Cognitive-Behavioural Therapy for ADHD in Adolescents and Adults

A Psychological Guide to Practice

Second Edition

Susan Young and Jessica Bramham

WILEY-BLACKWELL

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Susan Young is a Senior Lecturer in Forensic Clinical Psychology at the Institute of Psychiatry, King's College London and an Honorary Consultant Clinical and Forensic Psychologist at the high security Broadmoor Hospital. In 1994 Susan set up the clinical psychology service at the Maudsley Hospital's National Adult ADHD Service and has extensive clinical experience in the assessment and psychological treatment of youths and adults with ADHD. Susan participated in the British Association of Psychopharmacology Consensus Meeting (2007) to develop guidelines for management of transition for ADHD adolescents to adult services. She was a member of the National Institute for Health and Clinical Excellence (NICE) ADHD Clinical Guideline Development Group (2009); her main contribution being to provide expert guidance on psychological treatment of children and adults with ADHD. Susan is Vice President of the UK Adult ADHD Network (UKAAN), which aims to support practitioners establish adult ADHD clinical services. Susan has published articles in scientific journals, three psychological intervention programmes and has authored two books. She is currently leading a research group, supported by the Department of Health, which aims to develop projects that will establish the evidence base on ADHD and offenders and approaches to their management in the criminal justice system.

Jessica Bramham is a Lecturer in Clinical Neuropsychology in the School of Psychology, University College Dublin. She leads the Adult ADHD Service at St Patrick's University Hospital Dublin. She previously coordinated the National Adult ADHD Service at the Maudsley Hospital in London and was a Clinical Lecturer at the Institute of Psychiatry, King's College London. Jessica has a doctorate in Clinical Psychology and PhD from the Institute of Psychiatry and a MA from Cambridge University. Neuropsychological assessment is a particular interest. She is involved in researching cognitive functioning and the presentation of comorbid disorders in adults with ADHD.

FOREWORD BY MARGARET WEISS

'The journey started with the words "You have ADHD". To the client these words were not just a diagnosis, but a framework for self-understanding.' These words taken from the authors' module on terminating therapy are a statement of the central thesis of this book. This is a clinically driven manual for understanding and helping adults with ADHD. The strength of this manual is that it is clinically driven. The authors are not constrained by a particular view of how change occurs, the structures of the DSM or ICD, the ideology of a particular method of therapy, or a narrow arena of functional impairment.

Young and Bramham define three ways in which change may occur. Biological change may occur either through maturation or as a result of taking medication, in which case one observes a direct improvement in symptoms. Environmental change can occur when the patient's milieu is modified in such a way as to minimize the impact of symptoms or optimize the visibility of strengths. Psychological change occurs through the use of cognitive, behavioral, psychoeducational and interpersonal techniques that provide a scaffolding for building skills that were not previously present. The authors further simplify this schema for understanding change by noting that it can occur from the outside in, as well as from the inside out.

Psychiatrists who prescribe medication and CBT therapists are most interested in change from the inside out. The focus of these authors is not on any one direction of change. Instead they have focused on the dialectic between symptoms and functioning that is unique to this particular group of patients. This is a book by clinicians who have learned about ADHD from their patients. The result is a practical manual that can be as easily referenced in individual, group or workshop formats. The instrumental tools that accompany each module are made available to the reader on a website for ease of presentation.

What emerges from this perspective is clinical wisdom. One can see and feel both the patient and the therapy. Sometimes the authors sound almost simplistic in stating the obvious 'Achievement is a strong reinforcer', 'Self monitoring can increase a skill', 'Recognizing and preparing for problematic tasks makes a difference'. Yet each one of these statements represents tasty therapeutic spice.

The treatment described in this book would help some of the people, some of the time, with some of their problems. The change that would come out of this therapy would be meaningful and enduring.

