ENGLISH

DIVA-5-ID

Diagnostic Interview for ADHD in adults with Intellectual Disability (DIVA-5-ID)

Diagnostisch **I**nterview **V**oor **A**DHD bij volwassenen

DIVA Foundation

diagnostic interview for ADHD in adults

J.J.S. Kooij, MD, PhD, M.H. Francken, MSc, T.I. Bron, MSc, J. McCarthy, MD FRCPsych, & B.D. Perera MRCPsych

March 2017, DIVA Foundation, The Hague, The Netherlands

Colophon

The Diagnostic Interview for ADHD in adults with ID (DIVA- 5- ID) is a publication of the DIVA Foundation, The Hague, The Netherlands, September 2016. The original English translation by Vertaalbureau Boot was supported by Janssen-Cilag B.V. Backtranslation into Dutch by Sietske Helder.

Adjustments based on the DSM-5 criteria for people with ID by Dr. J McCarthy, Dr. B. D. Perera, Barnet, Enfield and Haringey Mental Health Trust, UK. Peter Deman, Parnassia, Department of Intellectual Disability and Psychiatry, The Netherlands. Dr. J.J. Sandra Kooij, and T.I. Annet Bron, DIVA Foundation, 2016.

Introduction

According to the DSM-5, ascertaining the diagnosis of Attention-deficit/hyperactivity disorder (ADHD) in adults involves determining the presence of ADHD symptoms during both childhood and adulthood.

The main requirements for the diagnosis are that the onset of ADHD symptoms occurred during childhood and that this was followed by a lifelong persistence of the characteristic symptoms to the time of the current evaluation. The symptoms need to be associated with significant clinical or psychosocial impairments that affect the individual in two or more life situations[1]. Because ADHD in adults is a lifelong condition that starts in childhood, it is necessary to evaluate the symptoms, course and level of associated impairment in childhood, using a retrospective interview for childhood behaviours. Whenever possible the information should be gathered from the patient and supplemented by information from informants that knew the person as a child (usually parents, carers or close relatives)[2].

Even though ADHD is statistically over represented among individuals with intellectual disability[3,4], ADHD in ID still continues to be under-diagnosed[5,6].

The Diagnostic Interview for ADHD in Adults with Intellectual Disability (DIVA-5-ID)

The DIVA is based on the DSM-5 criteria and is the third edition of the first structured Dutch interview for ADHD in adults (DIVA). The DIVA-5 is the successor of the DIVA 2.0 that was developed by J.J.S. Kooij and M.H. Francken and was based on the DSM-IV-TR criteria[2]. DIVA 2.0 has been validated in two studies[7,8].

In order to simplify the evaluation of each of the 18 symptom criteria for ADHD, in childhood and adulthood, the interview provides a list of concrete and real life examples, for both current and retrospective (childhood) behaviour in people with ID. The examples are based on the common descriptions provided by adult patients with ID and their carers in clinical practice. Examples are also provided of the types of impairments that are commonly associated with the symptoms in five areas of everyday life: work and education; relationships and family life; social contacts; free time / hobbies; self-confidence / self-image.
Whenever possible the DIVA should be completed with adults with ID and their carers to enable retrospective and collateral information to be ascertained at the same time. The DIVA in people with non ID usually takes around one and a half hours to complete. This can take longer in people with ID.

The DIVA only asks about the core symptoms of ADHD required to make the DSM-5 diagnosis of ADHD, and does not ask about other co-occurring psychiatric symptoms, syndromes or disorders. However comorbidity is commonly seen in both children and adults with ADHD, in around 75% of cases. For this reason, it is important to complete a general psychiatric assessment to enquire about commonly co-occurring symptoms, syndromes and disorders. The most common mental health problems that accompany ADHD include anxiety, depression, bipolar disorder, substance abuse disorders and addiction, sleep problems and personality disorders, and all these should be investigated. This is needed to understand the full range of symptoms experienced by the individual with ADHD; and also for the differential diagnosis, to exclude other major psychiatric disorders as the primary cause of 'ADHD symptoms' in adults[4].

