

UNDERSTANDING ADHD

A Complete Guide for Children & Adults

PART 1 OF 2

Symptoms • Causes • Diagnosis • Nutrition • What to Avoid

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Table of Contents

PART 1

Chapter 1. What is ADHD?

Overview, History & Core Concepts

Chapter 2. Symptoms

Children vs Adults — Detailed Breakdown

Chapter 3. Causes & Risk Factors

Biological, Genetic, Environmental

Chapter 4. Diagnosis & Tests

Recommended Assessments & What to Expect

Chapter 5. Nutrition for Children with ADHD

Foods to Eat, Supplements, What to Avoid

Chapter 6. Nutrition for Adults with ADHD

Foods to Eat, Supplements, What to Avoid

Chapter 7. Assessment Scales — Children

Conners, Vanderbilt, SNAP-IV & More

Chapter 8. Assessment Scales — Adults

ASRS, BAARS-IV, Brown ADD & More

PART 2 (Tomorrow)

Chapter 9. Physical Exercises for Children

10 Movement-Based Interventions

Chapter 10. Physical Exercises for Adults

10 Evidence-Based Movement Strategies

Chapter 11. Counselling Exercises for Children

10 Therapeutic Activities

Chapter 12. Counselling Exercises for Adults

10 Therapeutic Strategies

Chapter 13. Treatment Approaches

Medication, Therapy, Holistic Options

Chapter 14. Predictive Outcomes & Prognosis

Research-Based Forecasts

Chapter 15. References

Full Academic & Clinical Citations

Chapter 1: What is ADHD?

Attention-Deficit/Hyperactivity Disorder (ADHD) is one of the most common neurodevelopmental disorders worldwide. It is characterised by persistent patterns of inattention, hyperactivity, and impulsivity that interfere with daily functioning and development. ADHD is not a sign of laziness, low intelligence, or poor parenting — it is a neurological difference that affects how the brain manages attention, behaviour, and emotion.

ADHD affects children and adults across all cultures, socioeconomic backgrounds, and genders. Estimates suggest that approximately 5 to 7 percent of children and 2 to 5 percent of adults worldwide are affected. It is more frequently diagnosed in males during childhood, although females are often under-diagnosed due to differences in how symptoms present.

A Brief History

The condition now known as ADHD was first clinically described in 1902 by Sir George Still, who observed children with significant difficulties in sustained attention and behavioural control. Over the following century, the condition was referred to by various names including Minimal Brain Dysfunction (MBD) and Hyperkinetic Reaction of Childhood. In 1980, the DSM-III formally introduced Attention Deficit Disorder (ADD), which was later revised to ADHD in the DSM-III-R (1987). The current DSM-5-TR (2022) recognises ADHD as a neurodevelopmental disorder with three presentations.

Three Presentations of ADHD

Presentation	Description
Predominantly Inattentive	Difficulty sustaining attention, following instructions, and organising tasks. Often overlooked — especially in females and quieter children.
Predominantly Hyperactive-Impulsive	Excessive movement, talking, and acting without thinking. More visible and more often diagnosed in young males.
Combined Presentation	Significant symptoms of both inattention and hyperactivity-impulsivity. The most commonly diagnosed presentation.

Core Brain Differences

Neuroimaging research has consistently shown structural and functional differences in the ADHD brain compared to neurotypical individuals. Key areas involved include:

- **Prefrontal Cortex:** Responsible for executive functions such as planning, decision-making, and impulse control. Typically shows reduced activity and delayed development in ADHD.
- **Basal Ganglia:** Plays a role in motor control and reward processing. Abnormalities here contribute to hyperactivity and impulsivity.
- **Cerebellum:** Involved in timing and motor coordination. Often reduced in volume in individuals with ADHD.
- **Dopamine and Norepinephrine Pathways:** These neurotransmitter systems are dysregulated in ADHD, affecting motivation, reward, and attention regulation.

Key Fact

ADHD is not caused by too much screen time, sugar, or poor discipline alone. While these factors can worsen symptoms, the root cause is neurological and genetic.

Chapter 2: Symptoms of ADHD

Symptoms of ADHD vary considerably depending on age, gender, environment, and individual neurology. The DSM-5-TR requires symptoms to be present before age 12, appear in two or more settings, and cause clear functional impairment. What follows is a comprehensive breakdown of how symptoms manifest in children and adults.

