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Description and Demonstration of CBT for ADHD in Adults

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Abstract

ADHD in adulthood is a valid, prevalent, distressing, and interfering condition. Although medications help treat this disorder, there are often residual symptoms after medication treatment, and, for some patients, they are contraindicated. Compared to other disorders, such as mood and anxiety disorders, there are few resources available for clinicians wishing to conduct cognitive-behavioral treatment for this problem. The present manuscript provides a description of our cognitive-behavioral approach to treat ADHD in adulthood, which we have developed and tested in our clinic (Safren, Otto, et al., 2005), and for which detailed therapist and client guides exist (Safren, Perlman, Sprich, & Otto, 2005; Safren, Sprich, Perlman, & Otto, 2005). To augment the description of treatment, the present article provides video component demonstrations of several core modules that highlight important aspects of this treatment. This description and the accompanying demonstrations are intended as a practical guide to assist therapists wishing to conduct such a treatment in the outpatient setting.

Compared to other Axis I *DSM-IV* (American Psychiatric Association, 1994) disorders, there is a dearth of resources for mental health clinicians wishing to provide empirically informed treatments for adults with ADHD. This is of high public mental health significance because adult ADHD is a valid and impairing disorder (Ramsay, 2007), with a U.S. prevalence of 4.4% (Kessler et al., 2006). Beginning in childhood, its core neurobiological impairments of inattention, impulsivity, and hyperactivity contribute to the development of multidomain functional impairment affecting academic, behavioral, and social domains (Barkley, Fischer, Smallish, & Fletcher, 2006). As the disorder persists into adulthood, it further influences domains such as work performance, marital relationships, management of finances, health behaviors, and the frequency of driving accidents (Barkley, Murphy, & Fischer, 2008).

Although stimulants and other medications have been shown to reduce core neurobiological symptoms for many adults with this disorder (Prince, 2006), many continue to experience significant residual symptoms or cannot tolerate the medications. Even those who do respond to medications typically have significant residual symptoms. In most psychopharmacotherapy treatment studies, a 30% reduction in symptoms is enough to classify someone as a “responder”; however, depending on the person’s baseline level of symptoms, significant interference with daily functioning may persist (Steele, Jensen, & Quinn, 2006).

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[1]Video patients/clients are portrayed by actors.

Appendix A. Supplementary data
Supplementary data associated with this article can be found, in the online version, at doi:10.1016/j.cbpra.2009.09.002.

As a result, adults with ADHD may require psychosocial treatment; however, there are relatively few resources available to clinicians. In the last 5 to 10 years, several treatment approaches have received preliminary empirical support, though mainly in the form of uncontrolled trials or studies with small sample sizes (Knouse, Cooper-Vince, Sprich, & Safren, 2008). The approach we have developed (Safren, Perlman, Sprich, & Otto, 2005; Safren, Sprich, Perlman, & Otto, 2005) is the only individual psychosocial treatment for adult ADHD to have empirical support demonstrated by a randomized controlled trial (Safren, Otto, et al., 2005). This treatment was designed for and tested with adults with ADHD who were already receiving medication treatment but still experiencing significant residual symptoms. Compared to continued medication treatment alone (n=15), adults who received the CBT intervention (n=16) achieved significant reductions in self-reported and independent clinician-rated ADHD symptoms. Significant reductions were also observed in self-report and clinician-rated anxiety symptoms and in clinician-rated depressive symptoms. We are completing a larger randomized controlled trial of this treatment where we compared it to an active control group—applied relaxation (MH069812). Results of that trial are forthcoming.

The purpose of the present paper and accompanying video components is to provide an overview of the approach. Video components show role-play demonstrations by therapists who have worked in our intervention studies. Abbreviated descriptions of the overall treatment are provided and further detail can be found in our published treatment manual (Safren, Perlman, et al., 2005) and client workbook (Safren, Sprich, et al., 2005). Role-play examples provide demonstrations of commonly employed intervention techniques, and are based on typical client presentations. For all demonstrations, specifics were changed sufficiently so as to preserve anonymity and client roles are played by therapists from our program.

Description of CBT for ADHD in Adults

Our CBT for ADHD in adults follows a modular approach. Each module corresponds to a set of skills addressing a common domain of impairment in adults with ADHD. Accordingly, there are three “core modules” that we recommend administering to all clients, and two optional modules. The core modules are (1) psychoeducation and organizing/planning, (2) coping with distractibility, and (3) adaptive thinking. The optional modules are (4) addressing procrastination and (5) involvement of a partner or spouse. Below we provide a brief description of each module, background information on accompanying role-play demonstrations, and then a discussion of the issues depicted in each clinical demonstation.

