ATTENTION DEFICIT DISORDER (ADD)—ADULT

BEHAVIORAL DEFINITIONS

1. Childhood history of Attention Deficit Disorder (ADD) that was either diagnosed or later concluded due to the symptoms of behavioral problems at school, impulsivity, temper outbursts, and lack of concentration.
2. Unable to concentrate or pay attention to things of low interest, even when those things are important to his/her life.
3. Easily distracted and drawn from task at hand.
4. Restless and fidgety; unable to be sedentary for more than a short time.
5. Impulsive; has an easily observable pattern of acting first and thinking later.
6. Rapid mood swings and mood lability within short spans of time.
7. Disorganized in most areas of his/her life.
8. Starts many projects but rarely finishes any.
9. Has a "low boiling point" and a "short fuse."
10. Exhibits low stress tolerance; is easily frustrated, hassled, or upset.
11. Chronic low self-esteem.
12. Tendency toward addictive behaviors.

__. _____

_____

__. _____

_____

__. _____

_____

LONG-TERM GOALS

1. Reduce impulsive actions while increasing concentration and focus on low-interest activities.
2. Minimize ADD behavioral interference in daily life.
3. Accept ADD as a chronic issue and need for continuing medication treatment.
4. Sustain attention and concentration for consistently longer periods of time.
5. Achieve a satisfactory level of balance, structure, and intimacy in personal life.

__. _____

_____

__. _____

_____

__. _____

_____

SHORT-TERM OBJECTIVES

1. Describe past and present experiences with ADD including its effects on functioning. (1, 2)

2. Cooperate with and complete psychological testing. (3)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.

2. Conduct a thorough psychosocial assessment including past and present symptoms of ADD and their effects on educational, occupational, and social functioning.

3. Conduct or arrange for psychological testing to further assess ADD, other possible psychopathology (e.g., anxiety, depression), and relevant rule-outs (e.g., ADHD, conduct/antisocial features); provide feedback of testing results.

3. Cooperate with and complete a psychiatric evaluation. (4)

4. Comply with all recommendations based on the psychiatric and/or psychological evaluations. (5, 6)

5. Disclose any history of substance use that may contribute to and complicate the treatment of ADD. (7)

6. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (8, 9, 10, 11)

4. Arrange for a psychiatric evaluation of the client to rule out medical and substance-related etiologies and assess his/her need for psychotropic medication.

5. Process the results of the psychiatric evaluation and/or psychological testing with the client and answer any questions that may arise.

6. Conduct a conjoint session with significant others and the client to present the results of the psychological and psychiatric evaluations; answer any questions they may have and solicit their support in dealing with the client's condition.

7. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

8. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
10. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
11. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

7. Take psychotropic medication as prescribed, on a regular, consistent basis. (12, 13)

12. Monitor and evaluate the client's psychotropic medication prescription compliance, side effects, and the effectiveness of the medications on his/her level of functioning.
13. Confer with the client's psychiatrist on a regular basis regarding the effectiveness and side effects of the medication regimen.

8. Identify specific benefits of taking prescribed psychotropic medications on a long-term basis. (14, 15)
9. Identify the current specific ADD behaviors that cause the most difficulty. (16, 17, 18)
10. List the negative consequences of the ADD problematic behavior. (19)

14. Ask the client to make a "pros and cons" spreadsheet regarding staying on psychotropic medications; process the results.
15. Encourage and support the client in remaining on psychotropic medication and warmly but firmly confront thoughts of discontinuing when they surface (or assign "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma).
16. Assist the client in identifying the current specific behaviors that cause him/her the most difficulty functioning as part of identifying treatment targets (i.e., a functional analysis).
17. Review the results of psychological testing and/or psychiatric evaluation again with the client assisting in identifying or in affirming his/her choice of the most problematic behavior(s) to address.
18. Ask the client to have extended family members and close collaterals complete a ranking of the behaviors they see as interfering the most with his/her daily functioning (e.g., mood swings, temper outbursts, easily stressed, short attention span, never completes projects).
19. Assign the client to make a list of negative consequences that he/she has experienced or that could result from a continuation of the problematic behavior; process the list (or assign "Impulsive Behavior Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma).

11. Invite a significant other to join in the therapy to provide support throughout therapy. (20, 21)

20. Direct the client to invite a significant other to participate in the therapy; train the significant other throughout therapy to help support the change and reduce friction in the relationship introduced by the ADHD.

21. Instruct the client's significant other in the HOPE technique (i.e., Help, Obligations, Plans, and Encouragement) to help support the client's positive changes (see *Driven to Distraction* by Hallowell and Ratey).

12. Increase knowledge of ADHD and its treatment. (22, 23, 24)

22. Educate the client about the signs and symptoms of ADHD and how they disrupt functioning through the influence of distractibility, poor planning and organization, maladaptive thinking, frustration, impulsivity, and possible procrastination.

23. Discuss a rationale for treatment where the focus will be improvement in organizational and planning skills, management of distractibility, cognitive restructuring, and overcoming procrastination (see *Mastering Your Adult ADHD: Therapist Manual* by Safren et al.).

24. Assign the client readings consistent with the treatment model to increase their knowledge of ADHD and its treatment (e.g., *Mastering Your Adult ADHD: Client Workbook* by Safren et al; *The Attention Deficit Disorder in Adults Workbook* by Weis).