Symptoms in Children

Inattention Symptoms

1. Frequently fails to give close attention to details or makes careless mistakes in schoolwork.
2. Has difficulty sustaining attention in tasks or play activities for age-appropriate periods.
3. Does not seem to listen when spoken to directly — appears to be daydreaming.
4. Does not follow through on instructions; fails to finish schoolwork, chores, or duties.
5. Has difficulty organising tasks, activities, and belongings.
6. Avoids, dislikes, or is reluctant to engage in tasks requiring sustained mental effort.
7. Frequently loses items necessary for tasks (pencils, books, toys, glasses).
8. Easily distracted by unrelated thoughts or external stimuli.
9. Forgetful in daily activities — misses appointments, forgets homework, loses track of routines.

Hyperactivity and Impulsivity Symptoms

1. Fidgets with or taps hands or feet; squirms in seat.
2. Leaves seat in situations where remaining seated is expected.
3. Runs about or climbs in situations where it is inappropriate.
4. Unable to play or take part in leisure activities quietly.
5. Always 'on the go' — acts as if driven by a motor.
6. Talks excessively, often at inappropriate times.
7. Blurts out answers before questions have been completed.
8. Has difficulty waiting for a turn in games, conversations, or queues.
9. Interrupts or intrudes on others — butts into conversations or games.

Additional Signs in Children

- Emotional dysregulation — frequent meltdowns, frustration, or low frustration tolerance.
- Low self-esteem and increased sensitivity to criticism or failure.

- Difficulty with transitions — moving from one activity to another.
- Sleep difficulties — resisting bedtime, trouble falling asleep, or waking frequently.
- Challenges with peer relationships due to impulsive or intrusive behaviour.
- Academic underperformance inconsistent with apparent intellectual ability.

Symptoms in Adults

In adults, hyperactivity often becomes less overt and transforms into inner restlessness. The symptoms of ADHD in adults tend to be more internalised, and may be mistaken for anxiety, depression, or personality traits. Many adults are not diagnosed until their 30s, 40s, or later.

Inattention in Adults

1. Difficulty concentrating on tasks that are not personally stimulating or novel.
2. Frequently losing important items such as keys, wallet, phone, or documents.
3. Difficulty following through on projects — starts many things but finishes few.
4. Poor time management — chronically late, underestimates time needed for tasks.
5. Forgetfulness — missing appointments, deadlines, and commitments.
6. Easily distracted by internal thoughts (mind wandering) or external stimuli.
7. Difficulty reading long texts, following lengthy conversations, or watching films.
8. Difficulty organising paperwork, finances, home, or work responsibilities.
9. Hyperfocus on highly interesting activities while neglecting important duties.

Hyperactivity and Impulsivity in Adults

1. Inner restlessness — feeling constantly 'wired' or unable to relax fully.
2. Difficulty sitting through meetings, lectures, or quiet activities.
3. Excessive talking or interrupting others in social and professional settings.
4. Impulsive decision-making — financial, relational, or occupational.
5. Impulsive spending, eating, or substance use without considering consequences.
6. Road rage or impatience while driving; risk-taking behaviours.
7. Acting without thinking — sending regrettable messages, making snap judgements.
8. Mood instability — short fuse, emotional sensitivity, frustration intolerance.
9. Difficulty in relationships due to forgetfulness, distraction, or impulsivity.

Common Co-occurring Conditions

ADHD rarely occurs in isolation. The following conditions frequently co-occur:

Condition	Prevalence	Age Group
Anxiety Disorders	Up to 50% of individuals with ADHD	Children & Adults
Depression	Up to 38% of adults with ADHD	More common in adults

Condition	Prevalence	Age Group
Learning Disabilities	30–50% of children with ADHD	Dyslexia most common
ODD / Conduct Disorder	Up to 50% of ADHD children	More in boys
Sleep Disorders	Very common across all ages	Delayed sleep phase typical
Substance Use Disorders	Elevated risk in untreated ADHD	Adults primarily
Autism Spectrum Disorder	Overlapping features in 50–70%	Both presentations

Chapter 3: Causes & Risk Factors

ADHD is a complex, multi-factorial condition. There is no single cause. Current research supports an interaction of genetic, neurological, and environmental factors in its development.

