Adult ADHD Practitioner Training: Foundations

THE TALKING THERAPIES UK PRACTITIONER SERIES



Adult ADHD Practitioner Training: Foundations

Why generic CBT needs adapting, and the Safren model at a glance

Foundation level · 9.5 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

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First edition, 2026.

This manual accompanies the Adult ADHD Practitioner Training: Foundations course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 6. This printing was set on 22 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

This foundation course is designed for psychological practitioners, therapists, and trainees who already hold a working knowledge of standard cognitive behavioural therapy and wish to extend their competence to adult clients presenting with ADHD. It addresses a gap that is frequently reported in clinical supervision and continuing professional development feedback alike: that existing CBT skills, however well developed, do not transfer straightforwardly to this population, and that without deliberate adaptation the therapeutic frame can inadvertently replicate the very experiences of failure and frustration that many adults with ADHD have accumulated across a lifetime.

The course opens by examining precisely why adult clients with ADHD so consistently describe generic CBT as a poor fit. Drawing on the clinical and research literature, you will explore how the standard assumptions embedded in conventional CBT delivery — consistent between-session practice, linear progression through a structured formulation, reliable working memory for in-session material, and the capacity to sustain effortful self-monitoring across weeks — map poorly onto the neuropsychological profile that characterises ADHD in adulthood. You will study what NICE has said about this directly, working through the recommendations set out in NICE NG87, the guideline covering the diagnosis and management of ADHD across the lifespan. NICE NG87 is explicit about the role of structured psychological intervention alongside or in place of pharmacological treatment, and you will consider what that means in practice for the clinician who is already competent in CBT but has not yet received ADHD-specific training.

The second part of the course introduces the Safren model, the cognitive behavioural programme for adult ADHD that has the most robust randomised controlled trial evidence behind it. A landmark trial of medication-treated adults with persistent ADHD symptoms demonstrated that the Safren programme produced significantly greater symptomatic improvement than an active control condition of relaxation with educational support, a finding that underlines both the value of psychological

intervention and the importance of using a model genuinely adapted for ADHD rather than an unmodified standard protocol. You will study the model at a glance: its deliberate three-part sequence, which moves through behavioural skills first, then organisational and planning skills, and finally cognitive restructuring, and the reasoning behind that ordering. Crucially, you will also examine the psychoeducation on executive function and common comorbidities that underpins the entire programme, understanding why this psychoeducational foundation is not merely introductory scene-setting but a clinically active component that shapes the therapeutic relationship and the client's capacity to engage with what follows.

No prior ADHD-specific training is assumed, and the course is explicitly positioned at foundation level, making it an appropriate starting point for practitioners at any stage of their post-qualification career. Nine and a half CPD hours are awarded on completion.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at foundation level and carries 9.5 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Appraise the limitations of standard cognitive behavioural therapy protocols when applied to adult attention-deficit/hyperactivity disorder.
- Implement the structured three-part Safren model sequencing behavioural, organisational, and cognitive strategies.
- Evaluate the impact of executive function deficits on working memory, task initiation, and treatment engagement.
- Integrate NICE NG87 guidelines regarding the complementary roles of pharmacotherapy and psychological intervention.
- Manage therapeutic complications such as non-adherence and executive overload without resorting to punitive reframing.

PART 1

Why adult ADHD needs an adapted model

Why clients report generic CBT as a poor fit, and what NICE NG87 says about psychological intervention.

CHAPTER 1

Why clients report generic CBT as a poor fit

Adults who present with persistent attention deficit hyperactivity disorder often report that standard, unmodified cognitive behavioural therapy feels alien, frustrating and ultimately ineffective. The mismatch is not merely a matter of personal preference but is rooted in the core neurocognitive profile that characterises the condition. The therapeutic process of conventional CBT relies heavily on the client's ability to engage in self-monitoring, to complete structured homework, and to manipulate abstract cognitive constructs – all tasks that demand intact executive function. When these cognitive scaffolds are compromised, the entire therapeutic architecture can collapse. In this lesson we will unpack the evidence that demonstrates why the generic CBT model fails for many adults, explore the mechanisms by which executive dysfunction undermines core CBT processes, and outline the principles that guide the development of an adapted, structured programme that has been empirically validated. We will also examine why a therapist's competence in standard CBT does not automatically translate to competence in treating attention deficit hyperactivity disorder, and we will illustrate these points with a concrete, worked example that demonstrates the practical application of an adapted approach.

A landmark randomised controlled trial conducted by Safren and colleagues in 2010 provides the most robust evidence that a structured, ADHD-adapted programme can outperform educational support and relaxation training in medication-treated adults with persistent symptoms. The study recruited 140 participants, randomised them to either a 12-session, manualised cognitive-behavioural intervention or a control group that received relaxation training coupled with educational support. Outcomes were measured using the Adult ADHD Self-Report Scale (ASRS) and the Clinical Global Impression – Improvement (CGI-I). The adapted programme produced a mean reduction of 1.8 points on the ASRS, compared with a 0.4 point reduction in the control group, a difference that was statistically significant ($p < .001$). Importantly, the intervention also yielded significant improvements on the PHQ-9 and GAD-7, suggesting that targeting ADHD symptoms can have a cascading positive effect on comorbid mood and anxiety disorders. This trial underscores the necessity of a structured, theory-driven approach that explicitly addresses the executive function deficits that underlie the disorder.

Executive function encompasses a suite of cognitive processes – working memory, inhibition, cognitive flexibility, planning and organisational skills – that enable the individual to regulate behaviour, sustain attention and adapt to changing demands. In adults with attention deficit hyperactivity disorder, deficits in these domains are pervasive and profoundly impact daily functioning. Conventional CBT assumes that clients can reliably attend to session material, retain information across sessions, and apply newly acquired skills independently. When a client's working memory is compromised, they may struggle to keep track of the sequence of cognitive steps required for restructuring. Impaired inhibition can lead to impulsive responses that derail the systematic exploration of thoughts. Deficits in planning and organisation mean that even well-intentioned homework tasks become overwhelming, leading to incomplete or abandoned assignments. Thus, the very scaffolding that CBT relies upon is weakened by the neurocognitive profile that defines the disorder.

Homework completion and self-monitoring are often the first casualties in the therapeutic process. The CBT model posits that between-session practice consolidates learning and facilitates generalisation of skills. However, in the context of attention deficit hyperactivity disorder, the demands of self-monitoring – such as tracking mood, thoughts and behaviours over time – place a heavy load on working memory and

sustained attention. Clients frequently report forgetting to complete diaries, misplacing worksheets, or abandoning tracking altogether. Homework, which is designed to reinforce the cognitive and behavioural techniques introduced in session, becomes a source of frustration rather than empowerment. The failure to complete homework not only hampers skill acquisition but also erodes the therapeutic alliance, as clients may feel judged or misunderstood. Consequently, the therapeutic gains achieved in session are not translated into real-world change, and the cycle of disengagement is perpetuated.

The assumption that a therapist's competence in standard CBT automatically transfers to the treatment of attention deficit hyperactivity disorder is a dangerous shortcut. While the core principles of CBT – such as the identification of maladaptive cognitions, the use of behavioural experiments and the emphasis on collaborative goal setting – remain relevant, the delivery of these principles must be adapted to accommodate executive dysfunction. Therapists trained in conventional CBT may unconsciously rely on techniques that require intact working memory or sustained attention, such as complex cognitive restructuring or the use of abstract metaphors. Without explicit training in ADHD-specific adaptations – for example, the use of visual schedules, external cueing, or the incorporation of behavioural management strategies – therapists risk implementing a model that is structurally incompatible with the client's cognitive profile. Moreover, therapists may misinterpret the client's difficulties with homework or self-monitoring as lack of motivation or therapeutic alliance, rather than recognising them as manifestations of executive dysfunction. This misattribution can lead to premature termination of treatment or the implementation of punitive measures that further erode engagement.

Adaptation of CBT for attention deficit hyperactivity disorder requires a systematic, theory-driven approach that addresses the specific cognitive and behavioural challenges of the disorder. Key principles include: (1) the use of concrete, step-by-step worksheets that minimise cognitive load; (2) the incorporation of external memory aids such as phone reminders, colour-coded planners and visual cueing; (3) the segmentation of homework into short, manageable tasks with clear start and finish points; (4) the use of implementation intentions – concrete "if-then" plans that link situational cues to behavioural responses; (5) the integration of behavioural

management strategies such as token economies, contingency management and structured reinforcement schedules; (6) the emphasis on problem-solving skills that are directly linked to real-world challenges; and (7) the provision of frequent, brief feedback to reinforce progress and maintain motivation. These adaptations are grounded in the work of Safren, Barkley and colleagues, who have demonstrated that a structured, manualised programme that incorporates these elements yields superior outcomes compared with unmodified CBT.

Consider the case of Sarah, a 32-year-old marketing executive who sought therapy for chronic procrastination, disorganisation and persistent worry about meeting deadlines. Sarah had been diagnosed with attention deficit hyperactivity disorder in her late twenties and had been on stimulant medication for the past three years. She reported that her medication helped with concentration during work but did not alleviate her tendency to leave tasks unfinished or to forget appointments. In the first session, the therapist introduced a structured, ADHD-adapted CBT framework. A visual agenda was created, outlining the session's objectives and the homework tasks. Sarah was taught to use a colour-coded planner, with red for urgent tasks, yellow for important but not urgent tasks, and green for low-priority items. Each homework assignment was broken down into three micro-tasks: (1) identify the task, (2) estimate the time required, and (3) schedule the task on the planner. Sarah was also taught to use a smartphone reminder set for 15 minutes before the scheduled time, coupled with an implementation intention: "If I receive the reminder, then I will stop my current activity and begin the task." Over the next four weeks, Sarah's adherence to homework improved markedly, as did her ability to complete tasks on time. By the end of the programme, her ASRS score had decreased by 2.1 points, and her PHQ-9 score had fallen from 18 to 9, indicating a significant reduction in depressive symptoms.

