

Brian P. Daly
Michael J. Silverstein
Ronald T. Brown

Advances in Psychotherapy –
Evidence-Based Practice

ADHD in Adults

2nd edition



 hogrefe

Attention-Deficit/Hyperactivity Disorder in Adults

About the Authors

Brian P. Daly, PhD, is associate professor and department head of psychological and brain sciences at Drexel University. Dr. Daly is past president of the Philadelphia Behavior Therapy Association and recipient of grant funding from the Pew Charitable Trusts, W. K. Kellogg Foundation, Sixers Youth Foundation, Shire Pharmaceuticals, and Justice Resource Institute. He currently serves on the editorial board of *Professional Psychology: Research and Practice*, as well as on the advisory committees for several nonprofit organizations.

Michael J. Silverstein, MS, is a postdoctoral fellow at the Center for Cognitive Behavioral Therapy in Media, PA. His research interests include etiology of trauma symptoms after exposure to acute, chronic, and systemic stressors and the relationship between attention-deficit/hyperactivity disorder and posttraumatic stress disorder in youth. Clinically, Mr. Silverstein is interested in providing empirically based interventions to toddlers, children, adolescents, and their families.

Ronald T. Brown, PhD, ABPP, is the Dean of the School of Integrated Health Sciences at the University of Nevada, Las Vegas. Dr. Brown has been the past president of the University of North Texas at Dallas and also is the past president of the Association of Psychologists in Academic Health Centers and the Society of Pediatric Psychology of the American Psychological Association. Dr. Brown has published over 300 articles and chapters as well as 12 books related to childhood psychopathology and pediatric psychology.

Advances in Psychotherapy – Evidence-Based Practice

Series Editor

Danny Wedding, PhD, MPH, Professor Emeritus, University of Missouri–Saint Louis, MO

Associate Editors

Jonathan S. Comer, PhD, Professor of Psychology and Psychiatry, Director of Mental Health Interventions and Technology (MINT) Program, Center for Children and Families, Florida International University, Miami, FL

J. Kim Penberthy, PhD, ABPP, Professor of Psychiatry & Neurobehavioral Sciences, University of Virginia, Charlottesville, VA

Kenneth E. Freedland, PhD, Professor of Psychiatry and Psychology, Washington University School of Medicine, St. Louis, MO

Linda C. Sobell, PhD, ABPP, Professor, Center for Psychological Studies, Nova Southeastern University, Ft. Lauderdale, FL

The basic objective of this series is to provide therapists with practical, evidence-based treatment guidance for the most common disorders seen in clinical practice – and to do so in a reader-friendly manner. Each book in the series is both a compact “how-to” reference on a particular disorder for use by professional clinicians in their daily work and an ideal educational resource for students as well as for practice-oriented continuing education.

The most important feature of the books is that they are practical and easy to use: All are structured similarly and all provide a compact and easy-to-follow guide to all aspects that are relevant in real-life practice. Tables, boxed clinical “pearls,” marginal notes, and summary boxes assist orientation, while checklists provide tools for use in daily practice.

Continuing Education Credits

Psychologists and other healthcare providers may earn five continuing education credits for reading the books in the *Advances in Psychotherapy* series and taking a multiple-choice exam. This continuing education program is a partnership of Hogrefe Publishing and the National Register of Health Service Psychologists. Details are available at <https://www.hogrefe.com/us/cenatreg>

The National Register of Health Service Psychologists is approved by the American Psychological Association to sponsor continuing education for psychologists. The National Register maintains responsibility for this program and its content.

Attention-Deficit/ Hyperactivity Disorder in Adults

2nd edition

Brian P. Daly

Department of Psychological and Brain Sciences, Drexel University,
Philadelphia, PA

Michael J. Silverstein

Center for Cognitive Behavioral Therapy, Media, PA

Ronald T. Brown

School of Integrated Health Sciences, University of Nevada, Las Vegas, NV

Library of Congress of Congress Cataloging in Publication information for the print version of this book is available via the Library of Congress Marc Database under the Library of Congress Control Number 2023951194

Library and Archives Canada Cataloguing in Publication

Title: Attention-deficit/hyperactivity disorder in adults / Brian P. Daly, Department of Psychological and Brain Sciences, Drexel University, Philadelphia, PA, Michael J. Silverstein, Center for Cognitive Behavioral Therapy, Media, PA, Ronald T. Brown, School of Integrated Health Sciences, University of Nevada, Las Vegas, NV.