Genetic Factors

ADHD has a heritability of approximately 74 to 80 percent, making it one of the most heritable psychiatric conditions. If a parent has ADHD, their child has a 40 to 60 percent chance of also having the condition. Twin studies have consistently demonstrated that identical twins are far more likely to both have ADHD than fraternal twins. Several genes have been implicated, particularly those regulating dopamine (DRD4, DRD5, DAT1) and norepinephrine (NET1) pathways.

Neurological Factors

- **Brain Development:** Children with ADHD show a delay of approximately 3 years in the development of the prefrontal cortex, the area responsible for self-regulation and executive function.
- **Neurotransmitter Imbalance:** Deficiencies in dopamine and norepinephrine signalling impair the brain's ability to regulate attention, motivation, and impulse control.
- **Brain Volume Differences:** MRI studies show reduced volume in the caudate nucleus, prefrontal cortex, and cerebellum in individuals with ADHD.
- **Functional Connectivity:** Differences in the default mode network (DMN) and executive control network have been identified in fMRI research.

Prenatal & Perinatal Risk Factors

- Maternal smoking during pregnancy — increases risk by approximately 2 to 3 times.
- Alcohol and substance use during pregnancy, including certain medications.
- Premature birth (before 37 weeks) or low birth weight.
- Maternal stress, poor nutrition, or infections during pregnancy.
- Birth complications involving oxygen deprivation (hypoxia).

Environmental Risk Factors

- **Lead Exposure:** Even low levels of lead exposure in early childhood are associated with increased ADHD symptoms.
- **Pesticides:** Organophosphate pesticide exposure has been linked to ADHD-like symptoms in several epidemiological studies.

- **Food Additives:** Certain artificial colourants (e.g. tartrazine) may worsen hyperactivity in sensitive children, though they are not a primary cause.
- **Adverse Childhood Experiences (ACEs):** Trauma, neglect, and chronic stress can exacerbate ADHD symptoms and complicate diagnosis.
- **Screen Time:** While excessive screen time does not cause ADHD, it can significantly worsen symptoms in already-affected individuals.

What Does NOT Cause ADHD

Common Myths — Dispelled

ADHD is **not caused** by: too much sugar, bad parenting, lack of discipline, watching television, playing video games, poverty alone, or a child 'just being naughty.' These factors may influence behaviour but are not root causes of ADHD. Stigmatising beliefs delay diagnosis and harm affected individuals and families.

Chapter 4: Diagnosis & Recommended Tests

A diagnosis of ADHD requires a comprehensive evaluation conducted by a qualified professional — typically a psychiatrist, psychologist, developmental paediatrician, or neurologist. No single test can diagnose ADHD; assessment involves clinical interviews, standardised rating scales, behavioural observations, and ruling out alternative causes.

Diagnostic Criteria — DSM-5-TR

For children up to age 16: 6 or more symptoms of inattention and/or hyperactivity-impulsivity must be present. For adolescents 17 and older, and adults: 5 or more symptoms are required. Symptoms must:

- Have persisted for at least 6 months
- Be inconsistent with developmental level
- Be present in two or more settings (e.g. home and school)
- Cause significant impairment in social, academic, or occupational functioning
- Not be better explained by another mental disorder

Recommended Assessment Tests

For Children:

Assessment	Purpose
Clinical Interview	Developmental history, family history, symptom onset, school performance
Teacher & Parent Rating Scales	Conners-3, Vanderbilt ADHD Scale, SNAP-IV (see Chapter 7)
Cognitive / IQ Testing	WISC-V — to assess intellectual ability and identify learning disabilities
Continuous Performance Test (CPT)	Measures sustained attention and impulsivity (e.g. Conners CPT-3)
Educational Assessment	Academic achievement testing — WIAT-III or KTEA-3
Medical Evaluation	Thyroid function, vision, hearing, iron levels — to rule out physical causes
Behavioural Observation	Direct observation in classroom and home settings
Sleep Assessment	Sleep diary or actigraphy if sleep disorder suspected

For Adults:

Assessment	Purpose
Clinical Interview	Full psychiatric and developmental history; childhood symptom history
Self-Report Scales	ASRS-5, BAARS-IV, Brown ADD Scales (see Chapter 8)
Informant Rating Scale	Conners CAARS (partner or close contact version)
Neuropsychological Testing	TOVA, CPT-3 — for objective attention and impulsivity data
Medical Evaluation	Thyroid panel, CBC, ferritin, vitamin D, B12 — rule out mimicking conditions
Psychiatric Evaluation	Rule out bipolar disorder, anxiety, depression, sleep disorders
EEG / Qb Test	Optional — some clinicians use quantitative EEG (qEEG) or QbTest for objectivity

Important Note

Always seek a multi-disciplinary evaluation. A diagnosis from rating scales alone is insufficient. A thorough assessment considers the whole person — medical, psychological, educational, and environmental factors — before any diagnosis is made.