The success of Sarah's case illustrates the power of a structured, ADHD-adapted CBT programme. By aligning the therapeutic process with the client's cognitive strengths and compensating for deficits, the therapist was able to transform a potentially frustrating experience into a collaborative, goal-oriented journey. The key to this transformation lies in the therapist's willingness to move beyond the default CBT model, to recognise the unique challenges posed by attention deficit hyperactivity disorder, and to employ evidence-based adaptations that are tailored to the individual's needs.

In conclusion, the mismatch between standard CBT and the cognitive profile of adults with attention deficit hyperactivity disorder is well documented. The evidence from Safren et al. (2010) and subsequent studies demonstrates that a structured, ADHD-adapted programme can achieve superior outcomes by directly addressing executive dysfunction. Core CBT processes such as homework completion and self-monitoring become vulnerable when the client's working memory, inhibition and planning capacities are compromised. Therapists must therefore avoid the assumption that competence in conventional CBT automatically translates to competence in treating attention deficit hyperactivity disorder. Instead, they should adopt a systematic, theory-driven approach that incorporates concrete, low-cognitive-load techniques, external memory aids, and behavioural management strategies. By doing so, they can create a therapeutic environment that is both accessible and effective for adults who struggle with the executive demands of everyday life.

The implications for practice are clear: training programmes for clinicians should include a dedicated module on ADHD-specific CBT adaptations, and clinicians should be encouraged to routinely assess executive function as part of the intake process. When therapists recognise the signs of executive dysfunction early, they can tailor the therapeutic agenda to minimise cognitive load, thereby enhancing engagement and treatment adherence. Ultimately, the goal is to empower clients to translate the skills learned in therapy into lasting, real-world change, thereby reducing the burden of attention deficit hyperactivity disorder on individuals, families and society at large. By embracing an evidence-based, structured approach, clinicians can move beyond the limitations of generic CBT and offer a truly effective, personalised intervention for adults with attention deficit hyperactivity disorder.

When implementing these ADHD-adapted CBT principles in clinical practice, supervision plays a crucial role in ensuring fidelity and effectiveness. Supervisors should be particularly attuned to the subtle indicators that standard CBT approaches may not be adequately addressing a client's executive function needs. During case reviews, supervisors might explore how the therapist is adapting core CBT techniques for ADHD, such as whether homework assignments have been sufficiently segmented, whether external memory aids are being consistently utilised, and whether the therapist is appropriately interpreting missed homework as a potential

executive function challenge rather than a motivational issue.

A common pitfall in supervision is the assumption that therapists with strong general CBT skills will automatically recognise when adaptations are needed. Supervisors should actively guide therapists in developing a “clinical ADHD lens” that helps them identify executive dysfunction in session. This might involve reviewing session recordings to observe whether the therapist is noticing when a client loses track of cognitive restructuring steps, or whether they are adjusting their pace and complexity in response to the client’s working memory capacity.

Supervision itself may require adaptation when working with therapists treating ADHD clients. Given the executive function demands of case conceptualisation and treatment planning, supervisors should consider providing written summaries of supervision sessions, using visual aids to track treatment progress, and structuring supervision with clear agendas and time-bound segments. The supervisor might also model ADHD-adapted communication techniques during supervision, such as breaking down complex feedback into concrete, actionable steps.

In advanced supervision, therapists can be guided through the process of developing personalized ADHD adaptation protocols. This involves identifying the specific executive function challenges most relevant to each client and systematically tailoring interventions accordingly. For instance, a client with severe working memory deficits might benefit from smartphone-based reminder systems, while someone with planning difficulties might require more structured implementation intentions with environmental cues.

Ultimately, effective supervision for ADHD-adapted CBT requires the same principles as effective therapy: concrete guidance, external scaffolding, and frequent feedback. By creating a supervision environment that models the adaptations being taught, supervisors can help therapists internalise these approaches and apply them flexibly across diverse client presentations. This meta-level adaptation ensures that therapists themselves experience the benefits of an ADHD-sensitive approach, enhancing their ability to deliver effective treatment to their clients.

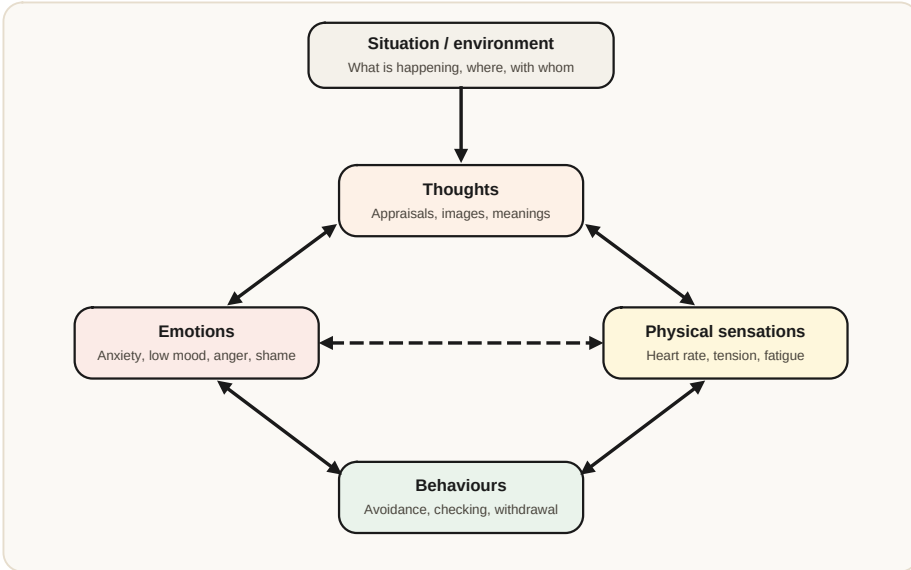


FIGURE 1.1 The five areas model

Greenberger and Padesky's five areas ("hot cross bun") model: a situation is processed through thoughts, emotions, physical sensations and behaviours, and every element influences every other. Change introduced at any point, most often at thoughts or behaviours, alters the whole system.

Points worth keeping

- Safren et al. (2010): a structured, ADHD-adapted programme outperformed educational support
- Standard CBT structure can be undermined by the executive function difficulties it assumes
- Homework completion and self-monitoring are often the first casualties
- Why existing CBT competence should never be assumed to transfer automatically

PRACTICE TASK

List three standard CBT homework expectations that might need to be restructured for a client with significant executive function difficulty.

CHAPTER 2

NICE NG87 and the context for psychological intervention

To practise as a psychologically informed clinician working with adults who have attention-deficit hyperactivity disorder, you need to understand not only the clinical features of the condition but also the policy and evidence landscape that gives your work its legitimacy and its limits. The National Institute for Health and Care Excellence guideline NG87, published in 2018 and covering the diagnosis and management of ADHD in children, young people and adults, is the single most important regulatory document shaping how psychological intervention is positioned within a UK clinical pathway. Before you can make sense of the adapted cognitive-behavioural model that this course teaches, you need to understand what NG87 actually says, why it says it, and what that means for the role you are being trained to occupy.

NG87 sits within a long history of NICE guidance on ADHD that has progressively expanded its scope. Earlier iterations of the guideline, particularly the 2008 version that preceded NG87, were criticised for underweighting the adult presentation and for treating pharmacological management as so dominant that psychological intervention barely registered as a clinical option. NG87 represents a meaningful shift. It acknowledges that ADHD in adulthood is a genuine, impairing and treatable condition, and it positions structured psychological intervention as a component of care that has an evidence base sufficient to warrant recommendation. This is not a minor bureaucratic update. For practitioners working in psychological therapies, it is the document that opens the door.

The guideline recommends that for adults with ADHD, medication should typically be the first-line treatment where it is appropriate and acceptable to the individual. This reflects the substantial evidence base for stimulant and non-stimulant pharmacotherapy in reducing core ADHD symptom severity. Methylphenidate, lisdexamfetamine and atomoxetine all have randomised controlled trial evidence supporting their efficacy, and NG87 is appropriately clear that this evidence is stronger, in terms of effect size and volume of trials, than the evidence for psychological intervention alone. A

psychologically trained practitioner who enters this field without acknowledging that reality is doing their clients a disservice. Medication works for a significant proportion of adults with ADHD, and the guideline is right to say so.

However, NG87 is equally clear that medication alone is rarely sufficient. Even when stimulant medication produces meaningful reductions in inattention and hyperactivity-impulsivity, many adults continue to experience significant functional difficulties. Years of undiagnosed or mismanaged ADHD leave a residue of learned avoidance, low self-efficacy, disorganised habits, interpersonal difficulties and, very often, comorbid anxiety and depression. Medication does not teach a person how to plan a project, regulate their emotional responses to frustration, repair a relationship damaged by years of forgotten commitments, or build the kind of structured daily routine that compensates for executive function deficits. These are skills, and skills require teaching, practice and supported consolidation over time. NG87 recognises this explicitly, recommending that structured, skills-based psychological intervention be offered alongside medication for adults who have responded only partially to pharmacotherapy, or who continue to experience functional impairment despite adequate medication management.

The guideline also addresses the substantial group of adults for whom medication is not a viable option. Some individuals have contraindicated cardiovascular conditions. Others experience side effects, including appetite suppression, sleep disruption, elevated anxiety or emotional blunting, that make sustained pharmacological treatment intolerable. A meaningful proportion of adults with ADHD decline medication on personal, philosophical or practical grounds, and that decision deserves to be respected rather than pathologised. For all of these individuals, NG87 is clear that psychological intervention should be available as a direct alternative rather than as a consolation prize. The evidence base for structured psychological approaches, particularly cognitive-behavioural therapy adapted for the specific profile of adult ADHD, is sufficient to justify offering it as a standalone treatment where medication is not appropriate or not wanted.

Understanding this dual positioning, psychological intervention as an adjunct to medication and as a standalone alternative, is essential for how you think

about your clinical role. You are not a prescriber. You are not a diagnostician in the formal sense, unless you hold specific qualifications that confer that role. You are a practitioner who delivers structured, evidence-informed psychological work, and NG87 gives that work a clear and legitimate place within the overall care pathway. Your role is complementary to medical management, not a replacement for it. This distinction matters clinically and ethically. It means that when you are working with a client who is also under the care of a psychiatrist or a specialist ADHD service, your job is to coordinate, communicate and collaborate, not to second-guess prescribing decisions or to position psychological work as superior to pharmacological treatment. It also means that when you are working with a client who has chosen not to take medication, your job is to deliver the best possible psychological intervention without subtly pressuring them towards a medical pathway they have declined.