Instructions for performing the DIVA

The DIVA is divided into three parts that are each applied to both childhood and adulthood:

- The criteria for Attention Deficit (A1)
- The criteria for Hyperactivity-Impulsivity (A2)
- The Age of Onset and Impairment accounted for by ADHD symptoms

Start with the first set of *DSM-5 criteria for attention deficit (A1)*, followed by the second set of criteria for *hyperactivity/impulsivity (A2)*. Ask about each of the 18 criteria in turn. For each item take the following approach:

First ask about adulthood (symptoms present in the last 6-months or more) and then ask about the same symptom in childhood (symptoms before the age of 12 years)[9-23]. Read each question fully and ask the person being interviewed whether they recognise this problem and to provide examples. Such questions may need to be simplified and broken down if the person finds hard to understand. Most questions need to be asked from individuals who have known the person with ID for a long time such as family members, carers and staff from day centres and colleges, as patients with ID may not be able to provide some answers. Patients and carers may give the same examples as those provided in the DIVA, which can then be ticked off as present. If they do not recognise the symptoms or you are not sure if their response is specific to the item in question, then use the examples, asking about each example in turn. If it is still difficult to establish presence or absence of symptoms, you may want to request carers to monitor for specific symptoms of ADHD as per DIVA. Always compare symptoms of the patient with someone of similar developmental age. It is important to differentiate whether the person's level of hyperactivity, impulsivity and inattention are compatible with level of intellectual disability, educational status, ASD or other genetic syndromes. Reports from people who work with other individuals with ID may make the distinction as they have worked with individuals with similar mental age without ADHD. For a problem behaviour or symptom to be scored as present, the problem should occur more frequently or at a more severe level than what is expected for the mental age of the person and to be closely associated with impairments. Tick off each of the examples that are described by the patient. If alternative examples that fit the criteria are given, make a note of these under "other". To score an item as present it is not necessary to score all the examples as present, rather the aim is for the investigator to obtain a clear picture of the presence or absence of each criterion.

For each criterion, ask whether the carers, partner or family member agrees with this or can give further examples of problems that relate to each item. As a rule, the partner would report on adulthood and the family member (usually parent or older relative) on childhood. The clinician has to use clinical judgement in order to determine the most accurate answer. If the answers conflict with one another, the rule of thumb is that the patient is usually the best informant[24].

The information received from the carers, partner and family is mainly intended to supplement the information obtained from the patient and to obtain an accurate account of both current and childhood behaviour; the informant information is particularly useful for childhood since many patients have difficulty recalling their own behaviour retrospectively. Many people have a good recall for behaviour from around the age of 10-12 years of age. It is useful to look at various reports from childhood. For each criterion, the researcher should make a decision about the presence or absence in both stages of life, taking into account the information from all the parties involved. If collateral information cannot be obtained, the diagnosis should be based on the patient's recall alone. If school reports are available, these can help to give an idea of the symptoms that were noticed in the classroom during childhood and can be used to support the diagnosis. Symptoms are considered to be clinically relevant if they occurred to a more severe degree and/or more frequently than in the peer group or if they were impairing to the individual.

Age of onset and impairment

The third section on *Age of Onset* and *Impairment accounted for by the symptoms* is an essential part of the diagnostic criteria. Find out whether the patient has always had the symptoms and, if so, whether any symptoms were present before 12-years of age. If the symptoms did not commence till later in life, record the age of onset.

Then ask about the examples for the different situations in which impairment can occur, first in adulthood then in childhood. Place a tick next to the examples that the patient recognises and indicate whether the impairment is reported for two or more domains of functioning. For the disorder to be present, it should cause impairment in at least two situations, such as work and education; relationships and family life; social contacts; free time and hobbies; self-confidence and self-image, and be at least moderately impairing.

Summary of symptoms

In the *Summary of Symptoms of Attention Deficit (A) and Hyperactivity-Impulsivity (HI)*, indicate which of the 18 symptom criteria are present in both stages of life; and sum the number of criteria for inattention and hyperactivity/impulsivity separately.

Finally, indicate on the Score Form whether six or more in childhood (<18 years) and five or more criteria in adulthood (>17 years) are scored for each of the symptom domains of

Attention Deficit (A) and Hyperactivity-Impulsivity (HI). For each domain, indicate whether there was evidence of a lifelong persistent course for the symptoms, whether the symptoms were associated with impairment, whether impairment occurred in at least two situations, and whether the symptoms might be better explained by another psychiatric disorder. Indicate the degree to which the collateral information, and if applicable school reports, support the diagnosis. Finally, conclude whether the diagnosis of ADHD can be made and which presentation type (with DSM-5 code) applies.

Explanation to be given beforehand to the patient/carers

This interview will be used to ask about the presence of ADHD symptoms that you/your client experienced during your childhood and adulthood. The questions are based on the official criteria for ADHD in the DSM-5. For each question I will ask you whether you recognise the problem. To help you during the interview I will provide some examples of each symptom, that describe the way that children and adults often experience difficulties related to each of the symptoms of ADHD. First of all, you will be asked the questions, then your carer, partner and family members (if present) will be asked the same questions. Your carers will most likely have known you only since adulthood and will be asked questions about the period of your life that he or she knew you for; your family will have a better idea of your behaviour during childhood. Both stages of your life need to be investigated in order to be able to establish the diagnosis of ADHD.