Chapter 5: Nutrition for Children with ADHD

Nutrition plays a meaningful supporting role in managing ADHD symptoms in children. While diet alone cannot replace clinical treatment, research consistently shows that certain nutrients support brain function, neurotransmitter production, and emotional regulation. The goal is a brain-supporting, anti-inflammatory diet.

Key Nutrients — What Children Need

Omega-3 Fatty Acids (EPA & DHA)

Essential for brain development, dopamine regulation, and reducing hyperactivity. Found in: oily fish (salmon, sardines, mackerel), flaxseeds, chia seeds, walnuts, and high-quality fish oil supplements.

Iron

Low ferritin levels are associated with worse ADHD symptoms. Required for dopamine synthesis. Found in: lean red meat, chicken, lentils, spinach, fortified cereals. Pair with vitamin C to improve absorption.

Zinc

Zinc deficiency is linked to increased inattention and hyperactivity. Zinc modulates dopamine. Found in: pumpkin seeds, chickpeas, beef, cashews, dairy products.

Magnesium

Deficiency is common in ADHD children. Magnesium supports nerve transmission and calms the nervous system. Found in: dark leafy greens, pumpkin seeds, almonds, whole grains, dark chocolate.

Vitamin D

Low vitamin D is associated with cognitive difficulties and mood dysregulation. Sources: sunlight, fortified milk, eggs, fatty fish, and supplements if levels are low.

Vitamin B6 and B12

B vitamins are essential for neurotransmitter production (serotonin, dopamine). Found in: eggs, meat, poultry, dairy, legumes, whole grains.

Protein

Protein supports sustained energy and neurotransmitter production. Helps prevent blood sugar spikes. Include at every meal: eggs, Greek yoghurt, lean meats, beans, lentils, nuts.

Complex Carbohydrates

Provide steady glucose to the brain. Avoid refined carbs which cause energy crashes. Found in: oats, brown rice, sweet potato, wholegrain bread, fruits and vegetables.

Recommended Supplements for Children

The following supplements have the strongest evidence base for children with ADHD. Always consult a paediatrician or registered dietitian before starting supplementation.

Supplement	Typical Dose	Notes
Omega-3 Fish Oil	1,000–2,500 mg EPA+DHA daily	Strongest evidence — reduces inattention and hyperactivity
Zinc	15–20 mg daily	Particularly useful if blood zinc is low
Iron / Ferritin	As prescribed	Only if ferritin levels confirm deficiency — avoid excess
Magnesium	100–200 mg daily	Supports sleep and calming of the nervous system
Vitamin D3	600–1,000 IU daily (or as tested)	Especially in low-sunlight environments
Multivitamin B-Complex	Age-appropriate dosing	Supports neurotransmitter synthesis

What Children with ADHD Should Avoid

- **Artificial Food Colourants:** Tartrazine (E102), Sunset Yellow (E110), Carmoisine (E122). These have been shown in studies to worsen hyperactivity in sensitive children.
- **Refined Sugar and Processed Carbohydrates:** Sweets, fizzy drinks, white bread, sugary cereals. Cause blood sugar fluctuations that worsen inattention and irritability.
- **Artificial Preservatives:** Sodium benzoate (E211) and BHA/BHT. Found in processed foods, packaged snacks, and some juices.
- **Trans Fats and Hydrogenated Oils:** Found in fast foods, processed pastries, and margarine. Harm brain cell membrane function.
- **Caffeinated Beverages:** Energy drinks, cola, and coffee. Can worsen anxiety, sleep disruption, and irritability in children.
- **Common Food Allergens (if sensitised):** Some children with ADHD show sensitivity to gluten or casein. An elimination trial under dietitian supervision may be beneficial for some.
- **High-Mercury Fish:** Shark, swordfish, king mackerel, and tilefish. Mercury can impair neurological development.