Our understanding of how patients with ADHD get better has at times been characterized by cognitive errors. Getting better is not black (no change) or white (remission). For the vast majority of patients change is qualified. Getting better is not a race to the finish line, in which how fast you get better is more important than how long you maintain that improvement. This is a struggle, or a journey as the authors frame it, in which time, persistence, creativity, resilience, and insight empower the greatest change in longer -term developmental gains. These authors have a developmental perspective on ADHD, but they also have a developmental perspective on how to optimize enduring functional change and quality of life.

DSM and ICD define the paradigm that allowed ADHD to obtain visibility. As a result of the research underlying the diagnostic systems for ADHD we were able to move from a moral view of laziness into a neuropsychologically informed understanding of executive function and inhibition. However, DSM and ICD have been both a friend and a foe. The history of ADHD is defined by a chronic and essential tension between a narrow definition of the core symptoms and broader schemas of the associated symptoms carried by this population. Contemporary research in ADHD has benefited profoundly from use of a narrow definition of ADHD. On the other hand, clinicians such as Rosemary Tannock, Tom Brown and Paul Wender are often pulled out of this cosy research nest by the clinical demands of patients who have other complaints and complex neuropsychological deficits. This book exists in that tension. It targets a population diagnosed by the symptoms and addresses clinical deficits in a wide range of associated symptom areas.

Adults with ADHD may be anxious, even when their anxiety is either not specific enough or not severe enough to meet criteria for an anxiety disorder. Young and Bramham observe that ADHD symptoms lead to difficulty with anxiety and depression, while anxiety and depression divert power away from the working memory engine that mobilizes attention and inhibition. You cannot divorce internalizing and externalizing symptoms and still engage and carry a patient with ADHD through therapeutic change. When someone with ADHD has to do something they are not equipped to handle (homework, taxes, housework, taking a test, driving, being on time) they will sense their own danger and remember their own failures.

One of the more energetic controversies of recent academic and clinical forums is the differential between bipolar disorder and ADHD. One has to wonder why this particular problem continues to generate such interest. It was therefore with some delight that I observed these two psychologists wrestle with this demon. They describe patients with ADHD as ‘passionate’ (a very un-DSM word), such that when they are low, they are ‘passionately low’. They note that ADHD is often associated with

dramatic mood swings within the hour rather than within the week. One might even say that they have impulsive mood swings. The clinical reality for people who work with ADHD is that these patients often suffer impairment from mood and anxiety symptoms. These symptoms overlap with but are not identical to the disorders described in DSM or ICD. Since Young and Bramham first described this phenomenon, more recent research by Barkley and Surman has validated that emotional dysregulation and emotional impulsivity are in fact central to the disability associated with ADHD.

The focus of treatment for ADHD has been on symptoms rather than functioning. This truly puts the cart before the horse. Symptom-based assessment is only a conceptual gateway to knowing how to help someone get better at day-to-day living. The trick to helping patients is to target the areas where they have problems. This is the underlying structure which defines the modules of the Young-Bramham program. Most patients do not need (or could not handle) the whole of this program, however, any patient would benefit from some of it.

The modules provided include many of the most common problems these patients complain of: time management, procrastination, anger management and interpersonal problems. The authors always start with symptoms and end with functioning. For example, the module on attention starts with a discussion of the varieties of attention deficits and how these manifest clinically. What follows is a description of how to support the development of executive function skills. The module on sleep starts by describing sleep itself, the sleep problems we see in patients with ADHD and ends with a description of time tested, common sense sleep hygiene. This is all the more original given that while adults with ADHD commonly complain of sleep problems, there is almost no research on the sleep problems specific to ADHD in adulthood.

The modules deal with many different problems. The authors note that although circumstances will dictate the usefulness of one or another module, the skills that develop are cumulative. When patients address one problem, they obtain a framework for establishing change that permits them to rework the same skills in another arena of impairment. The core modules on treatment, attention, impulsivity and termination of therapy are likely to be relevant to any patient.