NG87 specifies that the psychological intervention recommended for adults with ADHD should be structured and skills-based. This is an important qualifier. The guideline is not recommending open-ended exploratory psychotherapy, though that may have a role in addressing comorbidities or the psychological consequences of a lifetime of unrecognised ADHD. It is recommending an approach that teaches concrete, transferable skills: time management, planning and prioritisation, strategies for sustaining attention, techniques for managing emotional dysregulation, and methods for building and maintaining organisational systems. The intervention should be time-limited, goal-directed and grounded in an explicit model of how ADHD affects functioning. This is precisely the territory that cognitive-behavioural approaches occupy, and it is why the adapted CBT model, particularly the Safren model developed by Steven Safren and colleagues at Massachusetts General Hospital, has become the most widely cited and most clinically adopted framework for delivering NG87-consistent psychological intervention with adults.

The Safren model, which this course will teach in detail in subsequent modules, was developed specifically to address the functional impairment associated with adult ADHD rather than simply to reduce symptom counts. It organises intervention around three core skill domains: organisation and planning, reducing distractibility, and adaptive thinking. Each domain is addressed through structured, manualised sessions that build on one another in a logical sequence. The model was designed to be delivered

alongside medication, and the original randomised controlled trial by Safren and colleagues demonstrated that adults receiving the combined intervention showed significantly greater functional improvement than those receiving medication alone. This is exactly the kind of evidence that NG87 draws on when it recommends skills-based psychological intervention as an adjunct to pharmacotherapy, and it is why understanding the guideline's position is inseparable from understanding the clinical model you are being trained to deliver.

To make this concrete, consider a client we might call David, a thirty-eight-year-old project manager who received his ADHD diagnosis fourteen months ago after decades of struggling with what he had always attributed to laziness and poor character. David is taking lisdexamfetamine and reports that it has made a genuine difference to his ability to sustain attention during meetings and to begin tasks that he would previously have avoided for weeks. However, he continues to miss deadlines, loses important documents, frequently arrives late to appointments, and describes his home and workspace as chaotically disorganised. His self-esteem remains low, and he reports significant anxiety about his performance at work. His psychiatrist has referred him for psychological intervention because, in her clinical judgement, medication has taken him as far as it can and the residual functional difficulties require a different kind of help. This is precisely the scenario that NG87 anticipates. David is not a medication failure. He is a person whose ADHD has responded partially to pharmacotherapy and who now needs the complementary skills-based work that the guideline recommends. As his psychological practitioner, your role is not to revisit the question of whether his medication is correct, nor to suggest that psychological work might eventually allow him to reduce his dose. Your role is to deliver structured, evidence-based intervention that addresses the functional gaps that medication has not filled, working in communication with his prescribing psychiatrist and within the framework that NG87 establishes.

It is also worth being explicit about what NG87 does not say, because misreading guidance can be as clinically consequential as ignoring it. The guideline does not say that psychological intervention should replace medication as a matter of course. It does not say that CBT is equally effective to stimulant medication for reducing core ADHD symptom severity, because the evidence does not support that claim. It does not say that every

adult with ADHD requires psychological intervention, because some individuals manage very well with medication and their own adaptive strategies. What it says, carefully and specifically, is that structured skills-based psychological intervention has a defined and evidenced role in the overall management of adult ADHD, that this role is complementary to medical management in most cases and an appropriate alternative in others, and that practitioners delivering such intervention should do so within a coherent, structured model.

For you as a practitioner beginning this training, NG87 provides something invaluable: a clear mandate. It tells you that the work you are learning to do is not peripheral or experimental. It is recommended by the national body responsible for clinical guidance in England and Wales, it is grounded in a body of evidence that has been systematically reviewed, and it addresses a genuine and substantial unmet need in the adult ADHD population. At the same time, the guideline asks something of you. It asks you to understand your role accurately, to work collaboratively within multidisciplinary pathways, to deliver intervention that is genuinely structured and skills-based rather than loosely supportive, and to maintain the intellectual honesty to acknowledge both what psychological intervention can achieve and where its limits lie. The rest of this course is designed to equip you to meet that standard.

In practice, this translates directly into the structure of your very first session with David. You would not spend the hour exploring his childhood or his unconscious conflicts, as might be the case in a more traditional psychodynamic formulation. Instead, you would immediately orient him towards the skills-based work mandated by NG87. You might begin by collaboratively constructing a visual timeline of his week, identifying the specific moments where his executive function deficits manifest as missed deadlines or disorganisation. This is the “organisation and planning” domain of the Safren model in action. Crucially, you would frame this work not as a critique of his character or a demand for perfection, but as a pragmatic engineering problem: how can we build a system that accommodates his neurology rather than fighting against it? By doing so, you validate his experience of medication as helpful but insufficient, positioning yourself as the technician who provides the missing tools. This approach ensures that your intervention remains distinct from the psychiatrist’s role, respecting the boundary that NG87 establishes while directly addressing the functional

impairment that continues to derail his professional life. You would also need to be explicit about the time-limited nature of the intervention, setting clear expectations that this is a skills acquisition course, not an indefinite therapeutic journey.

This transparency helps manage David's anxiety, which is often exacerbated by the fear of "failure" inherent in ADHD. As you move through the subsequent sessions, you would continue to monitor his progress against the functional goals he set in that first meeting, using his response to medication as a baseline against which to measure his skill acquisition. If he reports that a new time-management strategy helps him start a project that he previously avoided, you would reinforce this behaviour, linking it directly to his improved self-efficacy. This cycle of setting, acting on, and reviewing skills is the engine of the NG87-compliant intervention, ensuring that every session moves him closer to the functional independence that medication alone cannot provide.

Furthermore, you would be vigilant about the "adaptive thinking" component, helping David reframe his internal narrative from one of chronic underachievement to one of neurodiverse processing that requires specific environmental scaffolding. By explicitly teaching him to recognise cognitive distortions—such as catastrophising about a missed deadline or all-or-nothing thinking about his organisational systems—you are addressing the emotional dysregulation that often accompanies the executive dysfunction. This dual focus on practical organisation and cognitive restructuring is what makes the Safren model so effective for the adult population, moving beyond symptom reduction to genuine quality of life improvement, which is the ultimate goal of the care pathway outlined in NG87.

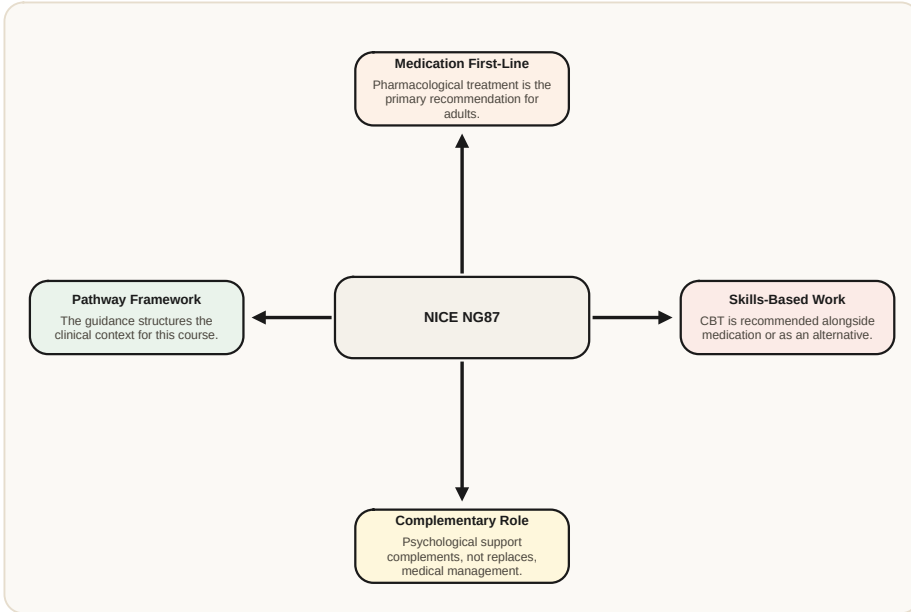


FIGURE 2.1 NICE NG87 and the Role of Psychological Intervention
This figure positions NICE NG87 as the central regulatory framework for adult ADHD care in the UK. It illustrates how the guideline defines the specific, complementary role of psychological therapy within the broader clinical pathway.

Points worth keeping

- NICE NG87's position on psychological intervention for adult ADHD
- Skills-based work alongside medication, and as an alternative when needed
- The practitioner's role: complementary to, not a replacement for, medical management
- How this guidance frames the rest of this pathway

PRACTICE TASK

Write two sentences explaining to a referrer when psychological intervention might be offered alongside medication, and when it might be offered instead of it, per NG87.

CHAPTER 3

From Diagnosis to Formulation: Building a CBT Case Conceptualisation for Adult ADHD

A diagnosis of ADHD tells a clinician that a client meets a threshold of symptoms across two domains — inattention and hyperactivity-impulsivity — and that those symptoms have been present since childhood, cause impairment across settings, and are not better explained by another condition. What a diagnosis does not tell a clinician is why this particular person, with this particular history, living this particular life, is struggling in the way they are right now. That gap — between categorical diagnosis and individualised understanding — is precisely the space that a CBT case conceptualisation is designed to fill. For practitioners new to adult ADHD work, learning to build a formulation that is both neurobiologically informed and genuinely collaborative is one of the most important foundational skills they can develop, and it is the subject of this lesson.

In standard CBT, the case conceptualisation draws on Beck's cognitive model to map the relationship between early experience, core beliefs, conditional assumptions, automatic thoughts, and the maintaining cycles of emotion, behaviour, and physiology. That framework remains relevant in adult ADHD work, but it requires meaningful extension. The practitioner must hold two levels of explanation simultaneously: the neurobiological substrate — the heritable, dopaminergic, prefrontal-cortical differences that characterise ADHD — and the psychological superstructure that has been built on top of it across years of lived experience. Failing to hold both levels leads to formulations that are either reductive (treating everything as a symptom of a brain difference) or incomplete (treating everything as a learned cognitive pattern while ignoring the biological floor beneath it).

