, rather than as establishing the diagnosis. In any treatment intervention, following an initial adequate trial, the associated reduction in impairment should be reviewed to determine if continuation is merited. This may take, in some cases, periods off and on treatment to understand treatment impact. Approach to initiating a treatment trial is discussed further in the chapter on stimulants in this volume.

Self-Regulatory Problems Are Commonly Associated with ADHD

It is clear that some individuals have self-regulation problems that extend beyond the focus, restlessness and impulsivity challenges highlighted in the DSM core criteria of the disorder—although they may be considered as separate attributes, problems with organizing personal schedule—such as sleep habits, eating habits or exercise habits, and problems controlling emotional expression are now thought to be common in, and etiologically very closely related to, ADHD in many individuals. A full evaluation of factors contributing to poor self-regulation of behavior extends beyond inventory of ADHD, to understanding the extent of self-regulatory challenges in domains like daily patterns and control of internal states or expression of them, such as emotion control.

Characterize the Extent of Organizational Challenges

Evaluation of ADHD should also assess a person's ability to organize themselves beyond ability to control attention and impulse so that appropriate supports can be set up. Only one item in the diagnostic criteria for ADHD—the symptom of "disorganization"—explicitly mentions organizational challenges. ADHD individuals present with varying forms of organizational challenges that are not explained solely by difficulty controlling attention, restlessness, or impulsivity—and varying level of skills to deal with them. See Table 2.6 for questions that can help identify patterns of difficulty organizing behavior.

Executive function deficits beyond the core traits of ADHD predict additional burden in daily life [21–24] and indicate need for specialized supports. The chapter on neuropsychological assessment in this guide notes how tools like the Behavior Rating Inventory of Executive Function and the Barkley Deficits in Executive Functioning Scale inventories can be applied to screen for and characterize these challenges, and how neuropsychological tests can be applied to document related cognitive capacities. However, in clinical care settings the patient or people who know them can be interviewed to determine level of organizational challenges and skills.

Table 2.6 Questions That Explore Executive and Self-regulatory Skills

– What habits—like using a planner, making lists—do you use to stay organized?
– When you have to plan or organize an activity, how does that go?
– Do you have trouble prioritizing?
– Is it hard for you to make choices?
– Do you have a good sense of time?
– Are you often late for things?
– Are you flexible if plans change?
– Are you consistent with organizational habits like putting things away, using a planner?
– Do you protect time for all the priorities in your life?
– Do you outsource things you are not good at?
– What kinds of tasks do you rely on other people for?

It can be helpful to help patients see that there is a difference between core ADHD traits and broader organizational challenges. For example, there is a difference between one's ability to attend—ability to focus during a task like studying, for example—and the executive skills necessary to stay on top of a study schedule. The latter requires choosing what to study, deciding when to study it, and sticking with the study schedule. Ability to prioritize, to keep track of time, and to monitor performance is also critical executive skills that are often impaired in the ADHD population.

It may be generalized that medications often help people with ADHD get around to, stick with, and finish tasks, but do not add executive skills. Some patients appreciate the following metaphor: medication for ADHD is to behavior pattern as a deeper keel is to a boat - one still has to chart a course and steer, but it is easier to keep on course. Thus, some patients will experience ability to focus more, but end up focusing on the wrong tasks. The subset of individuals with strong organizational skill deficits are likely to still suffer from these challenges despite medication treatment. The following chapter explores personalization of treatment for individuals with poor self-regulatory and organizational capacities.

Poor Control of Emotional Expression Is an Example of Poor Self-regulation Related to ADHD

The connection between ADHD and poor control of emotional expression is evidence of the importance of appreciating that ADHD broadly impacts an individual's function. A subset of adults with ADHD has worse problems with control of emotional expression. Our research group and others have found that this may be a majority of adults with ADHD [25–27]. Traits like irritable, angry, and overreactive emotion in adults with ADHD correlate with worse quality of life and impaired role function [28]. The combination of ADHD and such deficient emotional self-regulation was more common in siblings of adults who had ADHD suggesting it may be a familial variant of ADHD and may occur with ADHD for genetic reasons [27].