The section on impulsivity starts with a description of impulsive behaviour, affect and cognitions, and ends with practical strategies. If the patient has consequence blindness, reinforce the immediacy and salience of rewards. If the patient makes impulsive decisions, have them write down the pros and cons of decisions before acting. If the patient jumps to conclusions, teach them to review the evidence. Patients with ADHD could not learn these skills when they were symptomatic, but nor do they necessarily reverse a lifetime of habit when the neuropsychiatric potential for change becomes available. For someone with ADHD to grow, the symptoms have to

be manageable, expectations need to match potential, and the patient has to make up many lost years of potential skill development. The disabilities that accompany ADHD are varied enough to leave room for multiple treatment options.

The module I enjoyed the most was the discussion of social relationships. This is a description of ADHD symptoms seen through the distorting lens of the non-ADHD companion. If the patient zones out, they are not interested. If the patient is staring, they are aggressive. If the patient is fidgeting, they are trying to bother you. If the patient forgets to call, they do not love you. It is also a description of the profound social handicaps that ADHD symptoms engender such as hanging out with the wrong crowd, promiscuity, difficulty with pragmatic language, trouble listening. This is one of the first attempts to describe ways in which we might assist adults with ADHD with their interpersonal difficulties.

I appreciated the authors sensitivity to what is one of the greatest sources of psychological injury in ADHD: isolation. Patients with Asperger syndrome often come in as adults and discuss their wish to have a friend, but they are not actually lonely. They have grown into an awareness that there is an aspect of human gregariousness that they are not a part of, but they do necessarily feel what it is they are missing. By contrast, patients with ADHD are intensely social and what they see is denied to them. The authors have made an important beginning in making the patient's experience of social rejection a focus of treatment.

There are many aspects of ADHD we do not understand. A good clinical book will by its nature defy categories. It will also be enriched by insights that make no theoretical sense. For example, the authors note that patients with ADHD may apologize for misdemeanours they have neither processed nor understood. I am reminded of the husband who does not remember what he said to his wife, or the child who tells the principal he 'didn't do it' and is not lying in as much as he does not know at that moment that he actually did do it.

Of all the clinical wisdom in this book, by far the best is that the authors practice what they preach. Motivational interviewing and cognitive behavioural therapy are contingent upon helping the patient see the cup as half full. Yet as clinicians how often do we focus our interview on what is wrong rather than what is right? Young and Bramham capitalize on the greatest strength of ADHD patients: courage and resiliency. The authors note that these are patients who try and try again. Some patients with ADHD have great successes to attach to their name. Some have very few. All of them have tried and tried again and this is a powerful therapeutic niche. Young and Bramham use a metaphor to describe this. They say that patients with ADHD are 'life's true entrepreneurs'. This is true, and like all entrepreneurs they risk bankruptcy as well as wealth.

The authors note that adults with ADHD 'often feel that they are "survivors" of a syndrome that has left them with significant personal, social and occupational

consequences. This is anecdotally known as the "hangover" of ADHD'. There is long-term damage to self-esteem that ensues from a childhood corrupted by inattention, hyperactivity and motoric, cognitive and behavioural impulsivity. The focus on strengths capitalizes on the opportunity to rewrite a life history of injury and disability as a history of bouncing back. ADHD patients can be proud of their resiliency.

The constant refrain in lectures on ADHD has been to highlight the impairment, so as to make an invisible disability transparent and open the way to provision of credibility, accommodation and service. This has been important and successful. However, highlighting the functional impairment associated with ADHD has also had dangerous consequences. First, it has led to confusion between the consequences of ADHD and conduct disorder. Second, it has left clinicians with a feeling of therapeutic nihilism and thus indirectly increased the stigma associated with the disorder. Third, it has led to a reactive initiative where ADHD is perceived as a gift and 'being' ADHD has become a culture in its own right.