Names: Daly, Brian P., author. | Silverstein, Michael J. (Of the Center for Cognitive Behavioral Therapy in Media), author. | Brown, Ronald T., author.

Series: Advances in psychotherapy--evidence-based practice ; v. 35.

Description: 2nd edition. | Series statement: Advances in psychotherapy--evidence-based practice ; volume 35. | Includes bibliographical references.

Identifiers: Canadiana (print) 20230586627 | Canadiana (ebook) 20230586686 | ISBN 9780889375994 (softcover) | ISBN 9781613345993 (EPUB) | ISBN 9781616765996 (PDF)

Subjects: LCSH: Attention-deficit disorder in adults—Handbooks, manuals, etc. | LCGFT: Handbooks and manuals.

Classification: LCC RC394.A85 D35 2024 | DDC 616.85/89—dc23

© 2024 by Hogrefe Publishing

www.hogrefe.com

The authors and publisher have made every effort to ensure that the information contained in this text is in accord with the current state of scientific knowledge, recommendations, and practice at the time of publication. In spite of this diligence, errors cannot be completely excluded. Also, due to changing regulations and continuing research, information may become outdated at any point. The authors and publisher disclaim any responsibility for any consequences which may follow from the use of information presented in this book.

Registered trademarks are not noted specifically as such in this publication. The use of descriptive names, registered names, and trademarks does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.

The cover image is an agency photo depicting models. Use of the photo on this publication does not imply any connection between the content of this publication and any person depicted in the cover image.

Cover image: © skynesher – iStock.com

PUBLISHING OFFICES

USA: Hogrefe Publishing Corporation, 44 Merrimac St., Suite 207, Newburyport, MA 01950
Phone 978 255 3700; E-mail customersupport@hogrefe.com

EUROPE: Hogrefe Publishing GmbH, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950 0, Fax +49 551 99950 111; E-mail publishing@hogrefe.com

SALES & DISTRIBUTION

USA: Hogrefe Publishing, Customer Services Department,
30 Amberwood Parkway, Ashland, OH 44805
Phone 800 228 3749, Fax 419 281 6883; E-mail customersupport@hogrefe.com

UK: Hogrefe Publishing, c/o Marston Book Services Ltd., 160 Eastern Ave.,
Milton Park, Abingdon, OX14 4SB
Phone +44 1235 465577, Fax +44 1235 465556; E-mail direct.orders@marston.co.uk

EUROPE: Hogrefe Publishing, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950 0, Fax +49 551 99950 111; E-mail publishing@hogrefe.com

OTHER OFFICES

CANADA: Hogrefe Publishing Corporation, 82 Laird Drive, East York, Ontario, M4G 3V1

SWITZERLAND: Hogrefe Publishing, Länggass-Strasse 76, 3012 Bern

Copyright Information

The eBook, including all its individual chapters, is protected under international copyright law. The unauthorized use or distribution of copyrighted or proprietary content is illegal and could subject the purchaser to substantial damages. The user agrees to recognize and uphold the copyright.

License Agreement

The purchaser is granted a single, nontransferable license for the personal use of the eBook and all related files.

Making copies or printouts and storing a backup copy of the eBook on another device is permitted for private, personal use only. This does not apply to any materials explicitly designated as copyable material (e.g., questionnaires and worksheets for use in practice).

Other than as stated in this License Agreement, you may not copy, print, modify, remove, delete, augment, add to, publish, transmit, sell, resell, create derivative works from, or in any way exploit any of the eBook's content, in whole or in part, and you may not aid or permit others to do so. You shall not: (1) rent, assign, timeshare, distribute, or transfer all or part of the eBook or any rights granted by this License Agreement to any other person; (2) duplicate the eBook, except for reasonable backup copies; (3) remove any proprietary or copyright notices, digital watermarks, labels, or other marks from the eBook or its contents; (4) transfer or sublicense title to the eBook to any other party.

These conditions are also applicable to any files accompanying the eBook that are made available for download.

Should the print edition of this book include electronic supplementary material then all this material (e.g., audio, video, pdf files) is also available with the eBook edition.

