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Mental State Examination in Attention Deficit Hyperactivity Disorder

Prabhat Sitholey[1]

Department of Psychiatry
King George's Medical University
Lucknow (UP), INDIA

Introduction

With hyperactivity as a symptom, mental status examination (MSE) in attention deficit hyperactivity disorder (ADHD) may seem a straightforward thing and the diagnosis obvious, but this may not be so and the diagnosis may easily be missed if the child is not hyperactive or else is not so in a clinical assessment situation. Inattention and impulsivity, the other two core symptoms, may not be very easy to pick up as an MSE finding in an interview situation. Besides, co-morbidities like mental retardation (MR), anxiety disorder and oppositional defiant disorder (ODD) may mask ADHD unless mental age of the child is taken into account and special efforts are made to make a judgment on inattention, impulsivity and hyperactivity. Therefore, special attempts should be made to create clinical situations in which the symptoms of ADHD emerge and the clinician should be prepared to recognize them.

The DSM IV enlists the following symptoms of ADHD under section A.:

(1) ***Symptoms of inattention***

Inattention

(a) often fails to give close attention to details or makes careless mistakes in schoolwork,
work, or other activities
(b) often has difficulty sustaining attention in tasks or play activities
(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish schoolwork, chores, or
duties in the workplace
(e) often has difficulty in organizing tasks and activities
(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
(g) often looses things necessary for tasks or activities
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(2) ***Symptoms of Hyperactivity-impulsivity***

Hyperactivity

(a) often fidgets with hands or feet or squirms in seat
(b) Often leaves seat in classroom or in other situations in which remaining seated is expected
(c) Often runs about or climbs excessively in situations in which it is inappropriate
(d) Often has difficulty playing or engaging in leisure activities quietly
(e) Is often "on the go" or often acts as if "driven by a motor"
(f) Often talks excessively

Impulsivity

(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g. butts into conversation or games).

Mental Status Examination

Two approaches can be made. First, the child could be observed in various settings and secondly, he could be interviewed about his symptoms. It would be best to use standard instruments as aids for both observation and interview. This would help initially in training oneself and later on, in quantifying the symptoms and signs.

Assessment of Hyperactivity and Impulsivity

History given by the parent about the child's ADHD and co-morbid disorders would help the clinician to set up the clinical situations in which to asses the child.

Let us begin with MSE while the child is in the waiting area. He could be heard and seen talking loudly, shouting or making sounds, moving chairs and running to and fro. His mother may be heard asking him to keep quiet and remain still. This may stop him only for a very brief while and then he resumes his activity (runs about and climbs excessively, A (2) Hyperactivity (c); difficulty in engaging in leisure activities quietly, A (2) Hyperactivity (d)).

When the child and his family are asked to come into the interview room, he rushes in and is the first one to enter because he is unable to wait and keep behind (has difficulty awaiting turn, A (2) Impulsivity (h)).

Difficulty in waiting for one's turn, a symptom of impulsivity, may be elicited by creating situations in which the child is required to wait for some length of time as in an interesting game. It may not be possible to do this in the psychiatrist's office due to lack of time. The child may be observed in such a situation in the play room by a play or an occupational therapist or by a social worker. The child can be observed impatiently wanting to take the first turn, interrupting others and thus spoiling the game.

In the interview room, he runs to a chair and jumps into it. While in the chair he twists and turns, wriggles and slides forward and backward and slaps his hands on the armrest, picks up strings of his seat, pokes his fingers between them or drums on the

table with fingers. He shakes his legs (fidgets with hands or feet or squirms in seat, A (2) Hyperactivity (a)).

If the parents are asked a question, he replies before they get a chance to do so. If he is asked about his school he is out with the answer before the question is completed (often blurts out answers before questions have been completed, A (2) Impulsivity (g)). When interview with the parent is resumed, he interrupts the mother, pulling her by arm to attract attention and loudly asks her irrelevant questions or permission to do this or that and disrupts the interview (often interrupts or intrudes on others, A (2) Impulsivity (i)).

(j) He keeps on talking loudly and excessively even if asked to wait and keep quiet (talks excessively, A (2) Hyperactivity (f)). After being a while in the room he repeatedly gets up from the chair (Often leaves seat in (classroom or in other) situations in which remaining seated is expected, A (2) Hyperactivity (b)).

The symptom "is often on the go" or acts as if 'driven by a motor' (A (2) Hyperactivity (e)) requires that a child be seen thus. This may happen in a session if it is long enough for this observation otherwise one will have to depend upon historical evidence.