The starting point for any adult ADHD formulation is a thorough developmental history. Adults with ADHD have typically accumulated a long record of experiences that have shaped their beliefs about themselves and about the world's likely response to them. Decades of research, including the longitudinal work of Russell Barkley and the clinical writings of Ari Tuckman,

have established that adults with ADHD frequently present with histories of academic underachievement relative to intellectual potential, repeated interpersonal conflict, employment instability, and a pervasive sense of having tried hard and still failed. These experiences are not incidental biographical detail; they are the raw material from which core beliefs are constructed. The practitioner's task in the early sessions is to listen for the beliefs that have crystallised out of this history — beliefs such as 'I am fundamentally lazy', 'I cannot be trusted to follow through', 'I will always let people down', or 'There is something wrong with me that cannot be fixed' — and to begin mapping how those beliefs interact with current ADHD-related difficulties to create and sustain the client's presenting problems.

A useful organising framework for the adult ADHD formulation is the three-level model proposed by Safren and colleagues, which distinguishes between the core neurobiological deficits, the secondary psychological consequences of living with those deficits, and the tertiary comorbidities that have developed in response to chronic failure and distress. The formulation should make these levels explicit and show how they interact. At the first level, the practitioner notes the specific executive function difficulties that are most prominent for this client — whether that is working memory, sustained attention, inhibitory control, planning, or emotional regulation. At the second level, the practitioner maps the psychological consequences: the avoidance of tasks that feel overwhelming, the compensatory strategies that have developed (some helpful, many counterproductive), the shame and self-criticism that have accumulated, and the interpersonal patterns that have emerged. At the third level, the practitioner notes any comorbid presentations — most commonly depression and anxiety — and considers how these interact with the ADHD difficulties in a bidirectional way.

To make this concrete, consider the following worked example. Marcus is a 34-year-old software developer who was diagnosed with ADHD-combined presentation six months ago, following a referral from his GP after a period of prolonged sick leave due to low mood. He presents to the CBT practitioner reporting that he cannot complete projects at work, frequently misses deadlines, and has begun avoiding his manager's calls. He describes himself as 'a fraud who has somehow got away with it until now'. In the developmental history, Marcus recalls being told throughout school that he was 'bright but lazy', that he 'didn't apply himself', and that he 'wasted his

potential'. He received no support and developed a pattern of working in intense bursts close to deadlines — a strategy that worked well enough in education but has become increasingly unworkable in a professional environment that requires sustained, distributed effort. He has been in two long-term relationships, both of which ended partly because his partners felt he was unreliable and did not listen. He drinks more than he would like to, which he describes as 'the only thing that quietens my brain in the evening'.

The formulation for Marcus begins at the neurobiological level: his ADHD-combined presentation means that he has significant difficulties with sustained attention, working memory, and inhibitory control. These are not character flaws; they are neurobiological differences that have been present since childhood. At the psychological level, the practitioner maps how decades of being told he was lazy, combined with the objective experience of failing to complete things despite genuine effort, have produced a core belief of 'I am fundamentally inadequate'. This belief is maintained by a conditional assumption — 'If I start something and cannot finish it, it proves I am a failure' — which in turn drives avoidance of tasks (because starting feels like setting up a test he will inevitably fail), procrastination, and the deadline-driven burst pattern. The avoidance reduces short-term anxiety but increases the probability of actual failure, which then confirms the core belief. At the third level, Marcus has developed a secondary depressive episode, characterised by low mood, anhedonia, and hopelessness, which further reduces his capacity for effortful task engagement and creates an additional maintaining cycle. His alcohol use functions as an avoidance and self-soothing behaviour that provides short-term relief but disrupts sleep and worsens next-day executive function, adding a further loop to the formulation.

What makes this formulation distinctively adapted for ADHD, rather than a generic CBT conceptualisation of depression and avoidance, is the explicit acknowledgement of the neurobiological substrate and its role in generating the experiences that fed the core belief. When the practitioner shares this formulation with Marcus, the framing is not 'your thoughts are making you avoid tasks' but rather 'your brain has always found sustained effortful attention genuinely harder than it is for most people, and the world responded to that difference by telling you it was a moral failing. You built a belief about yourself on the basis of that response, and that belief is now running a maintenance cycle that makes things worse.' This reattribution —

from character deficit to neurobiological difference plus understandable psychological response — is itself a therapeutic intervention. Research by Knouse and colleagues has shown that psychoeducation and reattribution are among the most consistently valued components of CBT for adult ADHD, and the formulation is the vehicle through which that reattribution is delivered in a personalised, evidence-grounded way.

The formulation also needs to capture the client's strengths and compensatory strategies, because adult ADHD presentations are rarely characterised by pure deficit. Many adults with ADHD have developed considerable creativity, the capacity for hyperfocus on topics of genuine interest, high energy, and a willingness to take risks that can be genuinely adaptive in certain contexts. A formulation that maps only difficulties is both clinically incomplete and therapeutically demoralising. The practitioner should explicitly ask about contexts in which the client functions well, tasks that seem to engage sustained attention without effort, and strategies that have worked in the past, even if they have not been applied consistently. These strengths and adaptive strategies become resources within the treatment plan.

Collaboration in building the formulation deserves particular attention in adult ADHD work. Standard CBT guidance emphasises that the formulation should be developed with the client rather than delivered to them, and this principle is especially important here for two reasons. First, many adults with ADHD have had the experience of being assessed, labelled, and managed by professionals without feeling genuinely understood or involved, and a collaborative formulation process is an opportunity to establish a different kind of therapeutic relationship from the outset. Second, the client's own account of how their difficulties fit together is often clinically rich and should be taken seriously. The practitioner's role is to offer a framework that organises and extends the client's self-understanding, not to replace it with an expert account.

Practically, the formulation is best developed iteratively across the first two or three sessions rather than completed in a single sitting. The practitioner might begin by drawing a simple diagram — the classic 'hot cross bun' or a more extended version — and inviting the client to add to it, correct it, and comment on whether it feels accurate. With adult ADHD clients, it is worth being explicit about the purpose of the formulation: it is a working

hypothesis, not a final verdict, and it will be revised as treatment progresses and new information emerges. This framing reduces the pressure on the client to provide a complete and accurate account immediately, which is particularly helpful for clients whose working memory difficulties make it hard to retrieve and organise biographical information on demand.

Finally, the formulation should directly inform the sequencing of intervention. In Marcus's case, the formulation suggests that the depressive episode needs to be addressed early, because the hopelessness and anhedonia are reducing his capacity to engage with the behavioural and organisational work that will be central to the treatment. It also suggests that the alcohol use needs to be monitored and discussed, because it is maintaining the executive function difficulties that the treatment is trying to address. The core belief work — examining and beginning to revise the belief that he is fundamentally inadequate — will be most effective once some behavioural successes have been established, because those successes will provide the disconfirming evidence that cognitive work requires. The formulation, in other words, is not just a diagnostic summary; it is a clinical roadmap that tells the practitioner where to start, what to prioritise, and why.

When translating this clinical roadmap into weekly practice, a frequent pitfall for practitioners is treating the formulation as a static artefact that resides in the initial assessment notes rather than a dynamic clinical tool. In adult ADHD work, the maintaining cycles mapped during initial sessions will almost invariably play out inside the therapeutic frame itself. For example, by session four, Marcus missed an appointment after mis-entering the date into his calendar, arrived late for the rescheduled session, and brought an incomplete thought record. A clinician accustomed to standard CBT might be tempted to conceptualise this solely through a cognitive lens, interpreting the missed task as resistance, low motivation, or evidence of his core belief of inadequacy. Alternatively, an over-correction might lead the clinician to view these missed tasks purely as symptoms of executive dysfunction, offering advice on calendar apps while ignoring the emotional impact on Marcus.

In supervision, the effective practitioner uses the two-level formulation to hold both aspects simultaneously. The supervisor and supervisee examine how Marcus's working memory and time perception difficulties (the neurobiological substrate) directly caused the calendar error, which then

triggered his secondary conditional assumption ('If I fail at therapy tasks, it proves I am hopeless'). This assumption activated intense shame and task avoidance, leading him to put away the incomplete thought record rather than bring it to session. By bringing this sequence into the formulation collaboratively during the session, the practitioner models the exact reattribution process taught in the initial conceptualisation. Marcus learns that his missed task was not evidence of character flaw or lack of engagement, but rather an interaction between an executive function slip and his established pattern of self-critical avoidance.

Furthermore, supervision in adult ADHD CBT should systematically review the formulation at regular review points—typically every six to eight weeks—to evaluate whether the chosen sequence of interventions remains appropriate. For Marcus, as his low mood began to lift following targeted behavioural activation, the secondary depressive cycle receded, exposing the underlying executive dysfunction more clearly. At this juncture, the formulation was collaboratively revised in session to shift focus from mood monitoring towards environment-structuring strategies and cognitive restructuring of his core belief of inadequacy. Reviewing and updating the diagram in this way ensures that treatment stays aligned with the client's evolving clinical picture, ensuring that the formulation remains a living, working hypothesis throughout the therapeutic journey.

