Adult ADHD Practitioner Training in Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



Adult ADHD Practitioner Training in Practice

Delivering the Safren sequence session by session

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

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

This printing was set on 21 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 practitioner course teaches the practical, session-by-session delivery of the Safren sequence introduced in foundations. You will study the behavioural module in depth, building external scaffolding such as a single consistently used planning system rather than relying on willpower-based strategies that executive function difficulties tend to defeat, and the organisational and planning module that follows it, teaching structured problem-solving, prioritisation and managing distractibility during tasks. The course then teaches the cognitive module, addressing ADHD-related thought patterns such as demoralisation built up over years of perceived underachievement, while distinguishing genuine cognitive distortion from a realistic account of repeated struggle, and teaches how to adapt pacing and content when anxiety, depression or substance use are also present, including when liaison with a prescriber is needed. It is intended for practitioners who have completed adult ADHD practitioner foundations or hold equivalent working knowledge.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 10 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.

PART 1

Behavioural and organisational modules

Building external scaffolding, then structured problem-solving and prioritisation on top of it.

CHAPTER 1

Delivering the behavioural module

This lesson teaches the behavioural module in practice: establishing a single, consistently used planning system, whether a calendar, a task list or a combination, rather than introducing several competing systems at once, and breaking tasks down into steps small enough to be started without the task itself becoming another source of avoidance. The lesson teaches why this module favours simple, external scaffolding over strategies that depend on sustained internal willpower, since willpower-dependent strategies are precisely what executive function difficulties tend to defeat.

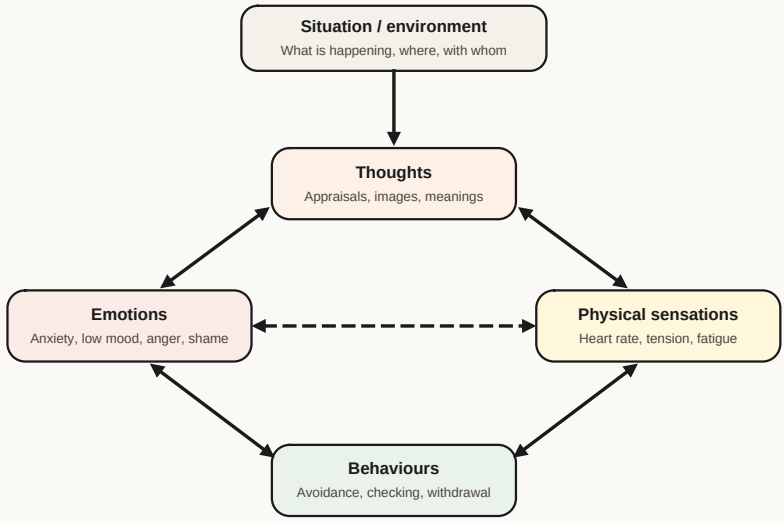


FIGURE 1.1 The five areas model

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

- A single, consistently used planning system, not several competing ones
- Breaking tasks into steps small enough to start without triggering avoidance
- External scaffolding over willpower-dependent strategies
- Why simplicity and consistency matter more than sophistication here

PRACTICE TASK

Design a simple, single-system planning structure you could introduce in session one of the behavioural module.

CHAPTER 2

Delivering the organisational and planning module

By the time a practitioner reaches the organisational and planning module with an adult client, a meaningful amount of therapeutic groundwork has already been laid. The behavioural scaffolding established in earlier sessions — activity scheduling, the introduction of external structure, and the collaborative development of routines — provides the platform on which this module is built. It is worth pausing at the outset of this lesson to appreciate why that sequence matters clinically. Adults with ADHD frequently present with a history of failed organisational attempts: planners abandoned after a week, to-do lists that grew until they became sources of dread rather than guidance, and digital reminder systems that were silenced and forgotten. If the practitioner moves too quickly into teaching planning skills before the client has experienced even modest success with behavioural activation and routine-building, the organisational module risks becoming yet another layer of failure. Padesky and Greenberger's emphasis on building on existing competencies rather than importing entirely new ones is directly applicable here. The practitioner's first task in this module is therefore to make explicit to the client that what follows is an extension of what is already working, not a replacement for it.

The module opens with a structured review of the behavioural work completed so far. This is not merely a warm-up exercise. It serves the specific function of helping the client identify which environmental and behavioural strategies have genuinely taken hold, and which remain effortful or inconsistent. That distinction matters because the organisational and planning work introduced in this module will need to be anchored to the strategies that are already functioning. A client who has successfully established a morning routine, for example, can be shown how to embed a brief daily planning review into that routine rather than treating planning as a separate, additional demand on their executive resources. This principle of integration rather than addition is central to the cognitive-behavioural approach to adult ADHD as described by Safren, Sprich, Perlman and Otto in their widely used treatment manual, and it reflects the neuropsychological

reality that executive function capacity in adults with ADHD is finite and easily depleted.