Psychoeducation and Organization/Planning

This module typically spans 4 sessions and involves orienting the client to a CBT model of treatment, providing psychoeducation about ADHD in adulthood, and training the client in organization and planning skills. The first set of skills in the organization and planning module is development and regular use of a calendar and task list system for appointments, schedule, and “to-do” items. We consider the calendar and task list the foundation for subsequent skills and central to the entire treatment. Other skills addressed in the first module include prioritizing tasks on the “to-do” list, two problem-solving skills, and organization of papers, bills, and files. The two problem-solving skills involve (a) techniques for selecting a best action plan for a given problem, and (b) breaking down a problem into manageable steps. In the video clips that follow, we illustrate some of the techniques involved in starting a calendar and task list system with a client. We show typical difficulties that clients present when developing this skill set, and ways in which a therapist can address these issues.

After the therapist has conducted the clinical assessment and provided education about ADHD and an orientation to the treatment, one of the first tasks for the therapist is to help the client develop and start to implement a system for having a calendar and task list. A workable calendar and task list system is the foundation for the remaining interventions because, to use other skills in the treatment, clients must first become aware of (a) what they have to do, and (b) when they need to do it. Essentially, we ask clients to develop systems in which they consolidate all appointment and deadline information into one calendar system, and then all "to-do" items in one organized task list. Accordingly, we ask them to update these systems at least once a day.

"Susan" is a 40-year-old woman who has two children. She utilizes many different but uncoordinated strategies for keeping track of appointments and tasks. On intake, she complained that people were often upset with her for forgetting appointments and being late. Also, she reported feeling disorganized and that she was often only able to complete a fraction of the tasks that she would like to complete in any given time period. Susan is typical of many clients with ADHD in that her system for organizing her appointments, tasks, and calendar is spread across multiple places at home and in her office. Her system involves several calendars that have partial information, sticky notes placed in various places, and multiple pieces of paper that she keeps in her bag. She has no central, consistent way of knowing where she should be at certain times, nor does she have a system for knowing exactly what she needs to accomplish on any given day at work or at home.

Starting a Calendar

Video clip 1 shows the therapist helping the client begin the actual setup of the calendar system during the session. Because problems of follow-through are persistent and are symptoms of the disorder itself, therapy homework can be a challenge. If possible, getting started with setting up the system in the session can help overcome initial barriers and give the client some forward momentum to continue with the system for homework. Thus, the therapist asks the client to actually go through her papers and sticky notes and enter appointments into her calendar *during* the session. He asks her to stay in the waiting room following the session to finish the task.

Also, as is typical of many clients, Susan reported that, in the past, she had read the first chapter of a book on getting organized but never finished it or used any of the techniques. The therapist explained one important point for the treatment, which is that in order to maintain the system, one needs to "practice it long enough to become a habit." Accordingly, many clients report that they have tried multiple systems in the past. They use them for a while, as long as the system is novel, and potentially exciting. The risk for discontinuing can be strong when the novelty wears off, but the new skill has not yet become automatic—a habit. Throughout skills acquisition and maintenance, the therapist encourages the client to continue to use the system during the time when it is no longer novel—when it might be boring—emphasizing that eventually it can become something that is worked into their life and requires minimal effort but yields consistent positive results.

Task List

This second interaction with Susan involves setting her up with her task list (see video clip 2). One important aspect of the demonstration is the therapist's emphasis on the importance of looking at the task list every day. Many clients report that they make a task list, but then never refer back to it. Some report that they find looking at the task list upsetting and overwhelming because it can be a reminder of everything that they have to do. They may look at the list, feel pressure to do everything right away, and then avoid key tasks altogether. The therapist needs to make the point that the goal of the task list system is for

the client to have the maximal control that they can in the situation. The daily and necessary act of looking at the task list is distinct from the internal interpretation that seeing what one has to do means that they should do everything right then. The goal of the task list is simply to make clients aware of the possible ways they could spend their time, giving them the ability to choose whether or not to do something. The alternative, not looking at the task list on a daily basis, can cause the consequence of unpredictable and uncontrollable stressors with forgotten tasks and deadlines. The client in this video component mentions that she does not have a consistent system for keeping track of her tasks and often ends up working on lower-priority tasks first and then realizing that she has missed an important task. This gives the therapist the opportunity to reiterate the importance of looking at the task list every day and then he and the client are able to agree on a time when she will do this on a consistent basis (when she first arrives at work each day).