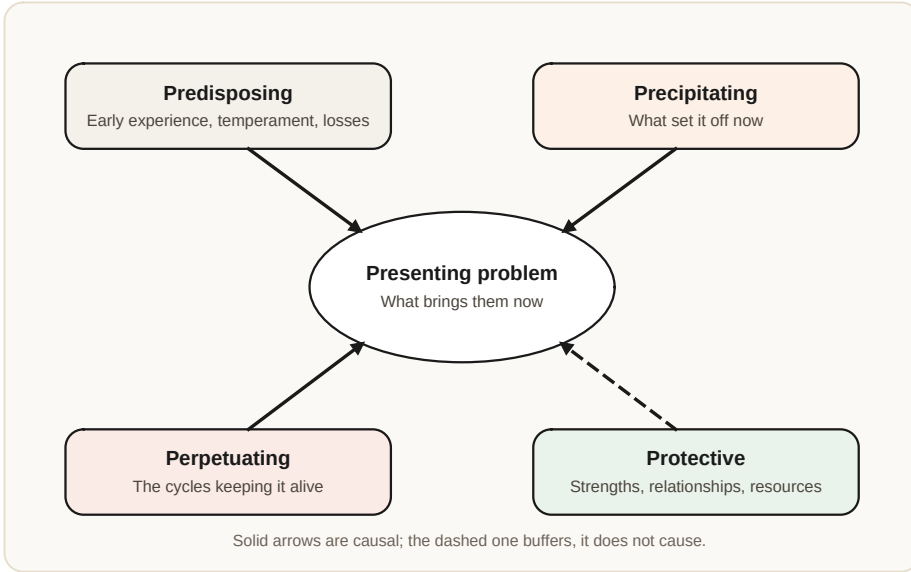


FIGURE 3.1 The five Ps of formulation

A shared map of how a difficulty came to be and what keeps it going: the presenting problem at the centre, with predisposing vulnerability, the precipitating trigger, perpetuating cycles, and protective strengths around it. A good formulation is provisional, collaborative, and rewrites itself as understanding deepens.

Points worth keeping

- A CBT formulation for adult ADHD must hold two levels simultaneously: the neurobiological substrate of executive dysfunction and the psychological superstructure of beliefs, assumptions, and maintaining cycles built on years of lived experience with that dysfunction.
- The three-level framework — core neurobiological deficits, secondary psychological consequences, and tertiary comorbidities — provides a structured scaffold for organising the adult ADHD formulation and making the interactions between levels explicit.
- Reattribution of difficulties from character deficit to neurobiological difference plus understandable psychological response is itself a therapeutic intervention, and the collaborative formulation is the primary vehicle through which this reattribution is delivered in a personalised way.
- The formulation should be built iteratively and collaboratively across early sessions, explicitly framed as a working hypothesis, and used directly to inform the sequencing and prioritisation of intervention components.

PRACTICE TASK

Select a current or recent adult client with an ADHD diagnosis (or use the Marcus vignette if no suitable client is available). Draw a formulation diagram with three explicit levels: (1) the specific executive function difficulties most prominent for this person; (2) the core beliefs, conditional assumptions, and maintaining cycles that have developed in response to living with those difficulties; and (3) any comorbid presentations and how they interact with the ADHD difficulties. Annotate the diagram to show at least two bidirectional arrows — places where one level or cycle feeds back into another. Then write two or three sentences describing how this formulation would influence the sequencing of your first three intervention sessions, and bring the diagram and your sequencing rationale to supervision for discussion.

CHAPTER 4

Neurobiological Underpinnings of Adult ADHD: What Every CBT Practitioner Must Understand Before Adapting Their Model

A practitioner who attempts to adapt cognitive behavioural therapy for adult ADHD without first understanding the neurobiological substrate of the condition is, in a very real sense, working in the dark. They may apply techniques with reasonable fidelity, set homework with apparent care, and structure sessions thoughtfully, yet still find that progress is slower, more erratic, and more demoralising than it ought to be. The reason, more often than not, is that the adaptations have been made at the level of technique without a corresponding shift in the practitioner's conceptual model of why the client behaves as they do. This lesson addresses that gap directly. It is not a neuroscience lecture, and it does not require the reader to become a neurologist. It does, however, require the reader to internalise a small number of well-evidenced neurobiological principles and to understand how those principles translate into the clinical encounter.

The most influential theoretical account of the neuropsychology of ADHD remains that of Russell Barkley, whose inhibitory deficit model, developed across the 1990s and refined substantially in subsequent decades, proposed that the primary impairment in ADHD is not one of attention per se but of behavioural inhibition. Barkley argued that the capacity to inhibit a prepotent response — that is, to pause before acting on the most immediately available impulse — is the foundational executive function upon which all others depend. When inhibition is impaired, the downstream consequences are extensive: working memory becomes less effective because the individual cannot hold information in mind long enough to act on it; self-regulation of affect becomes harder because the pause that would ordinarily allow emotional appraisal is truncated; internalised speech, the inner monologue that guides problem-solving, is disrupted; and the capacity to reconstitute behaviour in response to feedback is weakened. For the CBT practitioner, this matters enormously, because the entire architecture of standard cognitive behavioural therapy rests on precisely the capacities that Barkley's

model identifies as compromised. Thought records require the client to pause, notice, and reflect. Behavioural experiments require planning, anticipation of consequences, and the ability to hold a hypothesis in mind across time. Homework requires prospective memory — the ability to remember, at a future point, that one intended to do something. Each of these is an executive function, and in adult ADHD, each is unreliable.

It is important to be precise about what neurobiological impairment means in this context, because a common misunderstanding among practitioners new to this area is to interpret impairment as inability. Adults with ADHD are not unable to inhibit responses, reflect on thoughts, or complete tasks. They can and do, under certain conditions. The neurobiological literature, including the neuroimaging work of Castellanos and colleagues and the genetic and pharmacological research synthesised by Faraone and Biederman, points to a deficit that is better characterised as inconsistency than incapacity. The prefrontal cortex and its connections to the striatum, particularly the dopaminergic and noradrenergic pathways that modulate executive function, do not fail entirely in ADHD; rather, they operate with reduced efficiency and greater variability. This variability is itself a clinical phenomenon. A client may complete a thought record with apparent ease in one session and be entirely unable to engage with the same task a week later, not because they have forgotten how to do it, not because they are resistant, and not because the therapeutic alliance has deteriorated, but because the neurobiological conditions that support executive function fluctuate. Practitioners who do not understand this will be tempted to interpret inconsistency as motivational failure, passive resistance, or evidence of a deeper psychological block. All three interpretations are likely to be wrong, and all three risk damaging the therapeutic relationship.

The neurochemistry of ADHD is relevant here in a way that has direct clinical implications. The catecholamine hypothesis, associated with the work of Arnsten and colleagues at Yale, proposes that ADHD symptoms arise in significant part from suboptimal levels of dopamine and noradrenaline in the prefrontal cortex. These neurotransmitters are not simply mood regulators; they are modulators of signal-to-noise ratio in prefrontal networks. When their levels are suboptimal, the prefrontal cortex becomes less able to sustain attention on goal-relevant information and more susceptible to interference from competing stimuli. This is why adults with ADHD often report being able to concentrate intensely on activities that are intrinsically

motivating — a phenomenon sometimes called hyperfocus — while being unable to sustain attention on tasks that are important but not immediately rewarding. The brain's dopaminergic reward circuitry responds to novelty, urgency, and personal interest in ways that temporarily compensate for the underlying deficit. Standard CBT tasks, particularly between-session homework, are rarely novel, rarely urgent, and frequently feel disconnected from immediate personal reward. The neurobiological deck is therefore stacked against homework completion in a way that has nothing to do with willpower or therapeutic engagement, and everything to do with the architecture of the dopaminergic system.

To make this concrete, consider the following worked example. A practitioner is working with a thirty-eight-year-old woman, referred here as Diane, who was diagnosed with ADHD at the age of thirty-five following years of underachievement, relationship difficulties, and chronic low-level anxiety. Diane is intelligent, articulate, and highly motivated to engage with therapy. In the third session, the practitioner introduces a simplified thought record and asks Diane to complete one entry per day during the coming week, focusing on moments when she notices a strong emotional reaction. Diane agrees enthusiastically. The following week, she arrives having completed no entries. She reports feeling ashamed and frustrated with herself, describing herself as lazy and hopeless. The practitioner, drawing on a neurobiological understanding of ADHD, does not accept this self-attribution at face value. Instead, they explore with Diane what actually happened in the moments when she might have completed the record. Diane reports that she thought about it several times but that by the time she was in a position to write, the emotional moment had passed and she could no longer access the feelings with sufficient clarity to record them. On other occasions, she had the thought record in mind but could not locate the sheet. On one occasion, she sat down to complete it but became distracted by a notification on her phone and did not return to the task. Each of these failure points maps directly onto a known neurobiological mechanism: the difficulty accessing emotional memory after the moment has passed reflects the interaction between working memory deficits and the time-sensitive nature of emotional processing; the inability to locate the sheet reflects the organisational difficulties associated with prefrontal dysregulation; the distraction by the phone notification reflects the reduced inhibitory control over prepotent responses to novel stimuli. The practitioner uses this analysis not to excuse

Diane from the task but to redesign it collaboratively in a way that accommodates the neurobiological reality. The thought record is moved to Diane's phone as a note-taking app. A brief alarm is set for two times during the day when Diane is likely to be stationary. The record is simplified to three fields rather than five. The practitioner explicitly names the neurobiological rationale for each adaptation, not as a lecture but as a normalising explanation that directly challenges Diane's self-attribution of laziness.

This example illustrates a principle that runs through all competent ADHD-adapted CBT: the formulation must be neurobiologically informed, and that neurobiological information must be actively used to redesign the therapeutic environment rather than simply to explain away difficulty. Barkley's concept of ADHD as a disorder of performance rather than knowledge is particularly useful here. Adults with ADHD typically know what they should do; the deficit lies in doing it at the right time and in the right context. This distinction has a direct implication for how the practitioner conceptualises the role of insight in therapy. In standard CBT, developing cognitive insight — understanding the connection between thoughts, feelings, and behaviour — is often sufficient to initiate change. In ADHD-adapted CBT, insight is necessary but not sufficient. The practitioner must also attend to the environmental and structural conditions under which the client is expected to translate insight into action, because those conditions will either support or undermine the executive functions required for behaviour change.