References

1. American Psychiatric Association (APA): Diagnostic and Statistical Manual of Mental Disorders, (5th ed.). Arlington, VA: American Psychiatric Publishing, 2013.
2. Diagnostic Interview for ADHD in Adults 2.0 (DIVA 2.0), in: Kooij, JJS. Adult ADHD. Diagnostic assessment and treatment. Springer, 2013. Online available in many languages at *www.divacenter.eu*.
3. Lindblad I, Billstedt E, Fernell E, Gillberg C: Mild intellectual disability and ADHD; a comparative study of school age children's adaptive abilities. Dev Med Child Neurol 2013. Conference: 25th Annual Meeting of the European Academy of Childhood Disability Newcastle-Gateshead United Kingdom. Conference Start: 2013/10/10 – Conference End: 2013/10/12. Conference Publication: (var.pagings); 55:40-41.
4. O'Brien G: Disentangling disorder and disability: ADHD in intellectual disability. Aust N Z J Psychiatry 2013. Conference: Royal Australian and New Zealand College of Psychiatrists, RANZCP Annual Congress 2013 Sydney Australia. Conference Start: 2013/05/26 – Conference End: 2013/05/30. Conference Publication: (var.pagings); 47:61.
5. Perera B: Diagnosis of attention deficit hyperactivity disorder in adults with intellectual disability. J Intellect Disabil Res 2015. Conference: 10th International Congress of the Eamhid Florence Italy. Conference Start: 2015/09/09 – Conference End: 2015/09/11. Conference Publication: (var.pagings); 59:104.
6. Perera B: Diagnosis of attention deficit hyperactivity disorder in adults with intellectual disability: How are we doing with diagnosis and treatment? Eur Psychiatry 2015. Conference: 23rd European Congress of Psychiatry, EPA 2015 Vienna Austria. Conference Start: 2015/03/28 – Conference End: 2015/03/31. Conference Publication: (var.pagings); 30:862.
7. Pettersson R, Söderström S, Nilsson KW: Diagnosing ADHD in Adults: An Examination of the Discriminative Validity of Neuropsychological Tests and Diagnostic Assessment Instruments. J Atten Disord 2015; Dec 17:1-13.
8. Ramos-Quiroga JA, Nasillo V, Richarte V, Corrales M, Palma F, Ibáñez P, Michelsen M, Van de Glind G, Casas M, Kooij JJ: Criteria and Concurrent Validity of DIVA 2.0: A Semi-Structured Diagnostic Interview for Adult ADHD. J Atten Disord 2016; Apr 28:1-10.
9. Pearson DA, Lachar D, Loveland KA, Santos CW, Faria LP, Azzam PN, Hentges BA, Cleveland LA: Patterns of behavioral adjustment and maladjustment in mental retardation: comparison of children with and without ADHD. Am J Ment Retard. 2000;105(4):236–51.
10. Pearson D, Norton A, Farwell E: Attention-deficit/hyperactivity disorder in mental retardation: nature of attention deficits. In: Burack J, Enns J, editors. Attention, development, and psychopathology. New York: Guilford Press; 1997: 205–29.
11. Applegate B, Lahey BB, Hart EL, Biederman J, Hynd GW, Barkley RA, Ollendick T, Frick PJ, Greenhill L, McBurnett K, Newcorn JH, Kerdyk L, Garfinkel B, Waldman I, Shaffer D: Validity of the age-of-onset criterion for ADHD: a report from the DSM-IV field trials. J Am Acad Child Adolesc Psychiatry 1997; 36(9):1211-21.
12. Barkley RA, Biederman J: Toward a broader definition of the age-of-onset criterion for attention-deficit hyperactivity disorder. J Am Acad Child Adolesc Psychiatry 1997; 36(9):1204-10.
13. Faraone SV, Biederman J, Spencer T, Mick E, Murray K, Petty C, Adamson JJ, Monuteaux MC: Diagnosing adult attention deficit hyperactivity disorder: are late onset and subthreshold diagnoses valid? Am J Psychiatry 2006;163(10):1720-9.
14. Lindblad I, Svensson L, Langren M, Nasic S, Tideman E, Gillberg C, Fernell E: Mild intellectual disability and ADHD; a comparative study of school age children's adaptive abilities. Acta Paediatr 2013; 102(10):1027-31.
15. O'Brien G: Disentangling disorder and disability: ADHD in intellectual disability. Australian and New Zealand J Psychiat 2013: Conference: Royal Australian and New Zealand College of Psychiatrists, RANZCP Annual Congress 2013 Sydney Australia. Conference Start: 2013/05/26 – Conference End: 2013/05/30. Conference Publication: (var. pagings); 47:61.
16. Neece CL, Baker BL, Crnic K, Blacher J: Examining the validity of ADHD as a diagnosis for adolescents with intellectual disabilities: Clinical presentation. J Abnorm Child Psychol 2013; 41(4):597-612.
17. Ahuja A, Martin J, Langley K, Thapar A: Intellectual disability in children with attention deficit hyperactivity disorder. J Pediatr 2013; 163(3):890-5.e1.
18. Neece CL, Baker BL, Lee SS: ADHD among adolescents with intellectual disabilities: Pre-pathway influences. Res Dev Disabil 2013; 34(7):2268-79.
19. Bigham K, Daley DM, Hastings RP, Jones RSP: Association between parent reports of attention deficit hyperactivity disorder behaviors and child impulsivity in children with severe intellectual disability. J Intellect Disabil Res 2013; 57(2):191-7.
20. Freeman N, Cornish KM, Gray KM: Attention and activity profiles in children with intellectual disability: Development of a teacher rating scale. J Intellect Disabil Res 2012. Conference: 14th World Congress of the International Association for the Scientific Study of Disabilities, IASSID 2012 Halifax, NS Canada. Conference Start: 2012/07/09 - Conference End: 2012/07/14. Conference Publication: (var.pagings); 56(7-8):712.
21. Neece CL, Baker BL, Blacher J, Crnic KA: Attention-deficit/hyperactivity disorder among children with and without intellectual disability: An examination across time. J Intellect Disabil Res 2011; 55(7):623-35.
22. Lindblad I, Gillberg C, Fernell E: ADHD and other associated developmental problems in children with mild mental retardation. The use of the "Five-To-Fifteen" questionnaire in a population-based sample. Res Dev Disabil 2011; 32(6):2805-9.
23. Xenitidis K, Paliokosta E, Rose E, Maltezos S, Bramham J: ADHD symptom presentation and trajectory in adults with borderline and mild intellectual disability. J Intellect Disabil Res 2010; 54(7):668-77.
24. Kooij JJS, Boonstra AM, Willemsen-Swinkels SHN, Bekker EM, Noord Id, Buitelaar JL: Reliability, validity, and utility of instruments for self-report and informant report regarding symptoms of Attention-Deficit/Hyperactivity Disorder (ADHD) in adult patients. J Atten Disorders 2008; 11(4):445-58.