Structured problem-solving for recurring organisational difficulties forms the first substantive component of this module. The practitioner will already be familiar with the D'Zurilla and Nezu problem-solving therapy framework, which provides a useful backbone here. However, it is important to adapt that framework for the specific cognitive profile of adult ADHD rather than applying it wholesale. The standard problem-solving sequence — problem orientation, problem definition, generation of alternatives, decision-making, and solution implementation and verification — is sound in principle, but adults with ADHD frequently struggle at the problem definition stage. This is because the presenting difficulty is often experienced as a diffuse, overwhelming sense that everything is disorganised, rather than as a discrete, bounded problem that can be named and addressed. The practitioner's role at this stage is to help the client move from that global sense of chaos to a specific, workable problem statement.

A useful technique here is what might be called the recurring difficulty audit. The practitioner invites the client to identify not the most dramatic organisational failure they can recall, but the difficulties that happen repeatedly — the ones that occur week after week despite the client's best intentions. These recurring difficulties are the most clinically productive targets because they are predictable, which means solutions can be designed and tested in advance rather than improvised under pressure. Common examples include consistently missing the bin collection, failing to respond to important emails until they have become urgent, losing track of items needed for appointments, and allowing administrative tasks such as paying bills or renewing prescriptions to accumulate until they reach crisis point. Once a recurring difficulty has been identified and named precisely, the problem-solving process becomes considerably more tractable. The client and practitioner can then work through the generation of alternatives together, with the practitioner gently steering the client away from solutions that depend on willpower or memory alone — both of which are unreliable in the context of ADHD — and towards solutions that externalise the cue, reduce the number of steps required, or embed the action into an existing routine.

To illustrate this process concretely, consider a client — call him Marcus — a

thirty-eight-year-old project manager who has been working through the programme for six sessions. Marcus has established a reasonably consistent morning routine and has been using a paper-based weekly planner with moderate success. He identifies in the recurring difficulty audit that he repeatedly fails to prepare his bag the night before important early meetings, with the result that he arrives flustered, having forgotten documents or equipment. This has happened at least once a fortnight for as long as he can remember. The problem definition is refined collaboratively: the difficulty is not that Marcus does not know what he needs to bring, nor that he lacks the physical ability to prepare his bag, but that the preparation step is not reliably triggered at the right moment. The generation of alternatives produces several options: setting a phone alarm labelled ‘bag check’ for nine o’clock each evening; placing a sticky note on the kettle he uses every evening; creating a standing checklist kept in the bag itself; or building the bag preparation into the end of his working day rather than the evening at home. Marcus and the practitioner evaluate these options against the criterion of minimal reliance on memory and maximum environmental prompting. They agree to trial the standing checklist combined with an evening alarm, and to review the outcome at the following session. This is structured problem-solving applied precisely and practically, and it models for the client a transferable process they can begin to apply independently to other recurring difficulties.

Prioritisation skills represent the second major component of this module, and they address one of the most clinically significant features of adult ADHD: the experience that everything feels equally urgent. Barkley’s influential model of ADHD as a disorder of self-regulation rather than attention per se is particularly illuminating here. When the capacity to project oneself forward in time and to weight future consequences appropriately is impaired, the result is a flattened hierarchy of urgency in which a looming work deadline and an unread social media notification can feel neurologically equivalent. The practitioner needs to name this experience explicitly and validate it before introducing any prioritisation framework, because clients who have been told repeatedly to ‘just focus on what matters’ often carry considerable shame about their apparent inability to do so. Naming the neuropsychological basis of the difficulty — drawing on psychoeducation that will have been delivered in earlier sessions — reframes prioritisation not as a moral failing but as a skill that requires explicit,

effortful scaffolding rather than intuitive access.

The prioritisation framework introduced in this module is deliberately simple. Complexity in prioritisation systems tends to collapse under the demands of ADHD, as the system itself becomes a source of avoidance. The practitioner introduces a two-axis approach: urgency, meaning the time sensitivity of a task, and importance, meaning the degree to which the task aligns with the client's meaningful goals and responsibilities. This is broadly consistent with the Eisenhower matrix that has been adapted for use in ADHD-specific CBT programmes, though the practitioner should avoid presenting it as a rigid quadrant system that requires careful categorisation of every task. Instead, the client is taught to ask two questions at the start of each day or planning session: what on my list, if left undone today, would create a concrete negative consequence? And what on my list, if done today, would move me meaningfully towards something that matters to me? Tasks that satisfy the first question are addressed first; tasks that satisfy the second are protected from being endlessly deferred. Everything else is either delegated, scheduled for a specific future time, or consciously set aside. The practitioner works through this process with the client using the actual contents of their current to-do list or planner, making the exercise immediately relevant rather than hypothetical.