Problem Solving

"Steve" is a 38-year-old man. At this stage of the treatment, he would have already worked on developing a calendar and task list system and a system for using priority ratings for task list items. The goal of this session is to teach him to use problem solving to deal with items on his task list that are overwhelming or where there is not a clear solution. This session is framed as teaching skills to help with tasks that end up being pushed off from day to day or week to week. When the individual either feels overwhelmed by the task or does not really know how to approach it, avoidance is often the result. Avoidance of difficult or overwhelming tasks often makes the individual feel better in the short-term, but can cause problems in the long-term. As illustrated in the example that follows, the therapist helps the client (a) articulate the problem, (b) generate a list of potential solutions, (c) rate the solutions, and (d) pick the best solution.

Articulate the Problem

Video clip 3 illustrates a situation that we often encounter, where a client gets so overwhelmed and upset by their difficulties that they have a hard time even articulating the problem. The therapist must refocus the discussion on articulating the problem to be solved in a concise manner. After many attempts, during which the client makes self-critical remarks and extreme statements about his situation, the therapist is eventually able to get him to articulate the problem as "figuring out what to do about transportation." Articulating the problem in a nonjudgmental manner helps the client to be able to then move on to generate potential solutions to the problem. The next component provides an example of how to help the client generate a list of possible solutions.

Generating a List of Potential Solutions

In video clip 4, the therapist attempts to get the client to brainstorm and generate a list of possible solutions to this problem. She reminds the client to not judge the solutions at this point, but rather just generate as many as possible. If clients start to judge the situations too early, they will discount them without going through the whole problem-solving process. In the video example, each time the client starts to evaluate the possible solutions, the therapist redirects the client back to the task of generating possible solutions. This way, he will be able to view the full range of possible solutions before moving into an evaluative mode.

It is important to remind the client to include "leaving things as they are now" as a possible solution so that the pros and cons of this can be evaluated. When a client does not take a problem-solving approach, this solution ends up being the default result of his or her inaction and so should be evaluated along with other potential courses of action. In particular, examining the pros of inaction can help the client identify barriers that may be

keeping him or her "stuck" in the current avoidance pattern. Following this component, the therapist would continue to generate an exhaustive list of possible solutions before moving on to the next step of evaluating the pros and cons of each solution.

Rate the Solutions

Video clip 5 shows the therapist helping the client to generate the pros and cons of one solution and providing an overall rating of that solution. This is repeated for each possible solution. After going through the whole list, the client is able to look at the problem-solving worksheet and a clear solution emerges. At other times, the result is that there are a number of possible solutions, none of which is exactly perfect. The therapist can then work with the client to choose a "good enough" alternative and figure out how to implement the chosen solution.

Distractibility

The distractibility module addresses the fact that many clients with ADHD report that they are unable to complete tasks because other, less important tasks or distractions get in the way. The primary goals of the distractibility module are to help the client become more aware of the environmental factors that are contributing to distractibility and to develop techniques to manage their tendency to move from one task to another without finishing the first. As the clients move along with the treatment, a larger portion of the sessions involves review of previously learned skills, as well as the presentation of new skills that complement previously learned skills. This treatment involves helping clients with multiple compensatory executive functioning skills. This is different from most cognitive-behavioral therapies that address, over the course of the treatment, only one or two skills (i.e., exposure or cognitive restructuring). Accordingly, so as to not overwhelm clients, the distractibility module is two sessions long, and was designed to augment the organizing and planning techniques.

One technique in this two-session module involves determining a baseline length of time that a person can hold his or her attention on any one, relatively non-stimulating, activity. Once accomplished, problem-solving skills learned in the previous module are employed to break the tasks into units that fit within this amount of time. If distracted during the time when working, clients are taught to write down the distraction so that they can deal with it in a systematic way when the piece of the task is complete. This procedure, the "distractibility delay" is adapted from similar techniques used in anxiety management and worry control procedures (see Zinbarg, Craske, & Barlow, 2006).

In the distractibility module, clients are also taught cue-control procedures to cue awareness of whether one is on task. Clients are taught to use a cell phone or a watch to beep at certain intervals and to use colored dots as visual cues on distracting objects. Whenever the alarm sounds or they see a colored dot, participants are instructed to assess whether they have been distracted from the main task at hand, and, if so, to return to that task. Lastly, this module involves teaching the client techniques for scheduling breaks, reducing external environmental distractions (e.g., internet, telephone), and to set up specific locations where they will keep important objects to minimize the chance of misplacing them.