Hyperactivity is relatively easy to elicit. However, a child might be awed by the clinical context and not show hyperactivity initially and it might be missed if the session is very brief. But if one waited long enough, the child's fear will diminish and hyperactivity emerges. If the child has to wait for long he will be quickly bored and then also the symptoms will emerge. Else, if he is in the company of other children, social stimulation will bring on the symptoms. Due to a lack of time it may not be possible for the psychiatrist to directly observe everything himself. He could utilize the observations of trained paramedical colleagues. Clinician can use Rutter and Graham's child psychiatric interview and Hillside behavior Rating Scale that have observational scaled items for inattention, impulsivity and hyperactivity and are validated instruments. These or other similar instruments help one to make both qualitative and quantitative observations.

Assessment of Inattention

Assessment of inattention is a little more difficult. Again the symptoms of inattention may not be obvious in a brief session. Due to novelty of the situation, an inattentive child may pay attention to the interviewer or to the tasks suggested by him initially and briefly. But in a longer session, inattention is likely to become apparent. For eliciting inattention it would be best to give the child some academic task. It should be within his capacity considering his mental age and education, but not too easy. It should of enough length and take some time. Note whether the child is willing to carry it out. It not, his avoidance and reluctance to engage in the task (A (1) Inattention (f)) should be rated present. To test forgetfulness in daily activities, in the beginning, the child may be given three unrelated tasks to carry out at the end of the session before he leaves the room. For example, he may be asked to: 1. Remind the interviewer for a blank paper, 2. Keep the book on the floor and 3. Tap the table twice. The child should be told these things slowly and with deliberate engagement of his attention. At the end of the session, it should be checked whether the child does at

least two of tasks before leaving without a reminder. If the child does less than two tasks, the symptom of forgetfulness in daily activities may be rated as present (A1 Inattention (i)). While directly addressing the child or giving him instructions, observe whether he is looking at you attentively or else his gaze and attention wander. Note whether his not paying attention, looking elsewhere, and not meeting your gaze occurs just once or frequently. If it occurs frequently, the symptom of not listening when spoken to directly is present (A (1) Inattention (c)).

Next, explain some concept to be used or a method to be followed by the child in order to carry out the academic task. Note whether the child is paying careful attention or not. Observe him doing the task and check if he is making careless mistakes. If the child does it often the symptom (A (1) Inattention (a)) can be rated as present. Let him continue longer and see if he can sustain his attention on the task. If he cannot, despite a reminder, the symptoms (A (1) Inattention (b)) may be rated present. Produce some distraction like jangling of keys or softly hum a tune and watch its effect upon the child's concentration. Observe whether the child is distracted and has difficulty in resuming the task. If yes, rate the symptom (A (1) Inattention (h)) present. Further, note if the child leaves the task unfinished despite instruction to complete it. It is important to rule out oppositional behavior as a cause for not doing the assigned task and for not paying attention. If oppositional behavior is not present, rate for the child's inability to complete task (A (1) Inattention (d)).Observe the way the child approaches the academic task. Note whether he has a plan and he is organized is carrying out the task and in winding it up. If his work is messy and haphazard, it should be rated as a symptom (A (1) Inattention (e)).The symptom that the child loses things necessary for work (A (1) Inattention (g)) can only be rated present by obtaining history in this regard.

It should be understood that symptoms of ADHD could only be diagnosed as present if the symptoms occur frequently, last 6 months or more, and are associated with impairment to a degree that is maladaptive and inconsistent with developmental level. Some of the symptoms should be present before age 7. This can only be achieved by combining both history and the MSE.

The above scheme is likely to work well for school-age-children. Assessment may be more difficult in pre-school children and older adolescents between 16 and 18. I would like to say a few words about their assessments as well. Pre-school ADHD children may show frequent non-compliance, anger, loud, noisy, disruptive and bossy behavior apart from the other symptoms. The child may roughly handle the play material and may be destructive. During adolescence, the ADHD symptom 'always on the go' is replaced by an inner restlessness. This cannot be observed directly and will need to be asked about. This restlessness a motor phenomenon should be distinguished from anxiety, which is an affective phenomenon. It may be possible to observe hot temper and impulsivity during the interview. It may not be easy to obtain consent for doing an academic task unless a good rapport is achieved. More than one session may be needed. In such situations, greater reliance on historical evidence will be needed.

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1. **Prabhat Sitholey** MD (**Corresponding Author**)
   Professor and Head

Department of Psychiatry,
King George's Medical University,
Lucknow-226003 (UP), INDIA
psitholey@gmail.com