Name of the patient

Date of birth

Sex ❑ M / ❑ F

Level of intellectual disability: ❑ Mild ❑ Moderate ❑ Severe ❑ Profound

IQ (if known):

Other diagnosed neurodevelopmental disorder:

❑ Autism Spectrum disorder ❑ Tics/Tourettes
❑ Dyslexia ❑ Dyspraxia ❑ OCD

Date of interview

Other informants

Name of clinician

Patient number

Part 1: Symptoms of attention-deficit (DSM-5 criterion A1)

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

A1

A1. Does the person often fail to give close attention to details? Does the person make careless mistakes in their work or during other activities (ex-at day centres, work place) *And how was that during childhood (in school work or during other activities)?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Has trouble concentrating at school/day centres/work
- ❑ Misses out steps even though the person knows how to do well – Ex: daily activities
- ❑ Makes careless mistakes
- ❑ Work is inaccurate
- ❑ Work appears rushed and poorly done even though the person has the ability to complete it
- ❑ Able to complete tasks with some difficulties when they are given 1:1 attention with constant prompting to pay attention
- ❑ Works slowly to avoid mistakes
- ❑ Does not read instructions carefully
- ❑ Too much time needed to complete detailed tasks
- ❑ Works too quickly and therefore makes mistakes
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Careless mistakes in school or day to day work
- ❑ Mistakes made by not reading questions properly
- ❑ Work is inaccurate
- ❑ Leaves questions unanswered by not reading them properly
- ❑ Leaves the reverse side of a test/form unanswered
- ❑ Others comment about careless work
- ❑ Not checking the answers in homework
- ❑ Too much time needed to complete detailed tasks
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

A2

Does the person often have difficulty sustaining attention? *And how was that during childhood (in play activities)?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Not able to keep attention on tasks for long*
- ❑ Often moving from one task to another
- ❑ When start doing something, the person gets interested and excited by another task, therefore very quickly moves away from the task to another
- ❑ May be able to stay on tasks with difficulties if they are given 1:1 supervision and regular prompting
- ❑ Quickly distracted by own thoughts or associations
- ❑ Easily distracted by unrelated thoughts or what happens around the person
- ❑ Difficulty remaining focused during lectures and/or conversations
- ❑ Finds it difficult to watch a film through to the end, or to read a book*
- ❑ Quickly becomes bored with things*
- ❑ Other:

*Unless the subject is found to be really interesting (e.g. computer or hobby)

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Difficulty keeping attention on schoolwork
- ❑ Difficulty keeping attention on play*
- ❑ Difficulty remaining focused during conversations
- ❑ Easily distracted
- ❑ Difficulty concentrating*
- ❑ Needing structure to avoid becoming distracted
- ❑ Quickly becoming bored of activities*
- ❑ Other:

*Unless the subject is found to be really interesting (e.g. computer or hobby)

Symptom present? ❑ Yes / ❑ No

A3

Does it often seem as the person is not listening when they are spoken to directly? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Often finds difficult to follow verbal instructions
- ❑ Instructions need to be broken down and repeated many times for completion of a task
- ❑ Not answering the questions that have been asked
- ❑ Dreamy or preoccupied
- ❑ Difficulty concentrating on a conversation
- ❑ Afterwards, not knowing what the conversation was about
- ❑ Often changing the subject of the conversation
- ❑ Others saying that your thoughts are somewhere else
- ❑ Mind seems elsewhere, even in the absence of any obvious distraction
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Not knowing what parents/teachers have said
- ❑ Dreamy or preoccupied
- ❑ Only listening during eye contact or when a voice is raised
- ❑ Mind seems elsewhere, even in the absence of any obvious distraction
- ❑ Often having to be addressed again
- ❑ Questions having to be repeated
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

A4

Does the person often not follow through on instructions and often fails to finish chores or duties in the workplace/ day centre/home setting? *And how was that during childhood (in schoolwork)?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Does not finish tasks or leave important parts not done without 1:1 support and frequent prompting
- ❑ Miss out or not complete tasks even though they have the ability to do it and are keen to get it done
- ❑ Does things that are muddled up together without completing them
- ❑ Starts tasks but quickly loses focus and is easily sidetracked
- ❑ Difficulty completing tasks once the novelty has worn off
- ❑ Difficulty completing administrative tasks
- ❑ Difficultly following instructions
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Difficulty following instructions
- ❑ Difficulty with instructions involving more than one step
- ❑ Starts tasks but quickly loses focus and is easily sidetracked
- ❑ Not completing things
- ❑ Not completing homework or handing it in
- ❑ Needing a lot of structure in order to complete tasks
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

A5

Does the person often find it difficult to organise tasks and activities? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Struggling to plan activities of daily life as the person always seem to be in a rush
- ❑ Difficulty managing sequential tasks
- ❑ House and/or workplace are disorganised
- ❑ Difficulty keeping materials and belongings in order
- ❑ Works messy and disorganised
- ❑ Regularly booking things to take place at the same time (double-booking)
- ❑ Running late most of the time
- ❑ Not able to use an agenda or diary consistently due to chaotic nature
- ❑ Poor sense and management of time
- ❑ Creating schedules but not using them
- ❑ Needing other people to structure things even though the person has necessary skills
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Difficultly being ready on time
- ❑ Messy room / desk and/or work
- ❑ Difficulty keeping materials and belongings in order
- ❑ Difficultly playing alone
- ❑ Difficulty planning tasks or homework
- ❑ Doing things in a muddled way
- ❑ Arriving late
- ❑ Poor sense of time
- ❑ Difficulty keeping himself/herself entertained
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

A6

Does the person often avoid (or do they dislike, or are reluctant to engage in) tasks that require sustained mental effort? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Give up tasks if that requires sustained attention or lacks physical activity
- ❑ Refusing/avoid/not keen to engage in tasks that requires sustain attention or lack physical activity
- ❑ Do the easiest or nicest things first of all
- ❑ Often postpone boring or difficult tasks
- ❑ Postpone tasks so that deadlines are missed
- ❑ Avoid monotonous work, such as administration
- ❑ Do not like reading due to mental effort
- ❑ Avoidance of tasks that require a lot of concentration
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Avoidance of homework or has an aversion to this
- ❑ Reads few books or does not feel like reading due to mental effort
- ❑ Avoidance of tasks that require a lot of concentration
- ❑ Aversion to school subjects that require a lot of concentration
- ❑ Often postpones boring or difficult task
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

A7

Does the person often lose things that are necessary for tasks or activities? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Misplace tools, paperwork, eyeglasses, mobile telephones, wallet, keys, or personal belongings
- ❑ Often leaves things behind
- ❑ Loses a lot of time searching for things
- ❑ Gets in a panic if other people move things around
- ❑ Stores things away in the wrong place
- ❑ Loses notes, lists or telephone numbers
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Loses school materials, pencils, books or other items
- ❑ Mislays toys, clothing, or homework
- ❑ Spends a lot of time searching for things
- ❑ Gets in a panic if other people move things around
- ❑ Comments from parents and/or teacher about things being lost
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