People with ADHD have a disability, but they are human and human beings react to disability with plasticity. This is not a strength of ADHD, it is a strength of being human. The blind may be musical, but being musical does not make being blind a gift. Struggling with ADHD is long and lonely. The last module of the book helps the therapist recapitulate with the patient where they are in the space and time of development, and the meaning of the relationship that has developed. Termination is a difficult and significant moment in every short-term therapy, but it is all the more salient for patients caged by symptoms in a cell of social isolation. The authors know how to deal with the bittersweet aspects of a therapeutic success that foreshadows the difficulty of letting someone go it alone when life is never going to be easy.

There are many types of therapy in the food court of psychology manuals. This one borrows from psychoeducation, cognitive behavior therapy, interpersonal therapy, behavior therapy, social skills training, anger management, motivational interviewing, problem-solving, cognitive remediation, relaxation therapy, sleep hygiene and coaching. It is perhaps a sign of our times that the only major psychological intervention that I did not see was dynamically-oriented psychotherapy. ADHD does not grant immunity from conflict. While psychodynamic psychotherapy may not be an effective treatment for ADHD symptoms, ADHD does not preclude patients benefiting from psychotherapy for life problems.

Patients with ADHD will enter therapy thinking about medication, on medication, or having failed medication. Any psychological treatment has to help them integrate the experience of taking a pill to assist with focus and restraint. An effective treatment needs to capitalize on the strength and limitations of the context of attributions around medication. Patients may use medication and psychoeducation as a way of excusing them from the forced effort required for change. Good psychological treatment is an antidote. This book is grounded in the questions patients ask. 'What is ADHD and what is me?' 'Should I tell people or should I keep it a secret?'

Medication treatment is a rapidly evolving area and no book can do justice to the latest innovations. If the patient does not take the pill, has misguided expectations, or sees himself as in a contest with the pill, medication will not be as effective. The authors have tried to formulate a way of providing a pharmacotherapy alliance.

Research on psychological treatment of ADHD is very much in its infancy. Yet the very early and methodologically limited studies of psychological treatment consistently showed improvement in symptoms, improvement in skills and deterioration in self-esteem. Insight brought its rewards, but also carried side effects. The side effect of realistic assessment of oneself is diminished grandiosity. Shrinking narcissism is good for the soul if one endures, but if the patient's only strength is the capacity to try, try again then it is not without its dangers. Young and Bramham learned this well. You cannot get better if you fail to bounce back. Throughout every module one hears the therapist negotiate between the twin dangers of unrealistic grandiosity that leads to repeated failure and despair that precludes continued effort.

Every day we are confronted with the impossibility of making up the difference between the hopes and dreams of our patients and what we can realistically provide. It is therefore with fear and trembling that we are now starting a psychotherapy program. From this strategic point of view some therapy is better than no therapy. We have to find a way to provide education, skills and coping strategies to many people, with many different problems and levels of functioning. This is a manual that lends itself to being delivered in a group or workshop modality. With limited manpower and explosive demand, this allows us to find a way to begin to deliver the essentials to our patients in a cost effective manner.

The group forum has potential to deal with the here and now of social interaction. Group treatment capitalizes on peer support. It is easier to illustrate how symptoms put a stamp on life history when more than one example is under discussion. Most of all, if one of the trademarks of disability is isolation, then the brand equity of good treatment is companionship. The hardest part of ending a group for patients with ADHD is that for many of the patients there, this will have been their first experience of being understood. They fear it will be their last. This is the first published manual I am aware of dedicated to providing a guide to psychological treatment that can be accommodated in group and workshop formats.

The single most difficult task for a patient with ADHD is to prioritize. Patients complain that they procrastinate, lack motivation, become easily distracted, and cannot stay on task. There are many coping strategies that are useful to deal with these problems. However, when the rubber hits the road, the hardest thing to explain to a patient is how to know what matters most. The early formulations of cognitive behaviour therapy described cognitive errors. They did not provide instruction in cognitive talents. Seeing the wood for the trees is a talent that underlies both the strength and the weakness of cognition in the face of an attention deficit. The problem-solving, CBT

and motivational sections of this manual attempt to draw out therapeutic manoeuvres not just for getting it right, but getting what is most important.