A further neurobiological consideration that deserves explicit attention at this foundational level is the role of emotional dysregulation in adult ADHD. Although emotional dysregulation does not appear in the DSM-5 diagnostic criteria for ADHD, it is now recognised by a substantial body of researchers, including Barkley, Shaw, and Surman, as one of the most impairing features of the adult presentation. The neurobiological basis for this lies in the same prefrontal-subcortical circuitry that underlies inhibitory control. When the capacity to inhibit prepotent responses is reduced, the capacity to modulate emotional reactions is also reduced. Adults with ADHD frequently experience emotions with greater intensity and shorter latency than neurotypical adults, and they find it harder to return to baseline once an emotion has been triggered. This has implications for the therapeutic relationship, for the client's capacity to engage in cognitive restructuring during emotionally activated states, and for the interpretation of what might otherwise appear to

be personality-level difficulties. A practitioner who understands this neurobiological context will be less likely to formulate intense emotional reactions as evidence of a personality disorder and more likely to understand them as an expression of the same underlying deficit that produces inattention and impulsivity.

Finally, it is worth noting that the neurobiological account of ADHD is not a counsel of therapeutic pessimism. The same neuroimaging literature that documents structural and functional differences in the ADHD brain also demonstrates neuroplasticity and the capacity for compensatory development. Psychological intervention, when well-designed and neurobiologically informed, can support the development of external scaffolding that compensates for internal executive function deficits, and there is evidence from the trials reviewed elsewhere in this course that structured CBT adapted for ADHD produces meaningful improvements in functioning. The practitioner's task is to hold both truths simultaneously: that the neurobiological substrate creates genuine and persistent challenges, and that those challenges are not immutable. Understanding the neurobiology is not a reason to lower expectations; it is a reason to design the therapeutic environment with greater precision and greater compassion.

Returning to Diane at a later point in treatment illustrates how this neurobiological understanding continues to shape clinical decision-making well beyond the initial adaptation of homework tasks. By the eighth session, Diane has made genuine progress: she is using the phone-based thought record with reasonable consistency, and she and her practitioner have begun to work on the cognitive schema of incompetence that has accumulated over decades of unexplained underachievement. However, the practitioner notices a pattern that is easy to misread. In sessions where Diane arrives having had a difficult week — a conflict with her manager, a missed appointment, a forgotten commitment to a friend — her capacity to engage in cognitive restructuring is markedly reduced. She can describe events with fluency and feeling, but when the practitioner invites her to examine the evidence for and against a belief, Diane becomes frustrated, says the exercise feels pointless, and on one occasion abruptly changes the subject. A practitioner without a neurobiological frame might interpret this as avoidance, as ambivalence about change, or as a sign that the therapeutic relationship requires repair. A neurobiologically informed practitioner will recognise it as something more specific: emotional dysregulation, once

triggered, temporarily degrades the very prefrontal resources that cognitive restructuring requires. Asking Diane to evaluate evidence while she is in a state of heightened emotional arousal is, in neurobiological terms, asking her to use a system that is currently least available to her. The appropriate clinical response is not to press on with the cognitive work but to shift temporarily to affect regulation strategies — paced breathing, grounding, or simply naming and validating the emotional state — before returning to the cognitive task once arousal has reduced to a level at which prefrontal engagement is more accessible. This sequencing is not a departure from the CBT model; it is a neurobiologically informed application of it.

A common pitfall at this stage of training is to treat the neurobiological psychoeducation as a one-off intervention delivered early in therapy and then set aside. In practice, the normalising explanation needs to be returned to repeatedly, because the shame associated with a lifetime of inconsistent performance is deeply entrenched and is readily reactivated by each new instance of apparent failure. When Diane misses two sessions in a row due to diary confusion and arrives for the third apologising profusely and describing herself as a waste of the practitioner's time, the neurobiological frame is not background knowledge; it is an active clinical tool. The practitioner can draw an explicit connection between the missed sessions and the prospective memory difficulties that were named and explained weeks earlier, not to absolve Diane of all responsibility for the practicalities of attending, but to interrupt the automatic self-attribution of character failure before it consolidates into a setback that derails the work.

In supervision, this material surfaces in a particular way that is worth anticipating. Supervisees working with adults with ADHD for the first time frequently bring their cases with a note of exasperation that they are reluctant to name directly. They describe clients who are engaging and likeable in session but who seem to make the same practical errors repeatedly, who agree to adaptations and then do not implement them, and who appear to understand their difficulties intellectually without that understanding translating into change. The supervisor's task is partly to help the supervisee locate this experience within the neurobiological account rather than within an implicit model of the client as insufficiently motivated. Barkley's distinction between a disorder of knowledge and a disorder of performance is especially useful in supervision, because it reframes the supervisee's frustration: the client is not failing to apply what they know; they

are encountering, repeatedly and in different forms, the same underlying deficit in translating intention into timely action. Once the supervisee genuinely internalises this distinction rather than simply knowing it as a fact, their clinical stance tends to shift in ways that are perceptible to the client, and the therapeutic relationship frequently deepens as a result.

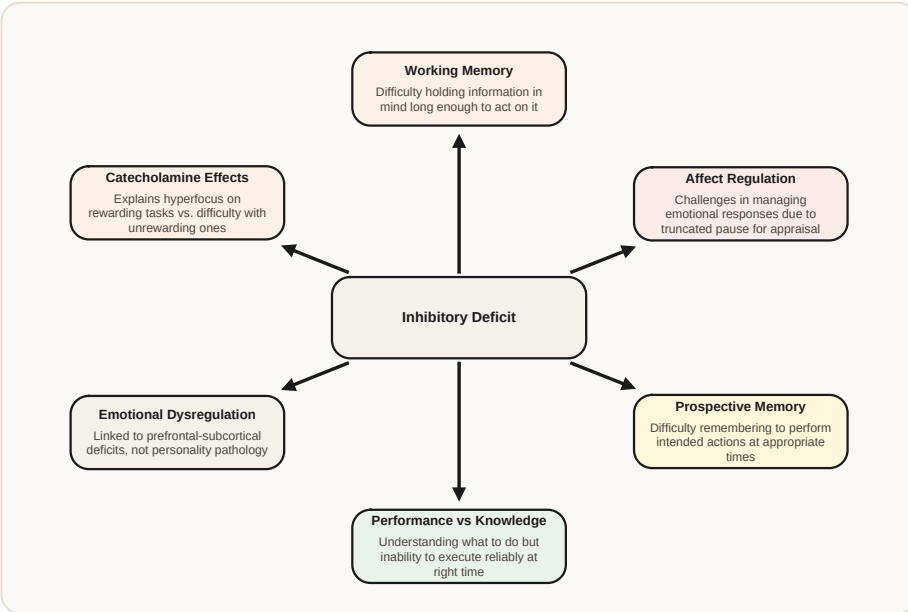


FIGURE 4.1 Neurobiological Model of ADHD
The inhibitory deficit model explains how impaired behavioral inhibition leads to multiple downstream effects that characterize ADHD.

Points worth keeping

- Barkley's inhibitory deficit model identifies behavioural inhibition, not attention per se, as the primary impairment in ADHD, with downstream consequences for working memory, affect regulation, and prospective memory — all of which are required for standard CBT tasks.
- The catecholamine hypothesis explains why adults with ADHD can hyperfocus on intrinsically rewarding activities yet fail to sustain effort on important but unrewarding tasks such as between-session homework, a pattern that reflects neurochemistry rather than motivation or resistance.
- ADHD is better characterised as a disorder of performance rather than knowledge: clients typically understand what is required of them but

cannot reliably execute it at the right time and in the right context, which means insight alone is insufficient and the therapeutic environment must be actively redesigned.

- Emotional dysregulation, though absent from DSM-5 criteria, is neurobiologically linked to the same prefrontal-subcortical inhibitory deficit that produces inattention and impulsivity, and must be understood as such rather than attributed to personality pathology.

PRACTICE TASK

Select a client with adult ADHD (or a detailed case vignette if you are not yet in practice) and identify one standard CBT task — such as a thought record, a behavioural experiment, or a homework assignment — that the client has found difficult to complete. Write a brief formulation paragraph of no more than 250 words that explains the difficulty specifically in terms of the neurobiological mechanisms discussed in this lesson (inhibitory control, working memory, dopaminergic reward circuitry, or emotional dysregulation as appropriate). Then propose two concrete, specific modifications to the task design that directly address the neurobiological barriers you have identified, and note how you would explain the rationale for each modification to the client in plain, non-stigmatising language.

CHAPTER 5

The diagnostic pathway: how adult ADHD assessment actually happens

A psychological practitioner working with adult ADHD will, in the overwhelming majority of cases, be working with someone who arrives already diagnosed, or who is somewhere in the process of seeking a diagnosis. Understanding what that process actually involves, who delivers it, how long it typically takes, and what a formal diagnostic assessment does and does not establish, is foundational knowledge that this course assumes but has not yet made explicit. Without it, a practitioner is poorly placed to interpret what a client means when they say "I'm still waiting for my assessment," to recognise when a client's account of their own diagnosis is incomplete or confused, or to have an informed conversation with a referrer or a client's GP about where psychological intervention fits relative to the diagnostic process itself.

In the United Kingdom, the route to an adult ADHD diagnosis typically begins with a conversation with a GP, who may complete an initial screening using a brief, widely used self-report tool, most commonly the World Health Organization's Adult ADHD Self-Report Scale, before making a referral to a specialist service. That specialist service may be an NHS community mental health team, a dedicated adult ADHD or neurodevelopmental service, or, increasingly, a provider accessed through the NHS Right to Choose policy, which allows patients to request assessment through an alternative NHS-commissioned provider when local waiting times are excessive. Waiting times for a specialist assessment vary enormously by region and by pathway, and in many parts of the country they are measured in years rather than months. This matters clinically because a practitioner may be working with a client for a sustained period before any formal diagnosis is confirmed, and the psychological work in that period needs to proceed on the basis of a working clinical picture rather than waiting for diagnostic certainty that may be a long way off.

The specialist diagnostic assessment itself, once it happens, is considerably more involved than a brief questionnaire. A thorough assessment, consistent

with the standard set out in NICE NG87, includes a detailed developmental history tracing symptoms back to childhood, because a defining diagnostic requirement for ADHD is that the core features were present before the age of twelve, even if they were not recognised or labelled at the time. The clinician conducting the assessment will typically use a structured or semi-structured diagnostic interview; the Diagnostic Interview for ADHD in Adults, commonly abbreviated as the DIVA-5, is one of the most widely used instruments internationally and in UK specialist services, and it works through each diagnostic criterion systematically, asking for concrete, dated examples from both childhood and adulthood rather than accepting general self-description alone. Wherever possible, the assessment also draws on collateral information: a parent's recollection of the client's childhood behaviour, a partner's or close friend's observations of current functioning, old school reports, all of which help to corroborate a history that any single person's memory, particularly a person whose working memory is itself affected by the condition being assessed, may struggle to reconstruct reliably and in sequence.