A8

Is the person often easily distracted by extraneous stimuli? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Easily distracted by things that happens around the person when other people with similar ID can ignore or are less distracted
- ❑ Often needs to bring back to the topic or task
- ❑ Increasing challenging behaviour due to distractions in busy environments/less behavioural difficulties in environments less distracting
- ❑ Goes off tasks and activities very easily
- ❑ Difficulty shutting off from external stimuli
- ❑ After being distracted, difficult to pick up the thread again
- ❑ Easily distracted by noises or events
- ❑ Easily distracted by the conversations of others
- ❑ Difficulty in filtering and/or selecting information
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ In the classroom, often looking outside
- ❑ Easily distracted by noises or events
- ❑ After being distracted, has difficultly picking up the thread again
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

A9

Is the person often forgetful in daily activities? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Often busy looking for things
- ❑ Forget to do tasks in their time table
- ❑ Forgets to pay bills or to return calls
- ❑ Needs frequent reminders and prompting
- ❑ Returning home as forgotten to take important things
- ❑ Forgets to do chores or run errands
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Forgets appointments or instructions
- ❑ Forgets to do chores or run errands
- ❑ Has to be frequently reminded of things
- ❑ Half-way through a task, forgetting what has to be done
- ❑ Forgets to take things to school
- ❑ Leaving things behind at school or at friends' houses
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Part 2: Symptoms of hyperactivity-impulsivity (DSM-5 criterion A2)

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

H/I 1

Do they often fidget with or tap hands or feet, or do they often squirm in their seat? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Difficulty sitting still
- ❑ Fidgets with the legs
- ❑ Constantly moving around
- ❑ Tapping with a pen or playing with something
- ❑ Fiddling with hair or biting nails
- ❑ Fidget with various items at the same time
- ❑ Able to control restlessness, but feels stressed as a result
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Parents often said "sit still" or similar
- ❑ Fidgets with the legs
- ❑ Tapping with a pen or playing with something
- ❑ Fiddling with hair or biting nails
- ❑ Unable to remain seated in a chair in a relaxed manner
- ❑ Able to control restlessness, but feels stressed as a result
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

H/I 2

Do they often leave their seat in situations where it is expected that they remain seated? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Often leaves his/her place
- ❑ Finds hard to sit and finish their meal
- ❑ Always first to get up and walk out
- ❑ Finds hard to sit and enjoy activities
- ❑ Prefers to walk around rather than sit
- ❑ Never sits still for long, always moving around
- ❑ Stressed owing to the difficulty of sitting still
- ❑ Makes excuses in order to be able to walk around
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Often stands up while eating or leaves his/her place in the classroom
- ❑ Finds it very difficult to stay seated at school or during meals
- ❑ Being told to remain seated
- ❑ Making excuses in order to walk around
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

H/I 3

Do they often appear as restless? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Appear restless or agitated a lot of the time
- ❑ Constantly busy walking around or doing something
- ❑ Very rarely sits in one place for long
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Always running around where it is inappropriate
- ❑ Climbing on furniture, or jumping on the sofa
- ❑ Climbing in trees
- ❑ Feeling restless inside
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

H/I 4

Do they often find it difficult to engage in leisure activities quietly? *And how was that during childhood (in play activities)?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Talks during activities when this is not appropriate
- ❑ Becoming quickly too cocky in public
- ❑ Being loud in all kinds of situations
- ❑ Finding it hard to do activities quietly
- ❑ Difficultly in speaking softly
- ❑ Laughing out loud in an inappropriate way to the situation
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Being loud-spoken during play or in the classroom
- ❑ Unable to watch TV or films quietly
- ❑ Asked to be quieter or calm down
- ❑ Becoming quickly too cocky in public
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

H/I 5

Are they often "on the go" or often act as if "driven by a motor"? *And how was that during childhood?*
Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Always busy doing something
- ❑ Is uncomfortable being still for extended time, e.g. in restaurants or meetings
- ❑ Has too much energy, always on the move
- ❑ Others find them restless or difficult to keep up with
- ❑ Stepping over own boundaries
- ❑ Finds it difficult to let things go, excessively driven
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Constantly busy
- ❑ Others find them restless or difficult to keep up with
- ❑ Is uncomfortable being still for extended time
- ❑ Excessively active at school and at home
- ❑ Has lots of energy
- ❑ Always on the go, excessively driven
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

H/I 6

Do they often talk excessively*? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?
*Not applicable for people who have no verbal communications skills

Examples adulthood

- ❑ So busy talking that other people find it tiring
- ❑ Known to be an incessant talker
- ❑ Finds it difficult to stop talking
- ❑ Tendency to talk too much
- ❑ Not giving others room to interject during a conversation
- ❑ Needing a lot of words to say something
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Known as a chatterbox
- ❑ Teachers and parents often ask you to be quiet
- ❑ Comments in school reports about talking too much
- ❑ Being punished for talking too much
- ❑ Keeping others from doing schoolwork by talking too much
- ❑ Not giving others room during a conversation
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