In the past year publications by Solanto, Safren and Emilsson have all demonstrated that CBT for adults with ADHD is highly effective. The publication of the manuals by Solanto and Safren differ from this book in that they describe a fixed program in which one treatment fits all. By contrast, the approach taken by Young and Bramham is unique in that they have provided therapists with a clear description of the problem, the tools for therapy and an approach to therapy. However, they recognize that adults with ADHD may have core symptoms in common, but differ significantly in terms of the areas in which they need assistance. This is the only manual that provides 'modules' that can be adapted to the needs of patients who have distinct difficulties in a particular area. They go beyond teaching executive function skills to also addressing interpersonal relationships, sleep, addiction, and other issues that may be the most significant problem for a particular patient. This is a book then that can be adapted by clinicians to meet the needs of patients of both genders, adolescents as well as adults, and patients who are both high functioning and low functioning. This book is open to interpretation by each therapist and flexible enough to help most clients. The therapeutic approach is multi-faceted, appropriately reflecting the complexity of individuals who have ADHD. What the Young Bramham programme contributes is perspective. They have worked out what is most important and why it matters. In so doing they also helped us to begin to work out how to help patients develop this skill.

Margaret Weiss
Clinical Professor, University of British Columbia

FOREWORD BY SAM GOLDSTEIN

For many years it was reassuring for professionals and parents to believe that the problems caused by ADHD simply represented a poor fit between some children and their environments. It was comforting to reassure parents that the problem would be outgrown and with patience and treatment, ADHD was not likely to cause children significant lifetime adversity. Over the past twenty years the belief that ADHD is just a childhood condition quickly outgrown by late adolescence has been increasingly tested. A significant number of individuals, male and female alike, suffering with ADHD in their childhood, continue to suffer and lead lives less than their capabilities often into their geriatric years. Though a number of early pioneers advised professionals to consider the plight of many adults with histories of ADHD, it was not until the concept of ADHD was popularized in the lay press and media that serious attention began to be paid to the condition. Though some would argue the condition and its treatments are controversial, within the scientific and mental health community little controversy remains (Asherson *et al*., 2010). The body of literature attesting to the emotional, cognitive, vocational, academic, substance use and criminal risks of the condition is quickly growing. As editor-in-chief of the *Journal of Attention Disorders* I have observed that in each of the past 8 years we have received an increasing number of articles researching adult ADHD issues and are devoting an increasing number of our journal pages and special issues to the condition in adulthood.

Though one-third of adults with ADHD may progress satisfactorily into their adult years, another one-third continues to experience some level of problems while the final third continues to experience and often develops significant problems related to ADHD and other comorbid conditions. Despite popular myth, ADHD is neither an asset driving greatness nor even a minor inconvenience for those affected individuals. By combining a number of outcome studies, it is reasonable to conclude that only 10 per cent to 20 per cent of adults with histories of ADHD experience few problems. Sixty per cent continue to demonstrate symptoms of ADHD and experience social, academic and emotional problems to at least a moderate degree and 10 per cent to 30 per cent develop more serious comorbid disorders as well as antisocial problems in addition to their continued difficulty with ADHD and other comorbidities. Many of these negative outcomes are linked to the continuity, severity and persistence of ADHD symptoms. Though males may experience more problems with disruptive

and aggressive behaviour, females with ADHD appear to suffer equally or to a greater degree in all other arenas of life.