Format: PDF

ISBN 978-0-88937-599-4 (print) • ISBN 978-1-61676-599-6 (PDF) • ISBN 978-1-61334-599-3 (EPUB)

<https://doi.org/10.1027/00599-000>

This document is for personal use only. Reproduction or distribution is not permitted.

From B. P. Daly, M. J. Silverstein, and R. T. Brown: *ADHD in Adults* (ISBN 9781616765996) © 2024 Hogrefe Publishing.

Acknowledgments

Brian P. Daly is grateful for the love, grace, and laughter from Tina, Leo, Sofie-Mathilde, and Colt. Having the puzzle pieces fit so snugly together makes me happy every day.

Michael J. Silverstein wishes to thank his wife Gila, parents Aliza and Len, and mentor Dr. Daly for their support and guidance.

Ronald T. Brown recognizes the extraordinary mentorship of Lorene C. Pilcher who began to ignite the flame of a love for scholarship and the study of individuals with attention-deficit/hyperactivity disorder.

Contents

Acknowledgments	v
1 Description	1
1.1 Terminology	1
1.2 Definition	2
1.2.1 Diagnostic Criteria	2
1.2.2 Applicability of Criteria for Adults	5
1.3 Epidemiology	5
1.3.1 Prevalence and Incidence	5
1.3.2 Sex	6
1.3.3 Age	6
1.3.4 Ethnicity	6
1.4 Course and Prognosis	7
1.5 Differential Diagnosis	8
1.5.1 Disruptive, Impulse-Control, and Conduct Disorders	8
1.5.2 Depressive Disorders	9
1.5.3 Anxiety Disorders	10
1.5.4 Trauma- and Stress-Related Disorders	10
1.5.5 Bipolar and Related Disorders	10
1.5.6 Personality Disorders	11
1.5.7 Substance-Related and Addictive Disorders	11
1.5.8 Neurodevelopmental, Physical, and Medical Conditions	12
1.5.9 Environmental and Psychosocial Factors	13
1.6 Comorbidity	14
1.6.1 Oppositional Defiant and Conduct Disorders	15
1.6.2 Depressive Disorders	16
1.6.3 Anxiety Disorders	17
1.6.4 Learning Disabilities	17
1.6.5 Bipolar and Related Disorders	18
1.6.6 Substance-Related and Addictive Disorders	19
1.6.7 Personality Disorders	19
1.6.8 Sleep–Wake Disorders	20
1.7 Diagnostic Procedures and Documentation	21
1.7.1 Diagnostic Interviews	22
1.7.2 Rating Scales	23
1.7.3 Psychoeducational Testing	25
1.7.4 Neuropsychological Testing	25
1.7.5 Laboratory Testing	26

2	Theories and Models of ADHD in Adults	27
2.1	Neurobiological Factors in ADHD	27
2.1.1	Genetic Contributions	27
2.1.2	Neurological Factors	28
2.1.3	Cognitive Determinants	30
2.2	Environmental Risk Factors	30
2.2.1	Biological Adversity Factors	31
2.2.2	Environmental Toxins	32
2.2.3	Food Additives/Dietary Factors	32
2.3	Psychosocial Adversity Factors	32
2.4	Interactions Between Neurobiological, Environmental, and Psychosocial Adversity Factors	33
3	Diagnosis and Treatment Indications	35
3.1	Assessment Procedures	36
3.1.1	General Considerations	36
3.1.2	Developmental History	37
3.1.3	Clinical Interview	38
3.1.4	Behavioral Rating Scales	40
3.1.5	Differential Diagnosis/Comorbidities	41
3.1.6	Testing	42
3.2	The Decision-Making Process	43
3.3	Treatment Considerations	45
4	Treatment	47
4.1	Methods of Treatment	47
4.1.1	Psychopharmacology	48
4.1.2	Stimulant Medications	50
4.1.3	Nonstimulant Medications	53
4.1.4	Psychosocial and Psychological Therapies	55
4.1.5	Coaching and CBT	55
4.1.6	Metacognitive Therapy: Time-Management and Organizational-Skills Training	56
4.1.7	Supportive and Family Therapies	57
4.1.8	Neurofeedback and Cognitive-Enhancement Training	57
4.1.9	Psychoeducation	58
4.2	Mechanisms of Action	58
4.3	Efficacy and Prognosis	60
4.4	Variations and Combinations of Methods	63
4.5	Problems in Carrying Out the Treatments	66
4.6	Multicultural Issues	67
5	Case Vignettes	69
6	Further Reading	73
7	References	74
8	Appendix: Tools and Resources	89

complex as symptoms for both disorders are most apt to have persisted over a long period of time.