13. Read self-help books about ADHD to improve

25. Assign the client self-help readings that help facilitate the

understanding of the condition and its features. (25)	client's understanding of ADHD (e.g., *Driven to Distraction* by Hallowell and Ratey; *ADHD: Attention-Deficit Hyperactivity Disorder in Children, Adolescents, and Adults* by Wender; *Putting on the Brakes* by Quinn and Stern; *You Mean I'm Not Lazy, Stupid or Crazy?* by Kelly and Ramundo); process the material read.
14. Learn and implement organization and planning skills. (26, 27, 28, 29)	26. Teach the client organization and planning skills including the routine use of a calendar and daily task list.
	27. Develop with the client a procedure for classifying and managing mail and other papers.
	28. Teach the client problem-solving skills (i.e., identify problem, brainstorm all possible options, evaluate the pros and cons of each option, select best option, implement a course of action, and evaluate results) as an approach to planning; for each plan, break it down into manageable time-limited steps to reduce the influence of distractibility.
	29. Assign homework (e.g., "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma) asking the client to apply problem-solving skills to an everyday problem (i.e., impulse control, anger outbursts, mood swings, staying on task, attentiveness); review and provide corrective feedback toward improving the skill.

15. Learn and implement skills to reduce the disruptive influence of distractibility. (30, 31, 32, 33)

30. Assess the client's typical attention span by having them do a few "boring" tasks (e.g., sorting bills, reading something uninteresting) to the point that they report distraction; use this as an approximate measure of their typical attention span.

31. Teach the client stimulus control techniques that use external structure (e.g., lists, reminders, files, daily rituals) to improve on-task behavior; remove distracting stimuli in the environment; encourage the client to reward himself/herself for successful focus and follow-through.

32. Teach the client to break down tasks into meaningful smaller units that can be completed without being distracted based on their demonstrated attention span.

33. Teach the client to use timers or other cues to remind him/her to stop tasks before he/she gets distracted in an effort to reduce the time they may be distracted and off-task (see *Mastering Your Adult ADHD: Therapist Guide* by Safren et al.).

16. Identify, challenge, and change self-talk that contributes to maladaptive feelings and actions. (34, 35)

34. Use cognitive therapy techniques to help client identify maladaptive self-talk (e.g., "I must do this perfectly," "I can do this later," "I can't organize all these things"); challenge biases, and generate alternatives.

35. Assign homework asking client to implement cognitive restructuring skills while doing tasks in which maladaptive

thinking has occurred previously; review and provide corrective feedback toward improving the skills.

17. Acknowledge procrastination and the need to reduce it. (36)

36. Assist the client in identifying positives and negatives of procrastinating toward the goal of engaging him/her in staying focused.

18. Learn and implement skills to reduce procrastination. (37, 38, 39)

37. Teach the client to apply new problem-solving skills to planning as a first step in overcoming procrastination; for each plan, break it down into manageable time-limited steps to reduce the influence of distractibility.

38. Teach the client to apply new cognitive restructuring skills to challenge thoughts that encourage the use of procrastination (e.g., "I can do this later" or "I'll finish this after I watch my TV show") and embrace thoughts encouraging action.

39. Assign homework asking the client to accomplish identified tasks without procrastination using the techniques learned in therapy; review and provide corrective feedback toward improving the skill and decreasing procrastination.

19. Combine skills learned in therapy into a new daily approach to managing ADHD. (40, 41, 42)

40. Teach the client meditational and self-control strategies (e.g., "stop, look, listen, and think") to delay the need for instant gratification and inhibit impulses to achieve more meaningful, longer-term goals.

41. Select situations in which the client will be increasingly

challenged to apply his/her new strategies for managing ADHD, starting with situations highly likely to be successful.

42. Use any of several techniques, including imagery, behavioral rehearsal, modeling, role-playing, or in vivo exposure/ behavioral experiments to help the client consolidate the use of his/her new ADHD management skills.

20. Implement relaxation procedures to reduce tension and physical restlessness. (43)

43. Instruct the client in various relaxation techniques (e.g., deep breathing, meditation, guided imagery) and encourage him/her to use them daily or when stress increases (recommend *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay).

21. Cooperate with brainwave biofeedback (neurotherapy) to improve impulse control and reduce distractibility. (44, 45)

44. Conduct, refer for, or administer EEG biofeedback (neurotherapy) to improve attention span, impulse control, and mood regulation.

45. Encourage the client to transfer the biofeedback training skills of relaxation and cognitive focusing to everyday situations (e.g., home, work, social).

22. List coping skills that will be used to manage ADD symptoms. (46)

46. Review with the client the symptoms that have been problematic and the newly learned coping skills he/she will use to manage the symptoms (or assign "Symptoms and Fixes for ADD" in the *Adult Psychotherapy Homework Planner* by Jongsma).

23. Attend an ADD support group with or without significant other. (47)

47. Refer the client to a specific group therapy for adults with ADD to increase the client's

	understanding of ADD, to boost his/her self-esteem, and to obtain feedback from others; encourage inclusion of significant other.
24. Report improved listening skills without defensiveness. (48)	48. Use role-playing and modeling to teach the client how to listen and accept feedback from others regarding his/her behavior.
__. _____	__. _____
_____	_____
__. _____	__. _____
_____	_____
__. _____	__. _____
_____	_____

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
	314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS
	296.xx	Bipolar I Disorder
	301.13	Cyclothymic Disorder
	296.90	Mood Disorder NOS
	312.30	Impulse-Control Disorder NOS
	303.90	Alcohol Dependence
	305.00	Alcohol Abuse
	304.30	Cannabis Dependence
	305.20	Cannabis Abuse
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
314.00	F90.0	Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Presentation
314.01	F90.1	Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation
314.01	F90.9	Unspecified Attention-Deficit/Hyperactivity Disorder
314.01	F90.8	Other Specified Attention-Deficit/Hyperactivity Disorder
296.xx	F31.xx	Bipolar I Disorder
301.13	F34.0	Cyclothymic Disorder
312.9	F91.9	Unspecified Disruptive, Impulse Control, and Conduct Disorder
312.89	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
305.20	F12.10	Cannabis Use Disorder, Mild

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.