Sample Brain-Boosting Meal for a Child

Breakfast: Scrambled eggs on wholegrain toast + a small handful of walnuts + fresh berries

Lunch: Grilled chicken wrap with avocado, spinach, and cucumber + water or diluted juice

Dinner: Baked salmon with sweet potato and steamed broccoli

Snacks: Greek yoghurt with fruit, celery with almond butter, or a boiled egg

Chapter 6: Nutrition for Adults with ADHD

Adults with ADHD face unique nutritional challenges — irregular eating patterns, impulsive food choices, hyperfocus causing skipped meals, and the stimulating effects of medication affecting appetite. A structured, nutrient-dense eating plan supports sustained focus, mood stability, and emotional regulation.

Key Nutrients — What Adults Need

Omega-3 Fatty Acids (EPA & DHA)

Strongest nutritional evidence in ADHD. Reduces inflammation, supports dopamine and serotonin function. Target: 2,000–3,000 mg combined EPA+DHA per day from oily fish or fish oil.

Protein — Every Meal

Supports steady neurotransmitter production and blood sugar regulation. Aim for 25–35g protein per meal: eggs, meat, fish, legumes, Greek yoghurt, cottage cheese.

Zinc and Magnesium

Adults with ADHD commonly show deficiencies in both. Both minerals are critical for dopamine metabolism and executive function. Foods: pumpkin seeds, spinach, cashews, black beans, beef.

Iron

Serum ferritin below 30 ng/mL is associated with ADHD symptom severity. Get ferritin tested; supplement only if deficient. Foods: lean red meat, lentils, leafy greens.

Vitamin D

Low vitamin D is associated with depression, cognitive fog, and worsened ADHD. Adults need 1,500–2,000 IU daily; test 25-OH vitamin D levels. Supplement if below 50 nmol/L.

B Vitamins (especially B6, B9, B12)

Support methylation pathways critical for neurotransmitter production. Many adults with ADHD have the MTHFR gene variant affecting folate metabolism.

L-Tyrosine

An amino acid precursor to dopamine and norepinephrine. Some adults find it helpful for focus when taken in the morning. Best sourced from protein-rich foods (chicken, soy, eggs, cheese).

Complex Carbohydrates and Fibre

Stabilise blood sugar and support gut-brain axis. The gut microbiome influences dopamine levels. Foods: oats, legumes, quinoa, sweet potato, whole grains, vegetables, fruit.

Recommended Supplements for Adults

Supplement	Typical Dose	Notes
Omega-3 Fish Oil	2,000–3,000 mg EPA+DHA	Take with meals to reduce fishy aftertaste
Zinc	25–40 mg daily	Picolinate form best absorbed; take with food
Magnesium Glycinate	200–400 mg daily	Glycinate form better tolerated; supports sleep
Vitamin D3 + K2	2,000 IU D3 with K2	K2 ensures calcium is directed to bones, not arteries
B-Complex or Methylated B12/Folate	As directed	Methylated forms recommended if MTHFR variant present
Iron	As prescribed only	Never self-supplement without confirmed ferritin deficiency
L-Theanine	100–200 mg	May ease anxiety related to ADHD; pairs well with caffeine

What Adults with ADHD Should Avoid

- **Simple Sugars and High-Glycaemic Foods:** White bread, pastries, sweets, sugary drinks. Cause rapid blood sugar spikes and crashes that worsen focus and mood.
- **Excessive Caffeine:** While low-dose caffeine can temporarily aid focus, excessive amounts worsen anxiety, sleep, heart rate, and rebound fatigue.
- **Alcohol:** Significantly worsens ADHD symptoms over time — impairs sleep quality, depletes B vitamins, and disrupts dopamine regulation.
- **Ultra-Processed Foods:** Fast food, packaged snacks, instant noodles. Promote neuroinflammation and worsen cognitive function.
- **Skipping Meals:** A critical ADHD pitfall. Skipping meals drops blood glucose and worsens inattention, irritability, and impulsivity. Set meal reminders.
- **Artificial Sweeteners:** Aspartame and saccharin have been linked to worsened mood and cognition in some individuals.
- **High-Mercury Fish:** Avoid shark, swordfish, tuna in excess. Choose salmon, sardines, and mackerel as safer sources of omega-3.