Deficient emotional self-regulation can be separated from other emotion-related clinical diagnoses by the absence of pertinent criteria, such as additional emotional

or physical symptoms. For example, while deficient emotional self-regulation symptoms may occur in, for example, a state of irritable depression or hypomanic irritability, these conditions require that an individual is stuck in a prolonged mood. While oppositional defiant disorder is identified typically in childhood, its traits include poor control of interpersonal reactions and emotion-laden tension with others. However, as it is conceptualized, the traits of oppositional defiant disorder highlight difficulty with authority figures. Of note, oppositional defiant traits can persist into adulthood [29] and often diminish with successful treatment of ADHD. Poor regulation of emotion is a feature of some personality disorders, but full criteria for the pattern of interpersonal function need not be met to have these traits.

There is limited experience to date applying inventories for poor control of emotional expression in clinical settings. There has been little exploration of whether these emotional control symptoms are responsive to pharmacotherapy for ADHD. It is clear that in some patients they are not. It may be rational to consider cognitive behavioral therapies for such patients.

Questions to Identify Difficulty with Emotional Self-Regulation

- Do you over-react emotionally?
- Do you often get frustrated or angry
- Do you often regret decisions made or actions taken while emotional?
- Do other people think your emotions cause problems?
- Do you wish you had more control over how you express emotions?

Getting to Know the Patient Helps Difficult Diagnoses

It is important to stress that in complex presentations it may not be possible to determine if a person has ADHD. Limited recall of past symptoms, difficulty determining if impairment is present, and presence of other mental health conditions are common reasons to defer making a diagnosis. In cases where possible ADHD cannot be separated from other conditions, it may take treating the other conditions to determine if ADHD is residual. This manual includes chapters on common comorbidity and disorders manifesting in adolescence and explores them in more detail.

It may be easier to make a diagnosis once one knows the patient better, has obtained third party information, or has obtained more historical records about the patient. However, these efforts should be pursued to address the core question—is there impairment due to ADHD—rather than as an academic exercise.

There are many pressures to evaluate patients quickly. Diagnosis of ADHD requires confident understanding of the patient. It is thus worth restating that evaluations can be spread over multiple appointments, or shared with a treater that can get to know the patient over many appointments. It can help to enlist the patient as a collaborator in this exploration—giving them homework, such as the Self and Informant versions of the ASRI at the back of this textbook, or a question to consider with you over the course of a few appointments, such as the relative importance of ADHD traits versus other challenges like learning style issues, anxiety or mood symptoms.

Offering a Diagnostic Impression

If the individual meets criteria for ADHD in adulthood, the subtype should be specified and explained—are inattentive, impulsive/hyperactive (a rare presentation in adults) or both (combined) type criteria fulfilled? In addition to identifying other comorbid conditions and challenges, self-regulatory problems such as poor emotional control or difficulties with executive capacities beyond core ADHD traits should be highlighted as important issues.

It is helpful to review with a patient which of the issues they have discussed are due to ADHD versus self-regulatory problems, because there are different supports for each. This can be done by reflecting back on day to day examples they raised in the interview. For example, reviewing content from the ASRI, a clinician may say "you said you were concerned that you put off work to the last minute, and get easily side tracked, so you end up working late. This is an example of how inattentive type ADHD impacts you." Reflecting on exploration of their self-regulatory abilities beyond core ADHD symptoms, a clinician might say "You also said that it is hard for you to know where to start on a project, and that you lose track of time and are often late for meetings—these are examples of what we call executive function challenges that come along with your ADHD." This kind of discussion helps clarify the connection between their experiences and the condition you can help them treat.

A diagnosis of ADHD will mean different things to different people. Asking the patient directly what they already know about ADHD, what having it means to them, or what questions they have about it can identify what kinds of education will help. Some individuals will be interested in resources to understand the neurobiology of ADHD, and the previous chapter offers a rich resource of factual perspectives on ADHD that may be helpful for education in the office. Others will be looking for resources to learn about treatment. It is helpful to identify a community or online group that offers evidence-based and medically factual information to consumers, such as Children and Adults with ADHD (CHADD), or the Canadian ADHD Resource Alliance (CADDRA). Because patients have quick access to information of varying qualities, it is also important to ask patients to bring concerns or questions they generate from their own research in for discussion.

Diagnostic impressions are empowering when they help individuals understand themselves or make healthy changes. The impact of receiving a diagnosis can be profound. For some patients it offers explanation for a lifetime of struggles, an explanation they can hold in mind instead of self-blame. It is useful to discuss ADHD as a set of "challenges," and to make it clear that there are treatments and skills that make these challenges much more manageable. Treatment planning should be rooted in this kind of productive perspective, giving the patient a hopeful mental framework for adapting to ADHD. The next chapter complements this one, describing a collaborative approach to personalized treatment planning for adults with ADHD.

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