A further and clinically important feature of a proper diagnostic assessment is differential consideration. ADHD shares surface features with several other presentations, and a competent assessor is explicitly screening for, and ruling in or out, conditions that can produce similar attentional and behavioural difficulties, including anxiety disorders, depressive episodes, sleep disorders, thyroid dysfunction, and autism spectrum conditions, which co-occur with ADHD at a substantially higher rate than chance would predict. The assessment is not simply confirming what the client suspects; it is testing that suspicion against alternative and co-occurring explanations, which is one reason the process cannot be compressed into a single short appointment without a meaningful loss of diagnostic rigour.

Once a diagnosis is made, the specialist service will typically produce a written report summarising the history taken, the instruments used, the differential considerations addressed, and the clinical conclusion reached, along with recommendations for management, which commonly include a discussion of pharmacological options and, per NG87, a recommendation that structured psychological intervention be considered where functional impairment persists. This report is often the single most useful document a psychological practitioner can request to see, with the client's consent, before beginning structured work, because it anchors the practitioner's

understanding in a documented clinical history rather than relying solely on what the client can recall and relay in session.

It is worth being explicit about where the psychological practitioner's role begins and ends in relation to this pathway, because confusion here causes real difficulties in practice. A practitioner delivering the kind of structured CBT intervention this course is building towards is not conducting a diagnostic assessment, is not qualified to confirm or rule out ADHD as a formal diagnosis unless they hold a specific additional qualification that confers that competence, and should not present psychological formulation, however clinically useful, as equivalent to or a substitute for specialist diagnostic assessment. This distinction matters most acutely in precisely the situation the next lesson in this module addresses: a client already in the practitioner's caseload for an unrelated presenting problem, whose history increasingly suggests undiagnosed ADHD. In that situation, the practitioner's job is to notice, to discuss the possibility sensitively with the client, and to support a referral for proper assessment, not to offer an informal verdict of their own.

A worked illustration clarifies how this plays out. Consider a client, Oliver, a 29-year-old referred to a psychological practitioner by his GP with a provisional note stating "query ADHD, awaiting specialist assessment, referred 14 months ago." Oliver has not yet had his specialist appointment, and in the first session he says, with evident frustration, "I don't even know if I actually have it. I've just been told to wait." The practitioner's first task here is not to speculate about whether Oliver has ADHD, nor to treat the referral note as diagnostic confirmation. It is to clarify, plainly, what the referral means: that a GP or another referrer has judged the presentation sufficiently suggestive to warrant specialist assessment, that the eventual outcome of that assessment is genuinely uncertain, and that the work the practitioner can usefully do in the meantime is to help Oliver build structure and self-understanding around the difficulties he is describing right now, regardless of what label is eventually applied. This framing avoids two opposite errors: treating Oliver as definitely having ADHD before any assessment has taken place, and withholding useful psychological support until a diagnosis materialises, which, given typical waiting times, could mean withholding help for a very long period indeed. The practitioner explains the assessment process Oliver can expect, including the kind of developmental history questions he is likely to be asked and the value of gathering his own

school reports or asking a parent in advance, which both demystifies an unfamiliar process and gives Oliver something concrete and useful to do while he waits.

This case also illustrates why understanding the pathway has direct clinical utility beyond simple orientation. Practitioners who understand what a thorough assessment actually involves are better placed to help a client prepare for it constructively, are less likely to either dismiss a client's self-identification prematurely or over-endorse it without appropriate caveat, and are able to have a genuinely informed conversation with referrers and prescribers about where their own structured psychological work sits relative to a diagnosis that may still be pending. Knowing the pathway is not administrative trivia. It is part of the clinical competence this course exists to build.

It is also worth being clear about what happens when an assessment concludes that ADHD is not, in fact, present, because this outcome is common and is not a failure of the process. A specialist assessment that rules out ADHD, having genuinely considered it, is doing exactly what it is meant to do, and a client who receives this outcome after a long wait often experiences a complicated mixture of relief, at having an answer, and disappointment, at being left once again without an explanation for difficulties that remain unresolved. A practitioner working with such a client should resist any temptation to quietly continue treating the presentation as ADHD regardless of the specialist conclusion, out of a wish to validate the client's own strong sense that the label fit. The appropriate response is to take the specialist conclusion seriously, to return with the client to the question of what else might account for their difficulties, drawing on the differential considerations such as anxiety, depression, sleep disruption or autism that a thorough assessment will typically have already screened for, and to continue psychological support on that revised basis rather than treating the ruling-out as simply one clinician's opinion to be set aside.

A further practical point concerns the private assessment route, which a growing number of clients pursue given NHS waiting times, often at considerable personal cost running into several hundred pounds or more depending on the provider. Private assessments conducted by appropriately qualified clinicians and following a comparably rigorous process, including structured interview and developmental history, are not inherently less valid

than NHS assessments, and NHS services and GPs are, in principle, expected to accept a properly conducted private diagnosis and to facilitate shared care arrangements for any resulting prescription. In practice, the degree to which local NHS services actually do this varies considerably, and clients who have paid privately for assessment sometimes then encounter further delay or resistance when trying to access shared care for medication, which can be a source of considerable frustration that a practitioner should be prepared to hear about and acknowledge as a genuine systemic difficulty rather than a misunderstanding on the client's part. Finally, where a client consents, requesting a copy of the diagnostic report directly from the assessing service, rather than relying solely on the client's verbal account of what it said, is good practice wherever it is feasible, since reports vary in detail and a client's own recollection of a lengthy and sometimes overwhelming assessment appointment may not capture every clinically relevant observation the assessor recorded.

A practitioner should also be able to form a basic, informal judgement about the apparent rigour of an assessment report a client brings to session, not in order to second-guess a specialist diagnosis, which remains outside this course's remit, but in order to notice when a report looks thin in a way that might be clinically relevant to how confidently the formulation work that follows should proceed. A thorough report, consistent with the process described earlier in this lesson, will typically document a developmental history reaching back to childhood, will note what collateral information, if any, was available and used, and will set out an explicit consideration of differential and co-occurring explanations rather than simply recording the conclusion reached. A report that consists of little more than a brief symptom checklist and a diagnostic statement, with no developmental history and no documented differential consideration, is not necessarily wrong, but it tells a practitioner less than a thorough report would, and it is reasonable, with the client's agreement, to hold the diagnosis somewhat more provisionally in early formulation work when the documentation supporting it is this limited, revisiting the formulation as the client's own account over subsequent sessions either corroborates or complicates the picture. The proliferation in recent years of rapid-turnaround online assessment services, some of which complete the entire process over a single video call, has made this kind of informal quality judgement more clinically relevant than it once was, since the thoroughness of assessment

processes available to clients now varies considerably more than it did when specialist assessment meant, almost without exception, a lengthy, in-person, multi-appointment NHS or equivalent specialist process.

Points worth keeping

- The UK adult ADHD diagnostic pathway typically runs from GP screening through specialist referral, often via NHS Right to Choose given long local waiting times, to a structured specialist assessment.
- A thorough assessment uses a structured diagnostic interview such as the DIVA-5, traces symptoms to before age twelve, draws on collateral history where possible, and explicitly screens for differential and co-occurring conditions.
- A psychological practitioner delivering structured CBT is not conducting or substituting for diagnostic assessment, and should be clear with clients about that boundary, especially where diagnosis is still pending.
- Understanding the pathway has direct clinical value: it helps practitioners support clients constructively while they wait, and avoid both premature endorsement and premature dismissal of a client's self-identification.

PRACTICE TASK

Write two or three sentences you could say to a client who is still waiting for a specialist ADHD assessment, explaining what that assessment will likely involve and what kind of psychological support is appropriate to offer in the meantime.

CHAPTER 6

Recognising when a presentation may reflect undiagnosed ADHD

Most adults who are eventually diagnosed with ADHD spend years, often decades, being treated for something else first. Anxiety, depression, chronic low self-esteem, relationship difficulties and workplace problems are frequently the presenting complaints that bring an adult into psychological therapy, and in a meaningful proportion of cases, underlying and unrecognised ADHD is a significant part of why those difficulties developed and why they have proven resistant to standard treatment. A practitioner who has completed this course and gone on to specialise in adult ADHD work will usually encounter such clients only after a diagnosis is already confirmed or well underway. But many practitioners taking this course are, at this stage, general CBT practitioners who do not yet specialise in this area, and their most valuable immediate skill is not advanced ADHD-specific technique; it is the capacity to notice, in an existing caseload, a pattern that warrants a conversation about assessment. This lesson addresses that noticing skill directly.

The starting point is to hold a genuinely different question in mind than the one most training in general mental health difficulties encourages. Standard CBT training teaches practitioners to ask what thoughts, feelings and behaviours are maintaining a presenting problem. Recognising possible undiagnosed ADHD requires an additional question running alongside that one: is there a lifelong pattern here, present since childhood, that a purely adult-onset account of this client's difficulties does not fully explain? This is a subtle but important shift in orientation. A client presenting with persistent, treatment-resistant anxiety about work performance might, on a standard formulation, be understood entirely in terms of perfectionistic beliefs and intolerance of uncertainty developed in adulthood. The same presentation, viewed through an ADHD-aware lens, might also be understood as anxiety that has developed in direct response to a lifelong, as-yet-unexplained pattern of underperforming relative to genuine effort and ability, a pattern the client has typically attributed to personal inadequacy rather than to any underlying cognitive difference, because no one, including previous

professionals, has offered them an alternative explanation.