Practical Eating Tips for Adults with ADHD

- Set phone alarms for mealtimes — do not rely on hunger cues alone
- Meal prep on weekends to avoid impulsive food choices during the week
- Keep protein-rich snacks visible and accessible (boiled eggs, nuts, cheese sticks)
- Eat breakfast within one hour of waking — protein-centred
- Use a simple food tracking app if helpful — ADHD-friendly options include Cronometer

Chapter 7: Assessment Scales for Children

The following standardised rating scales are widely used by clinicians, psychologists, and educators to assess ADHD in children. These tools support diagnosis, track symptom severity, and monitor treatment response. They are not standalone diagnostic tools and must be interpreted by a qualified professional.

1. Conners Third Edition (Conners-3)

Age Range: 6 to 18 years | **Completion Time:** 20–40 minutes | **Completed By:** Parent, Teacher, Self-report (ages 8+)

The Conners-3 is one of the most widely used and rigorously validated ADHD rating scales in clinical practice worldwide. It assesses inattention, hyperactivity/impulsivity, learning problems, executive function, peer relations, and conduct.

Scoring Key:

T-Score Range	Interpretation
Below 60	Average — not clinically significant
60–64	Slightly Elevated — monitor closely
65–69	Elevated — clinical attention recommended
70 and above	Very Elevated — highly clinically significant

Reference: Conners, C.K. (2008). *Conners Third Edition*. Multi-Health Systems.

2. Vanderbilt ADHD Diagnostic Rating Scale (VADRS)

Age Range: 6 to 12 years | **Completion Time:** 10–15 minutes | **Completed By:** Parent and Teacher

A free, widely-used public domain tool developed for primary care settings. It assesses all DSM ADHD symptoms and screens for co-occurring conditions including ODD, conduct disorder, anxiety, and depression.

Scoring: Each item rated 0 (Never) to 3 (Very Often).

Form	Content
Parent Form	55 items — ADHD symptoms + performance ratings + comorbid screens
Teacher Form	43 items — classroom behaviour, academic performance, and ADHD symptoms

Reference: Wolraich, M.L., et al. (2003). *Vanderbilt ADHD Diagnostic Rating Scales*. *Pediatrics*, 111(3), 536–547.

3. SNAP-IV Rating Scale

Age Range: 5 to 18 years | **Completion Time:** 10 minutes | **Completed By:** Parent and/or Teacher

The Swanson, Nolan, and Pelham Rating Scale (SNAP-IV) contains the 18 DSM ADHD symptom items plus items for ODD. Each item is rated on a 4-point scale (Not at all, Just a little, Quite a bit, Very much). A free tool with established norms.

Average Item Score Threshold: A score above 1.5 per item in any subscale is considered clinically significant.

Reference: Swanson, J.M. (1992). School-based Assessments and Interventions for ADD Students. KC Publishing.

4. Child Behaviour Checklist (CBCL / ASEBA)

Age Range: 1.5 to 18 years | **Completion Time:** 15–20 minutes | **Completed By:** Parent

The CBCL is a broad-spectrum measure assessing emotional and behavioural problems. While not ADHD-specific, it is valuable for identifying co-occurring conditions and providing a comprehensive developmental picture. It includes DSM-oriented scales aligned with ADHD, anxiety, depression, ODD, and conduct disorder.

Clinical Threshold: T-scores at or above 65 are considered borderline clinical; T-scores at or above 70 are in the clinical range.

Reference: Achenbach, T.M. & Rescorla, L.A. (2001). Manual for the ASEBA School-Age Forms. ASEBA.

5. Strengths and Difficulties Questionnaire (SDQ)

Age Range: 4 to 17 years | **Completion Time:** 5 minutes | **Completed By:** Parent, Teacher, or Self-report (11+) | **Cost:** Free

A brief 25-item screening tool used widely in schools, paediatric settings, and research. Covers five domains: emotional symptoms, conduct problems, hyperactivity/inattention, peer problems, and prosocial behaviour. Available in over 80 languages.

Scale	Score Range	Interpretation
Total Difficulties Score	0–13	Normal
Total Difficulties Score	14–16	Borderline
Total Difficulties Score	17–40	Abnormal
Hyperactivity Subscale	0–5	Normal
Hyperactivity Subscale	6	Borderline
Hyperactivity Subscale	7–10	Abnormal

Reference: Goodman, R. (1997). The Strengths and Difficulties Questionnaire. Journal of Child Psychology and Psychiatry, 38(5), 581–586.

Chapter 8: Assessment Scales for Adults

Accurate assessment of ADHD in adults requires tools specifically normed and validated for the adult population. Adult ADHD frequently goes undiagnosed because symptoms manifest differently from childhood presentations. The following scales are the most commonly used in clinical, research, and self-screening contexts.