Managing distractibility once a task is underway is the third component of this module, and it is one that is frequently underemphasised in organisational skills training. Much of the literature on ADHD and task management focuses on initiation — overcoming procrastination, getting started, reducing avoidance — and while these are genuinely important targets, they do not address the equally common experience of beginning a task and then losing the thread of it within minutes. The client who sits down to write a report and finds themselves, twenty minutes later, reading about a topic entirely unrelated to the report, has not failed to initiate; they have failed to sustain. These are neuropsychologically distinct difficulties, and they require distinct strategies.

The practitioner introduces the concept of implementation intentions, drawing on the work of Peter Gollwitzer, as a tool for managing within-task distractibility. An implementation intention specifies not only what the client will do, but when, where, and — crucially — what they will do if a specific obstacle arises. For ADHD clients, the most important obstacle to specify in

advance is the distraction itself. The client is taught to form an explicit if-then plan: 'If I notice that my attention has drifted from this task, then I will write down the distracting thought on my notepad and return to the task.' This externalises the distraction — giving it a place to go — without requiring the client to suppress or ignore it, which tends to increase its intrusive quality. The notepad becomes a capture tool, a concept familiar from productivity literature but here given a specific neuropsychological rationale.

Additional strategies for within-task distractibility include the use of time-bounded work intervals, often referred to in the ADHD literature as time-boxing, in which the client commits to working on a single task for a defined period — typically fifteen to twenty-five minutes — before taking a brief, structured break. This approach reduces the cognitive demand of sustaining attention indefinitely, which is particularly taxing for adults with ADHD, and replaces it with the more manageable demand of sustaining attention for a finite, visible period. The practitioner helps the client identify the interval length that is challenging but achievable for them individually, since this varies considerably across clients and across different types of task.

The session closes with the practitioner and client collaborating on a written plan that integrates the skills introduced in this module with the behavioural scaffolding already in place. This integration plan is not an additional system; it is a revision of the existing structure to incorporate the new skills. Marcus, for example, leaves the session with his morning routine updated to include a two-minute daily prioritisation review, a standing checklist in his bag, and an if-then plan written on a card kept at his desk. The written plan is specific, realistic, and directly connected to the difficulties he identified at the start of the module. This specificity is not incidental; it is the mechanism through which the module's content becomes clinically effective rather than merely intellectually understood.

Points worth keeping

- Structured problem-solving for recurring organisational difficulties
- Prioritisation skills for deciding what needs attention first
- Managing distractibility once a task is underway
- Building this module on the behavioural scaffolding already in place

PRACTICE TASK

Write a simple prioritisation question set a client could use when several tasks feel equally urgent.

PART 2

The cognitive module and comorbidity-sensitive delivery

Addressing ADHD-related thought patterns, and adapting delivery when comorbidity is present.

CHAPTER 3

Delivering the cognitive module

This lesson teaches the cognitive module, delivered only once behavioural and organisational scaffolding is in place per the Safren sequence: addressing ADHD-related thought patterns such as a belief that one always fails at organisational tasks, built up over years of genuinely repeated struggle. The lesson teaches the important distinction between a genuine cognitive distortion, which can be challenged through standard cognitive techniques, and a realistic account of a long pattern of difficulty, which needs validating honestly rather than disputed as if it were irrational.

Points worth keeping

- Addressing ADHD-related demoralisation and self-critical beliefs
- Delivering cognitive work only once earlier modules are established
- Distinguishing genuine distortion from a realistic account of repeated struggle
- Validating a realistic account rather than disputing it as irrational

PRACTICE TASK

Write one client statement that reflects realistic difficulty rather than distortion, and explain how you would respond to it differently from a true distortion.

CHAPTER 4

Adapting delivery for common comorbidities

This lesson teaches how to adapt pacing and content when anxiety, depression or substance use are also present alongside ADHD: slowing the sequence where a comorbidity is competing for attention and capacity, recognising when a presentation has moved beyond what this pathway's scope supports and onward referral or adjunct treatment is needed, and the basics of liaising appropriately with a prescriber, supporting medication adherence through psychological strategies without taking on a prescribing role or commenting on dosage decisions.

Points worth keeping

- Slowing the sequence when a comorbidity competes for attention and capacity
- Recognising when a presentation exceeds this pathway's scope
- Supporting medication adherence without taking on a prescribing role
- Appropriate liaison with a prescriber

PRACTICE TASK

Describe how you would adjust the Safren sequence's pacing for a client whose depression is currently severe, without abandoning the sequence altogether.

The end of the sample

This is a free sample of “Adult ADHD Practitioner Training in Practice”, 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.