H/I 7

Do they often blurt out an answer before questions have been completed *? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?
*Not applicable for people who have no verbal communications skills

Examples adulthood

- ❑ Being a blabbermouth, saying what you think
- ❑ Saying things without thinking first
- ❑ Giving people answers before they have finished speaking
- ❑ Completing other people's sentences
- ❑ Being tactless
- ❑ Difficulty waiting for turn during a conversation
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Being a blabbermouth, saying things without thinking first
- ❑ Wants to be the first to answer questions at school
- ❑ Blurts out an answer even if it is wrong
- ❑ Interrupts others before sentences are finished
- ❑ Difficulty waiting for turn during conversations
- ❑ Coming across as being tactless
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

H/I 8

Do they often find it difficult to await for their turn? *And how was that during childhood?* Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Difficulty waiting in a queue, jumping the queue
- ❑ If their demands are not met straightaway, they can become challenging in behaviour
- ❑ Difficultly waiting turn in group activities
- ❑ Always being the first to talk or act
- ❑ Being impatient
- ❑ Quickly starting relationships/jobs, or ending/leaving these because of impatience
- ❑ Crosses the road without looking
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Difficultly waiting turn in group activities
- ❑ Difficultly waiting turn in the classroom
- ❑ Always being the first to talk or act
- ❑ Becomes quickly impatient
- ❑ Crosses the road without looking
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

H/I 9

Do they often interrupt or intrude on others, or intrude on others? *And how was that during childhood?*
Are these difficulties more than what is expected for their developmental age/intellectual disability?

Examples adulthood

- ❑ Being quick to interfere with others
- ❑ Intrudes on others
- ❑ Reacts to everything
- ❑ Unable to wait
- ❑ Disturbs other people's activities without being asked, or takes over their tasks
- ❑ Comments from others about interference
- ❑ Difficulty respecting the boundaries of others
- ❑ Having an opinion about everything and immediately expressing this
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Examples childhood

- ❑ Interrupts the games or activities of others
- ❑ Starts using people's things without asking or permission
- ❑ Interrupts the conversations of others
- ❑ Reacts to everything
- ❑ Unable to wait
- ❑ Other:

Symptom present? ❑ Yes / ❑ No

Part 3: Impairment on account of the symptoms (DSM-5 criteria B, C and D)

Criterion B

Have you always had these symptoms of attention deficit and/or hyperactivity/impulsivity?

- ❑ Yes (several symptoms were present prior to the 12th year of age)
- ❑ No

If no is answered above, starting as from ____ year of age

Criterion C

In which areas do you have / have you had problems with these symptoms?

Adulthood

Work (paid, supported or voluntary) /education or college/ day centre

- ❑ Did not complete education/training needed for work
- ❑ Work below level of education/level of intellectual abilities
- ❑ Tire quickly of a workplace
- ❑ Pattern of many short-lasting jobs
- ❑ Difficulty with administrative work/planning
- ❑ Not able to manage in work or college or day centre
- ❑ Disruptive in work or college or day centre
- ❑ Challenging behaviour at home, work, college or daycentre
- ❑ Not achieving promotions
- ❑ Under-performing at work
- ❑ Left work following arguments or dismissal
- ❑ Sickness benefits/disability benefit as a result of symptoms
- ❑ Limited impairment through compensation of external structure
- ❑ Other

Relationship and/or family

- ❑ Tire quickly of relationships
- ❑ Fall out with friends/relatives
- ❑ Not been able to manage in different care settings
- ❑ Impulsively commencing/ending relationships
- ❑ Unequal partner relationship owing to symptoms
- ❑ Relationship problems, lots of arguments, lack of intimacy
- ❑ Divorced owing to symptoms
- ❑ Problems with upbringing as a result of symptoms
- ❑ Difficulty with housekeeping and/or administration
- ❑ Financial problems or gambling
- ❑ Other:

Childhood and adolescence

Education

- ❑ Lower educational level than expected based on IQ
- ❑ Staying back (repeating classes) as a result of concentration problems
- ❑ Education not completed / rejected from school
- ❑ Took much longer to complete education than usual
- ❑ Achieved education suited to IQ with a lot of effort
- ❑ Difficulty doing homework
- ❑ Followed special education on account of symptoms
- ❑ Comments from teachers about behaviour or concentration
- ❑ Limited impairment through compensation of high IQ
- ❑ Limited impairment through compensation of external structure
- ❑ Other:

Family

- ❑ Frequent arguments with brothers or sisters
- ❑ Frequent punishment or hiding
- ❑ Little contact with family on account of conflicts
- ❑ Required structure from parents for a longer period than would normally be the case
- ❑ Other:

Adulthood *(continuance)*

Social contacts

- ❑ Challenging behaviour/behavioural difficulties
- ❑ Tire quickly of social contacts
- ❑ Difficultly maintaining social contacts
- ❑ Conflicts as a result of communication problems
- ❑ Difficulty initiating social contacts
- ❑ Low self-assertiveness as a result of negative experiences
- ❑ Not being attentive (i.e. forget to send a card/empathising/phoning, etc)
- ❑ Other:

Free time / hobby

- ❑ Unable to relax properly during free time
- ❑ Having to play lots of sports in order to relax
- ❑ Injuries as a result of excessive sport
- ❑ Unable to finish a book or watch a film all the way through
- ❑ Being continually busy and therefore becoming overtired
- ❑ Tire quickly of hobbies
- ❑ Accidents/loss of driving licence as a result of reckless driving behaviour
- ❑ Sensation seeking and/or taking too many risks
- ❑ Contact with the police/the courts
- ❑ Binge eating
- ❑ Other:

Self-confidence / self-image

- ❑ Frequently needing attention from others or engage in such behaviors
- ❑ Frequently seeking reassurance or engage in such behaviors
- ❑ Uncertainty through negative comments of others
- ❑ Negative self-image due to experiences of failure
- ❑ Fear of failure in terms of starting new things
- ❑ Excessive intense reaction to criticism
- ❑ Perfectionism
- ❑ Distressed by the symptoms of ADHD
- ❑ Other:

Childhood and adolescence *(continuance)*

Social contacts

- ❑ Difficultly maintaining social contacts
- ❑ Conflicts as a result of communication problems
- ❑ Difficultly entering into social contacts
- ❑ Low self-assertiveness as a result of negative experiences
- ❑ Few friends
- ❑ Being teased
- ❑ Shut out by, or not being allowed, to do things with a group
- ❑ Being a bully
- ❑ Other:

Free time/hobby

- ❑ Unable to relax properly during free time
- ❑ Having to play lots of sport to be able to relax
- ❑ Injuries as a result of excessive sport
- ❑ Unable to finish a book or watch a film all the way through
- ❑ Being continually busy and therefore becoming overtired
- ❑ Tired quickly of hobbies
- ❑ Sensation seeking and/or taking too many risks
- ❑ Contact with the police/courts
- ❑ Increased number of accidents
- ❑ Other:

Self-confidence / self-image

- ❑ Uncertainty through negative comments of others
- ❑ Negative self-image due to experiences of failure
- ❑ Fear of failure in terms of starting new things
- ❑ Excessive intense reaction to criticism
- ❑ Perfectionism
- ❑ Other:

Adulthood: Evidence of impairment in ≥2 areas?	❑ Yes / ❑ No
Childhood: Evidence of impairment in ≥2 areas?	❑ Yes / ❑ No

End of the interview. Please continue with the summary.

Potential details:

Summary of symptoms A and H/I

Indicate which criteria were scored in parts 1 and 2 and add up

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

Score form

DSM-5 criterion A	**Childhood** Is the number of A characteristics ≥ 6? Is the number of H/I characteristics ≥ 6? **Adulthood** Is the number of A characteristics ≥ 5? Is the number of H/I characteristics ≥ 5?	❑ Yes / ❑ No ❑ Yes / ❑ No ❑ Yes / ❑ No ❑ Yes / ❑ No
DSM-5 criterion B	Are there signs of a lifelong pattern of symptoms and limitations, starting before the 12th year of age?	❑ Yes / ❑ No
DSM-5 criterion C and D	The symptoms and the impairment are expressed in at least two domains of functioning Adulthood Childhood	❑ Yes / ❑ No ❑ Yes / ❑ No
DSM-5 criterion E	The symptoms cannot be (better) explained by the presence of another psychiatric disorder	❑ No ❑ Yes, by
	Is the diagnosis supported by collateral information? Parent(s)/brother/sister/other, i.e. _____ * Partner/good friend/other, i.e. _____ * School reports 0 = none/little support 1 = some support 2 = clear support	❑ N/A ❑ 0 ❑ 1 ❑ 2 ❑ N/A ❑ 0 ❑ 1 ❑ 2 ❑ N/A ❑ 0 ❑ 1 ❑ 2 Explanation:

	Diagnosis ADHD**	❑ No Yes: ❑ 314.01 Combined presentation type ❑ 314.00 Predominantly inattentive presentation type ❑ 314.01 Predominantly hyperactive-impulsive presentation type ❑ 314.01 Other specified attention-deficit/hyperactivity disorder ❑ 314.01 Not specified attention-deficit/hyperactivity disorder ❑ Partly in remission
	Severity	❑ mild ❑ moderate ❑ severe

*Indicate from whom the collateral information was taken.

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

ENGLISH

DIVA-5

DIVA Foundation

diagnostic interview for ADHD in adults