In 2002, Dr. Ann Teeter-Ellison and I had the pleasure to edit the first comprehensive, clinical volume addressing adult ADHD, *Clinician's Guide to Adult ADHD: Assessment and Intervention* (Goldstein and Teeter-Ellison, 2002). At the time, there were a limited number of peer reviewed, research studies focusing on adults, even fewer research tested methods for evaluating and most importantly treating adults with ADHD through combined medical and psychological interventions. It was our intent in this volume to begin aggressively addressing these issues by offering authors with promising though not completely tested ideas, particularly in regards to psychological and psychosocial treatment, the opportunity to contribute to our volume. A number of years earlier I had the opportunity to meet and spend time with Susan Young in London. Susan was focusing her treatment efforts on developing a model of psychotherapy for adults with ADHD. Susan agreed to author a contribution to our text. Her chapter (Young, 2002) provided one of the first, published comprehensive approaches to treating adult ADHD through a cognitive behavioural therapy model. In her chapter, Dr. Young reviewed the typical impairments confronting adults with ADHD, provided four extensive case examples and then set out to outline a cognitive behavioural therapy approach for treating adults with ADHD based on her work and her published article applying cognitive behavioural therapy in the treatment of adults with ADHD (Young, 1999). One of the aspects of Dr. Young's approach that appealed to me was that she emphasized that psychotherapists and mental health professionals should seek out and help adults with ADHD take advantage of their strengths as a means of creating balance in their lives and learning to cope with their symptoms and impairments. She noted at the conclusion of her chapter that, with the help of caring professionals, adults with ADHD 'have choice and opportunity to develop these talents and adapt the environment to suit their personal needs. What they often lack is the vision and courage to do so' (p. 158).

In the following years, Dr. Young joined forces with Jessica Bramham and other colleagues in expanding her work. They have worked diligently to continue studying adult ADHD and to create a psychosocial model to treat adult ADHD utilizing a cognitive behavioral framework (Bramham *et al*., 2009; Gudjonsson *et al*., 2009; Young, 2005; Young and Gudjonsson, 2008).

The first edition of this volume was well received. Reviewers noted that the program outlined in the initial volume offered a useful and practical set of tools for clinical practice. This second edition represents an important second step in standardizing the psychosocial treatment of adults with ADHD. The Young-Bramham program has been empirically validated (Bramham *et al*., 2009). Similar to the work of American researchers Safren *et al*. (2005a) and Safren *et al*. (2005b), Dr. Young and colleagues have continued the important process of validating a cognitive behavioural approach to treating adults with ADHD (see also Emilsson

et al., 2011; Young *et al*. (forthcoming). This approach has been found to not only offer personal insight and psychological relief but also the reduction of symptom severity and daily impairment.

This expanded second edition extends the Young-Bramham treatment model into the adolescent years, a critical time setting the stage for an important transition for this population (Young, Murphy and Coghill, forthcoming). New to this volume are outlines suggesting delivery of strategies and interventions in a group format as well as separate modules designed to develop and facilitate attention and memory. Each chapter has been extensively revised and updated. New references have been added. Examples relevant to adolescents as well as adulthood have been expanded. The structure of each module has been reorganized and streamlined following a consistent format. Finally, the chapter on assessment of ADHD in the initial volume has been eliminated to make space for the additions and extensions noted above.

The hypothesis that ADHD represents a lifetime condition has been tested and verified. Current theory for the aetiology of ADHD is consistent with a lifetime presentation reflecting developmental rather than pathological differences between affected individuals and the general population. The consequences of living with the burden of a significantly disabling condition, and one that leads to impaired self-discipline, has resulted in demonstrated problems across all arenas of life for adults with ADHD. The condition serves as a global risk factor limiting the potential for academic and vocational achievement as well as acting as a catalyst for comorbid psychiatric and life problems. Though much work remains to be done to understand the developmental course, risk and protective factors involved in the adult outcome of ADHD, the expanded second edition of this volume will continue to serve as a bright beacon guiding professionals in their care of adolescents and adults with ADHD in what has been an often dark and murky journey.