The first session in the distractibility module includes the use of the "distractibility delay" technique and begins to address environmental strategies to reduce distractions. In this module, strategies are designed to increase the likelihood that the client will be able to stay on-task by setting up the task and environment to reduce distractions, by increasing the client's awareness of distractions and instances in which they have become distracted, and

by giving the client specific strategies to manage distracting thoughts or stimuli. In this way, the client "sets herself up for success" through environmental modification and skill use.

The client, "Jen," is a 35-year-old woman who is a stay-at-home mother and is trying to write a book that she hopes to get published. On intake, she complained that she was often unable to work on her book, even though she had a lot of free time while her children were off at school. The therapist assessed the barriers to Jen working on her book, which included (a) difficulty getting started on the task, (b) lack of distraction-free, dedicated space to do her writing, and (c) getting distracted by extraneous stimuli or distracting thoughts while writing. After trouble-shooting getting started on the task by scheduling a "writing appointment" for herself in her calendar book and setting an alarm to remind her of that appointment, the therapist moves on to discuss application of the distractibility delay strategy to Jen's writing task.

Distractibility Delay

As seen in video clip 6, the therapist first discusses a reasonable writing goal for Jen. In this component, Jen had already completed the exercise of measuring her attention span the previous week—that is, she measured the amount of time she could work on an unattractive task before she actually was drawn to a distraction, and arrived at an average attention span. She was then encouraged to break her 1-hour writing task into "chunks" of 15 minutes—echoing the strategy of breaking down tasks into smaller pieces in the organization and planning module. When providing instruction on how to use the notebook to triage distracting thoughts, the therapist encourages Jen to become aware of the attractiveness of distractions and what feelings or thoughts might lead to getting distracted (e.g., momentary anxiety about not attending to a distracting thought). The therapist asks the client to use the distractibility delay technique of writing down distractions but not addressing them until the 15-minute time period is up and the timer has gone off. Throughout the skills training, the therapist encourages a flexible, empirical attitude toward the new strategy, encouraging the client to give it a try as presented, and to gather information about what is most effective to discuss and troubleshoot at the next session.

Environmental Strategies

In video clip 7, the therapist assesses the physical space that Jen is currently using when trying to write, and identifies difficulties with the current situation. In anticipation of the next session, which focuses on reducing distractions in the environment, Jen is encouraged to establish her own work space in the house, separate from the work spaces used by other family members, with all of the items required to write close at hand. Following the strategy of breaking down tasks, the therapist chooses to focus on this single, concrete goal for Jen over the next week rather than trying to address all of the less-than-ideal aspects of the situation (e.g., sharing a laptop with her son). A more diffuse focus could be overwhelming for Jen and the likelihood that she would follow through might decrease. In the next session, Jen and the therapist would take a more detailed look at her writing environment, making a list of the distractions in her physical space and formulating a trouble-shooting strategy for each.

Adaptive Thinking

The primary goal of the adaptive thinking module is to help the client become more aware of thoughts that are causing difficulties for him or her and develop strategies to modify these thoughts. The cognitive restructuring procedures used in the three-session adaptive thinking module are those used by Beck (1995), except that they account for specific skills deficits due to ADHD. As detailed by McDermott (2000), cognitive restructuring training in this

population must account for the tendency for clients with ADHD to be drawn to maladaptive thoughts. We have found that there are two areas where cognitive restructuring is quite relevant for our clients with ADHD. One area where cognitive restructuring can be useful is in the area of low self-esteem and negative predictions about one's ability to succeed in the future. The other area in which cognitive restructuring can be helpful with these clients is with "overly positive" thinking. Often adult clients with ADHD will overestimate their ability to accomplish a task or complete it within a specified time and then have negative thoughts about themselves after they find that they have not been able to accomplish their unrealistic goals. Mitchell, Anastopoulos, Knouse, Kimbrel, and Benson (2008) found that ADHD symptoms in a college sample predicted endorsement of "ADHD-specific maladaptive thoughts," many of which were overly optimistic in nature. Adults with ADHD may overestimate their performance in domains in which they are actually less skilled than others (Knouse, Bagwell, Barkley, & Murphy, 2005). Therefore, work with these clients involves identifying both the overly negative and the overly positive thoughts in order to set more realistic goals and cue skill use rather than avoidance. The process is similar to that described by Beck (1995) in that clients are asked to complete thought records in their notebooks and then work on developing more realistic, effective, and helpful rational responses to replace problematic automatic thoughts that have been identified.