1. Adult ADHD Self-Report Scale (ASRS-5)

Age Range: 18 years and above | **Completion Time:** 5 minutes | **Completed By:** Self | **Cost:** Free (WHO)

The ASRS-5 was developed by the WHO and is the most widely used adult ADHD screening tool globally. The current version (ASRS-5) consists of 6 items directly aligned with DSM-5 criteria, revised from the original 18-item version. It is validated for both screening and treatment monitoring purposes.

Scoring:

Score	Interpretation	Recommended Action
0–3	Unlikely ADHD	Results inconsistent with adult ADHD
4–6	Consistent with ADHD	Warrants full clinical evaluation

Reference: Ustun, B., et al. (2017). The WHO Adult ADHD Self-Report Scale (ASRS-5). World Psychiatry, 16(1), 77–87.

2. Barkley Adult ADHD Rating Scale — IV (BAARS-IV)

Age Range: 18 to 89 years | **Completion Time:** 10–15 minutes | **Completed By:** Self and Informant | **Cost:** Purchased

Developed by Dr. Russell Barkley, the BAARS-IV assesses current and childhood ADHD symptoms using both DSM-IV and DSM-5 criteria. Includes self-report and informant forms. Normative data from a large US adult sample. Particularly valuable for evaluating symptom onset in childhood as required by diagnostic criteria.

Subscales: Inattention, Hyperactivity-Impulsivity, Sluggish Cognitive Tempo (SCT), and Total ADHD score.

Threshold: Scores at or above the 93rd percentile (approximately 1.5 SD above the mean) are considered clinically significant.

Reference: Barkley, R.A. (2011). Barkley Adult ADHD Rating Scale-IV. Guilford Press.

3. Brown Attention-Deficit Disorder Scales (Brown ADD)

Age Range: 12 and above (separate versions) | **Completion Time:** 10–20 minutes | **Completed By:** Self | **Cost:** Purchased

The Brown ADD Scales focus on executive function impairments associated with ADHD — a key distinction from symptom-based scales. Dr. Thomas Brown's model emphasises six clusters of executive function: activation, focus, effort, emotion, memory, and action. Particularly useful for adults who primarily struggle with executive function rather than overt hyperactivity.

Reference: Brown, T.E. (1996). Brown Attention-Deficit Disorder Scales. Psychological Corporation.

4. Conners Adult ADHD Rating Scales (CAARS)

Age Range: 18 to 90+ years | **Completion Time:** 15–20 minutes | **Completed By:** Self and Observer | **Cost:** Purchased

The CAARS assesses ADHD symptoms in adults across four key subscales: Inattention/Memory Problems, Hyperactivity/Restlessness, Impulsivity/Emotional Lability, and Problems with Self-Concept. The observer version (completed by a partner or family member) adds significant diagnostic validity.

Scoring: T-scores above 65 are elevated; above 70 are very elevated.

Reference: Conners, C.K., et al. (1999). Conners Adult ADHD Rating Scales (CAARS). MHS.

5. Wender Utah Rating Scale (WURS)

Age Range: Adults | **Completion Time:** 10 minutes | **Completed By:** Self | **Cost:** Free

The WURS is a retrospective scale designed to assess ADHD symptoms during childhood, as recalled by the adult patient. This is critical for confirming that symptoms were present before age 12 — a key DSM-5 diagnostic requirement. It consists of 61 items with a validated 25-item short form.

Scoring (25-item version): A score of 46 or above is the recommended cut-off for retrospective childhood ADHD.

Reference: Ward, M.F., Wender, P.H., & Reimherr, F.W. (1993). The Wender Utah Rating Scale. American Journal of Psychiatry, 150(6), 885–890.

Clinical Note on Adult Scales

No single scale provides a diagnosis. All adult ADHD assessments should be interpreted within the context of a full clinical interview, developmental history, and rule-out of differential diagnoses including bipolar disorder, anxiety, sleep disorders, thyroid dysfunction, and trauma-related conditions. Consult with a qualified clinician for diagnosis.

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Part 2 Preview

Part 2 of this guide will cover: Physical Exercises for Children and Adults (10 each), Counselling Exercises for Children and Adults (10 each), Treatment Approaches (medication, therapy, holistic), Predictive Outcomes and Prognosis based on current research, and a full extended Reference list.