Sam Goldstein
Salt Lake City, Utah

PREFACE

We have frequently been asked for advice from clinicians working with adult ADHD clients in many different settings, including general adult mental health services, learning disability services, children's transition to adulthood services, forensic services, neuropsychiatry and neuropsychology services. These days we are being increasingly asked for advice from educational and occupational settings, prison and probation services. We wrote the Young-Bramham Programme to develop a conceptual framework and a unique approach for assessing and treating people with ADHD and associated problems. The book was first published in 2007 and focused on adults with ADHD. However, feedback from colleagues across the world was that they were successfully applying the programme for use with young people in their adolescent years. This led us to systematically revise the programme modules to make the book more 'user friendly' for therapists who are also working with adolescents. We have also responded to feedback suggesting that we provide template sessions for modules to be provided in group format and these can be found at the end of each chapter.

A lot has happened since the publication of the first edition in 2007. The scientific knowledge about ADHD has mushroomed and it is now widely accepted to be a condition that affects many people across the lifespan. The UK NICE Guidelines, published in 2009, provided clear guidelines for ADHD across the lifespan and the requirement for adult mental health services to recognize the disorder and provide diagnostic and treatment services. The Guidelines also drew attention to the importance of psychological interventions as a firstline treatment for children, for those with mild symptoms, and as an important complementary treatment for adults with ADHD. A key priority of the Guidelines was that drug treatment for children and young people with ADHD should always form part of a comprehensive treatment plan that includes psychological, behavioural and educational advice and interventions. NICE recommended that for older adolescents direct individual psychological interventions, using cognitive behavioural and social skills paradigms, may be more effective and acceptable to the young person. They recommended that active learning strategies should be used for a range of treatment targets, including social skills with peers, problem-solving, self-control, listening skills and dealing with and expressing feelings. These recommendations endorse the cognitive

behavioural paradigm that is employed by the Young-Bramham Programme and introduced in this revised book for ADHD adolescents and adults.

Both of us are clinical psychologists and clinical neuropsychologists and we have spent several years working in a national referral service for adults with ADHD at the Maudsley Hospital in London. Between us, we have assessed and treated many hundreds of people with hundreds of people with ADHD have gained considerable insight into their problems and developed skills in working with this client group. In the book we have drawn on our knowledge and experience and provided case examples for illustration. All case examples provided throughout the book have been adapted so that clients remain anonymous. The book is accompanied by the Young-Bramham Programme Companion Website, which provides all the materials outlined in the chapters. These materials can be downloaded for use in sessions and by clients outside the sessions.

The Young-Bramham Programme is intended to help clinicians who have some knowledge of psychological approaches or cognitive behavioural therapy with clients with mental health difficulties, but who may not have worked with many adolescents or adults with ADHD. It will also be useful for therapists who have some knowledge of childhood ADHD, who are interested in how the disorder progresses and potential treatment strategies for ADHD 'graduates' or young adults. It is always gratifying to get feedback directly from clients, and it has been pleasing to hear that the book is pitched at a level that makes it accessible to clients as a 'self-help' book and has been used in this way for people to develop techniques for managing their own difficulties.

We have learnt a great deal from our clients and, in the Young-Bramham Programme, we hope to convey many of our positive experiences working with clients with ADHD. For us, their determination to access services, their motivation to change and receive psychological therapy has provided a consistent incentive to share our knowledge and experience.

Susan Young
Jessica Bramham

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First and foremost, we wish to thank our clients who have shared with us their experiences, hopes and problems. We are grateful to those who supported us during the preparation of the first edition of the book and now with this revised edition. In particular we are grateful to Jane Adams, Seamus O'Ceallaigh, Philippa Bramham, Professor Gisli Gudjonsson, Josip Lizatovic, Helen Fleck, Amie Doidge and Catherine Lorek.

We dedicate this book to our children, Charlotte, Aengus and Élis, with the knowledge that you reach your dreams one step at a time.