Generally, the first session of this module is spent orienting the client to the cognitive model and talking about how thinking can impact behaviors and emotions. In the first session, clients are given thought records and asked to complete them for homework. The second session of this module is spent helping the client develop rational responses to their overly negative or overly positive thoughts. The final session is spent consolidating the skill of cognitive restructuring and talking about how the client can continue to apply this skill in new situations.

"Laura" is a 30-year-old woman who reports problems at work and with friends. Her difficulties arise as a result of letting others down by being late, cancelling plans, and not completing tasks as promised. She is very distressed about this and is frustrated with herself that she has been unable to change her behavior. She is working part-time at a school and completing an advanced degree in education. Prior to the scene depicted in video clip 8, Laura has described an upsetting situation that occurred the previous week. She said that she had agreed to run an assembly at the school where she is working part-time. She had gotten up early so that she would have a lot of extra time. She described the choices that she made around how to spend this time—sorting out recycling, playing with cat—and talked about how she had told herself that she needed to leave at 10:40 because it takes around 20 minutes to get to the school and the assembly was set to start at 11:00.

In video clip 8, the therapist helps the client identify the overly optimistic thinking patterns that contributed to her being late in this situation, in addition to the negative thoughts that occurred after the situation. The therapist and client discuss how the client might be able to identify the "red flag" overly optimistic thoughts to avoid similar problems in the future. The therapist describes the difficulties with identifying overly optimistic thoughts. Since clients are feeling positive at the time (e.g., "I have plenty of time to get to the assembly"), it is important that they learn to identify the thoughts that were problematic so that they can identify them when they arise in future situations.

Additional Modules

The current manuscript was designed to provide an overview of this treatment approach, and show some examples of common issues among the most important modules. The treatment, however, also includes two additional modules that are optional based on the client's needs

and circumstances. The first is a one-session module on procrastination, and the second is a one-session module that involves a spouse or partner. The module with the spouse or partner provides educational information about ADHD in adulthood and encourages the couple to identify ways to support and maintain positive behavior changes. The module on procrastination involves adapting and applying skills from prior modules specifically to the problem of procrastination.

Relapse Prevention

The final session of the treatment is focused on relapse prevention. In this session, all strategies that the client has learned are reviewed and rated according to their usefulness. The therapist guides the client in developing a plan for continued use and addresses how the client can get back on track if he or she experiences a reemergence of symptoms. Plans are made for the client to complete a self check-in 1 month after treatment ends.

Conclusion

This manuscript with case illustrations provides a brief description of cognitive behavioral therapy for ADHD in adults as developed and tested by our team. Additional details about the treatment can be found in the published manual and client workbook (Safren, Perlman, et al., 2005; Safren, Sprich, et al., 2005). For therapists who have not worked with this population before, the video components that accompany this article also provide examples of the types of problems typically reported by adults with ADHD—both in their daily lives and during treatment sessions. Even so, ADHD in adulthood is a heterogeneous disorder and clients may present with a wide variety of different patterns of problematic behaviors and beliefs. It is important to note that, thus far, we have empirically tested this treatment with adults who are already receiving medication to help control their symptoms of ADHD through a randomized design. We are currently collecting pilot data on nonmedicated adults, and there are promising preliminary data for other psychosocial treatment packages with nonmedicated adults (e.g., Solanto, Marks, Mitchell, Wasserstein, & Kofman, 2008). However, the efficacy of this treatment for nonmedicated adults with ADHD has yet to be established.

While work with this population can certainly be challenging, it is our experience that often simple behavioral and cognitive interventions consistently applied by the client can result in significant improvements in daily functioning and in the client's sense of self-efficacy. Further development of psychosocial treatments for adults with ADHD is needed to build upon the strengths of this and other treatment packages and to fully address the multifaceted problems experienced by this previously neglected clinical population.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Video 1.
Setting up the calendar system.

Video 2.
Setting up the task list.

Video 3.
Problem solving: Articulating the problem.

Video 4.
Problem solving: Generating a list of potential problems.

Video 5.
Problem solving: Generating pros and cons and rating the solutions.

Video 6.
Using the “distractibility delay”.

Video 7.
Modifying the environment to reduce distractions.

Video 8.
Identifying overly optimistic thinking.