Certain features in a client's history and presentation should prompt a practitioner to hold the possibility of undiagnosed ADHD actively in mind, without treating any single feature as diagnostic on its own. A history of underachievement markedly inconsistent with evident intelligence or capability, particularly where school reports or the client's own recollection include phrases such as "doesn't apply himself," "could do so much better," or "bright but lazy," is a common and recognisable thread. A pattern of repeated, similar failures across different contexts and relationships, rather than failure confined to one domain, is also suggestive, as is a client's own account of chronic difficulty with time, organisation, and follow-through that long predates the onset of their current presenting mood or anxiety difficulty. Clients sometimes offer the clue directly, almost in passing, describing themselves as having "always been like this, even as a kid," or mentioning in an unrelated context that a sibling, parent or child has since been diagnosed with ADHD, which raises the prior probability of the condition running in the same family. None of these features, singly, establishes anything. Taken together, and particularly when several appear in combination with a presenting problem that has proven unusually resistant to otherwise well-delivered standard treatment, they justify raising the possibility explicitly rather than continuing to treat the presenting anxiety or depression as the whole clinical picture.

Equally important is understanding what this noticing skill is not. It is not licence for a practitioner without specific diagnostic training to tell a client they believe the client has ADHD. It is not a reason to abandon or deprioritise the standard, evidence-based treatment of the presenting difficulty while a possible underlying ADHD question is explored. And it is emphatically not an invitation to see ADHD everywhere; ordinary variation in organisational ability, attention and follow-through exists across the whole population, most disorganised or inattentive adults do not have ADHD, and raising the possibility of a significant neurodevelopmental condition with a client who does not have one can be unhelpful, even mildly iatrogenic, particularly if it is done clumsily or with unwarranted confidence. The clinical skill being taught here is calibrated suspicion, not pattern-matching enthusiasm.

When a practitioner has formed a genuine, evidence-grounded suspicion, raising it well matters as much as noticing it. The conversation is best

framed tentatively and collaboratively, offered as an observation for the client to consider rather than a conclusion being delivered. A practitioner might say something along the lines of noticing that several of the difficulties the client has described go back much further than the current period of low mood, and asking whether the client has ever wondered whether something like ADHD might be part of the picture. This framing leaves the client room to agree, to disagree, to feel relieved, or to feel unsettled, all of which are legitimate responses that the practitioner should be prepared to sit with rather than needing to resolve immediately. Where the client is open to exploring it further, the practitioner's role is to support a referral through the pathway described in the previous lesson, not to attempt an assessment of their own.

A worked example illustrates the clinical stakes involved in getting this right. Grace, a 41-year-old primary school teacher, was referred for CBT for recurrent depressive episodes that had not responded fully to two previous courses of standard cognitive restructuring and behavioural activation. In the third session, in the course of discussing a recent episode triggered by a missed report-writing deadline, Grace mentioned, almost as an aside, that she had "always been like this with paperwork, even at university," that she had been described throughout her school years as having "so much potential if she'd just focus," and that her younger brother had been diagnosed with ADHD as an adult two years earlier. None of this had come up in the referral information or in the standard depression-focused formulation the practitioner had been working from. Rather than filing this away as incidental biographical colour, the practitioner returned to it directly, asking Grace whether she had ever considered that her own lifelong pattern with organisation and follow-through might be connected to the same thing her brother had been diagnosed with. Grace's response was immediate and visibly emotional: she said she had wondered this for years but had always assumed she was "just not disciplined enough," and that hearing someone else name the possibility out loud felt like the first time anyone had offered her a different explanation.

The practitioner did not change the depression-focused treatment plan on the spot, nor did she offer any view on whether Grace did or did not have ADHD. She continued the agreed course of depression treatment, while also discussing with Grace how to raise the possibility with her GP and supporting her in doing so between sessions. Grace's eventual specialist

assessment, some considerable time later, confirmed a diagnosis of ADHD, predominantly inattentive presentation, and the subsequent psychological work benefited substantially from a formulation that could finally account for the lifelong pattern underlying the depressive episodes rather than treating each episode as an isolated event. This outcome depended entirely on the practitioner holding the noticing skill described in this lesson actively in mind, even while working from a referral that said nothing about ADHD at all, and on resisting the temptation either to dismiss the aside as irrelevant or to leap to a confident diagnostic conclusion of her own.

This noticing skill is not confined to new referrals. It applies with equal relevance to clients already well established in a practitioner's caseload, sometimes clients who have been seen, on and off, for years across several different presenting problems, none of which has previously prompted the question this lesson addresses. A practitioner reviewing their own longer-standing caseload, specifically with this lens in mind rather than waiting for the question to arise spontaneously, will sometimes identify a client whose repeated returns to therapy, for what have looked on each occasion like separate episodes of anxiety or low mood, in fact describe a single, continuous, lifelong pattern that no one, including the practitioner across several previous episodes of care, had previously framed as a single coherent picture. This is a useful exercise to undertake deliberately rather than passively, precisely because the fragmentary way presenting problems are typically referred and reviewed, as discrete episodes each requiring its own formulation, makes a genuinely lifelong pattern easy to miss even when the clues have been present in the clinical record for years.

It is equally important to hold the opposite risk in mind, which is the danger of over-identifying the possibility once a practitioner has become sensitised to it. Having learned to notice the suggestive features described in this lesson, a practitioner can, for a period, begin to see them everywhere, in clients whose disorganisation, forgetfulness or inconsistent follow-through reflects nothing more than ordinary human variation, situational stress, or a different and unrelated difficulty entirely. The clinical skill being taught is genuinely one of calibration rather than detection, and a practitioner who notices themselves raising the possibility of ADHD with unusual frequency across their caseload should treat that pattern itself as worth discussing in supervision, as a check on whether the threshold being applied has drifted too low.

A related and practically important situation arises when a practitioner raises the possibility carefully, as described above, and the client firmly rejects it, sometimes with visible irritation at the suggestion. This should not automatically be read either as confirmation that the practitioner's observation was mistaken or as denial requiring gentle persistence. A client may reject the suggestion for entirely legitimate reasons, having already considered and ruled it out themselves, or may reject it because the idea is genuinely unwelcome at this point, perhaps because they are not ready to take on another significant piece of self-understanding alongside whatever already brought them to therapy, or because a family member has strong views that make the possibility feel threatening to raise at home. The appropriate response to a firm rejection is to accept it without pressing further in that session, to note explicitly that the observation remains available to revisit later should the client wish to, and to continue with the agreed treatment plan for the presenting problem exactly as before. Raising the possibility a second time, having already been told clearly that the client does not wish to pursue it, without some new and clinically significant development that changes the picture, risks the relationship being experienced as the practitioner pursuing their own agenda rather than responding to the client's.

There is a useful middle path available between pressing the point and dropping it entirely, which is to make the observation available for the future without returning to it unprompted. A practitioner might say, once, that they will not raise the subject again unless the client wishes to, but that if anything changes, or if the client finds themselves thinking about it later, the door remains open. This single statement, offered calmly and without any implication that the client is making a mistake by declining now, often does more to preserve the possibility of a future conversation than either repeated gentle reminders or complete silence on the matter, and it respects the client's autonomy over their own pace of self-discovery, which matters as much in this specific clinical situation as it does throughout psychological practice generally.

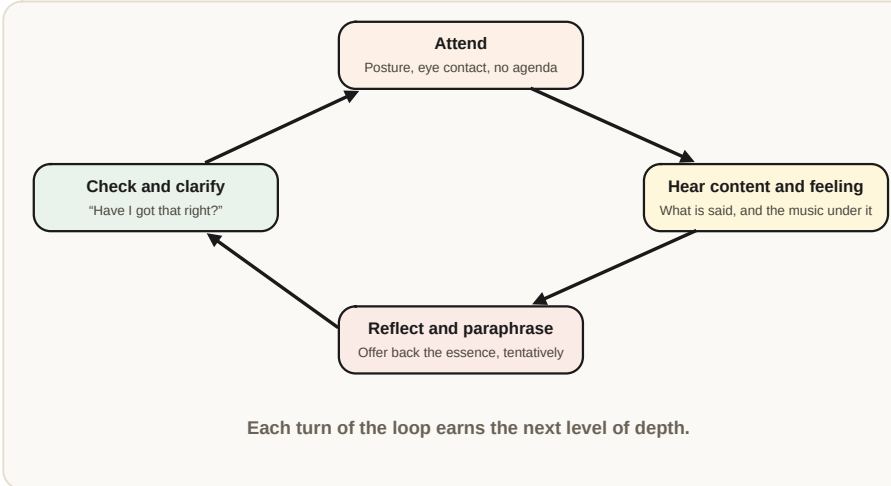


FIGURE 6.1 The active listening loop
Listening is a discipline with a shape: attend fully, take in both content and feeling, reflect back what was heard, and check the reflection. Each accurate reflection invites the client one level deeper; each check repairs the small misses before they become ruptures.

Points worth keeping

- A significant proportion of adults eventually diagnosed with ADHD are first seen in therapy for anxiety, depression, or relational difficulties, with the ADHD itself unrecognised.
- Suggestive features include lifelong underachievement inconsistent with ability, repeated similar failures across contexts, a presenting problem resistant to otherwise well-delivered standard treatment, and a family history of ADHD.
- This is a skill of calibrated suspicion, not diagnostic confidence: no practitioner without specific training should tell a client they have ADHD, and most disorganised or inattentive adults do not have it.
- Raising the possibility well means offering it tentatively as something to consider, supporting a proper referral, and continuing evidence-based treatment of the presenting difficulty rather than pausing it to wait for assessment.

PRACTICE TASK

Think of a current or past client whose presenting difficulty has been unusually resistant to otherwise appropriate treatment. Without concluding anything, note down whether any of the suggestive features described in this lesson are present in their history, and if so, draft one sentence you could use to raise the possibility with them tentatively and collaboratively.

The end of the sample

This is a free sample of “Adult ADHD Practitioner Training: Foundations”, and it ends here.

Everything you have read here is from the opening of the book, set exactly as it is printed in it. The rest follows in the same way, chapter by chapter, with its worksheets, its examples and its reference list.

The full book is on sale in the Talking Therapies UK shop. A copy is yours to keep, as a PDF and an ebook, licensed to you by name: a short line saying so is printed at the foot of each page of the PDF and on the title page of the ebook.