PART I

BACKGROUND AND TREATMENT

1

INTRODUCTION

This book aims to provide clinicians with a comprehensive psychological guide to practice when working with adolescents and adults with ADHD by providing cognitive behavioural therapy (CBT) to treat core symptoms of the condition and its associated problems. As ADHD is a heterogeneous disorder, each individual is likely to present with a different constellation of symptoms with a range of psychological strengths and weaknesses. For this reason, this book consists of stand-alone modules that can be delivered in individual or group format and which together form the Young-Bramham Programme. The Young-Bramham Programme provides an innovative and intensive practical approach to the presentation of ADHD using cognitive behavioural and motivational interviewing techniques, which are described in detail using case examples. Each module is presented in a separate chapter of this book and can be used independently or in conjunction with other modules.

Practitioners often report feeling underequipped to treat this client group and there remains a limited literature on psychological treatment for adolescents and adults. Up to two-thirds of ADHD children continue to suffer with symptoms into adult life, many of whom experience residual problems which warrant treatment (Young and Gudjonsson, 2008). In addition, there are many young people who do not receive a diagnosis until they are adults in spite of having presented on numerous occasions to health services (Huntley and Young, submitted; Young, Toone and Tyson, 2003). ADHD has often been missed in the past, and misdiagnosis abounds. Aside from these clinical groups, there are additionally many individuals who have symptoms that fall below the threshold for formal diagnosis, but who nevertheless may benefit from psychological treatment to address their problems and functional impairments. Thus, the Young-Bramham Programme was developed as an intervention suitable for individuals with a formal ADHD diagnosis, individuals who are in partial remission of their symptoms, and individuals who present with an undiagnosed constellation of ADHD symptoms and related problems.

Cognitive-Behavioural Therapy for ADHD in Adolescents and Adults: A Psychological Guide to Practice, Second Edition. Susan Young and Jessica Bramham.

A second reason for writing the book was that we have talked to our clients and listened to their life histories. They have such stories to tell and it is clear that for many the pathway is far from easy, yet over and over again we have recognized characteristics of determination, resilience, ingenuity and creativity. We interviewed some of our patients and their partners with the aim of analyzing their experience of receiving a diagnosis and treatment for ADHD in adulthood and, for their partners, their experience of supporting them through this process. After feelings of relief and a sense of hope and expectation for the future, they were disappointed with treatment as this was not a panacea. They were not 'cured' and core functional problems persisted associated with organization and time-management skills, procrastination and low self-esteem (Young, Bramham and Gray, 2009; Young *et al*., 2008). Thus our long experience in delivering psychological interventions to adolescents and adults with ADHD, together with our extensive research on the topic, led us to develop the Young-Bramham Programme to address the persisting problems that people experience regardless of whether they receive medication or not. We are not saying that this programme will fully bridge the gap and provide a 'cure' for adults and young people with ADHD, we are however confident that the strategies and techniques provided in the Young-Bramham Programme will provide additional and valued support.

THE COMPANION WEBSITE

The Young-Bramham Programme book is supplemented by a Companion Website, which provides practical and pragmatic exercises that allow the client to identify personal specific problems and methods to address them. Strategies which involve writing ideas down or making lists of potential consequences target difficulties in organizational skills and memory problems which are inherent in ADHD. The therapist therefore needs to maximize the opportunity to create lists and structure plans during sessions. Examples, charts, diaries, figures, diagrams and illustrations are presented in both the book and on the Companion Website (the latter in a format suitable for use in sessions) to clarify information, and/or to improve accessibility and understanding of the concepts and issues presented. The Companion Website provides psychoeducational handouts and blank copies of relevant materials introduced in the programme. It can be accessed with the password provided. The materials can be downloaded, copied and used in treatment sessions to determine, evaluate and treat specific symptoms, problems and strategies. The materials will help the therapist and the client to collaboratively tailor the Young-Bramham Programme interventions according to the clients' specific needs.

ADHD IN ADOLESCENCE AND ADULTHOOD

ADHD is an established neurodevelopmental condition characterized by inattention, hyperactivity and impulsivity or a combination of these problems that commences in childhood and often persists into adolescence and occupational lives. There is a clear