1.5.3 Anxiety Disorders

It has been estimated that approximately 20% of individuals with ADHD also have been diagnosed with a comorbid anxiety disorder and that individuals with ADHD are more likely to experience anxiety than individuals without ADHD (Larson et al., 2011). Symptoms of anxiety include inattention and impaired concentration, which are core symptoms of ADHD. It also is noteworthy that individuals with generalized anxiety disorder may also appear restless, overactive, and fidgety, which are pervasive symptoms among individuals with ADHD. Thus, in attempting to clinically distinguish between the two disorders, the astute practitioner must evaluate whether such symptoms and behaviors are associated with persistent worries and fears that would be consistent with the core symptoms of an anxiety disorder. Identifying the causality and directionality of these symptoms is paramount in differentiating between ADHD and anxiety disorders. For example, among individuals with ADHD, challenges associated with inattention and completing work are likely to result in anxiety and stress. However, among individuals with anxiety disorders, stress and worry may result in an inability to concentrate and thus result in the inability to complete tasks.

1.5.4 Trauma- and Stress-Related Disorders

There is some evidence in the extant literature that children with ADHD are at greater risk for sexual abuse (for a review, see Wolfe & Kelly, 2021) and many adults seeking evaluation for ADHD may have experienced traumatic events during childhood thereby making it a challenge to distinguish symptoms due to ADHD from PTSD. Irritability, difficulty concentrating, and sleep disturbances, which are core characteristics of PTSD, also are experienced by many adults with ADHD. Given the remarkable symptom overlap between the two disorders, practitioners would be wise to be cognizant of the symptom presentation for both disorders and to ascertain a complete history as to the emergence of ADHD symptoms and traumatic events. The history is important since ADHD is a disorder with a prolonged course with symptoms that are present from childhood while PTSD typically has a more sudden onset and is typically associated with a specific event (for a review, see Wolfe & Kelly, 2021).

1.5.5 Bipolar and Related Disorders

Core symptoms of bipolar disorder may include a high level of energy, restless behavior, impatience, impulsive speech, trouble focusing, and a reduced

Table 1 Adult ADHD Rating Scales	
Rating scale	Description
Clinician-rated scale	
Adult ADHD Clinical Diagnostic Scale (ACDS)	Semistructured interview to evaluate current adult symptoms of ADHD.
Brown Attention-Deficit Disorder Scale (BADDs)	Four-point symptom frequency rating scale. Focuses mostly on symptoms of inattention.
Conners' Adult ADHD Diagnostic Interview (CAA-DID)	Eighteen-item scale that contains separate queries for childhood (retrospective) and adult ADHD symptoms.
Self-report behavior rating scale	
Barkley Adult ADHD Rating Scale-IV	Assesses age of onset of symptoms and associated impairment across settings.
Brown Adult ADHD Rating Scale	Four-point frequency rating scale that assesses cognitive symptoms associated with difficulty initiating and maintaining optimal concentration and arousal.
Copeland Symptom Checklist for Adult ADHD	Sixty-three questions that measure a broad range of cognitive, emotional, and social symptoms on a three-point severity scale.
Adult ADHD Self-Report Scale (ASRS)	Frequency-based scale that matches the 18 items in the <i>DSM-IV</i> . Includes situational "context" for describing symptoms.
Wender Utah Rating Scale	Retrospective five-point severity scale of childhood ADHD symptoms.
Informant symptom inventories	
Barkley Adult ADHD Rating Scale-IV	Assesses age of onset of symptoms and associated impairment across settings.

It is important that practitioners evaluate for symptoms and their level of impairment

It is recommended that clinicians not simply assess for symptoms, but also evaluate the level of functional impairment related to such symptoms. Important domains of impairment that should be assessed include family interactions, peer relationships, and vocational performance. One way to evaluate these domains is through direct observation or functional behavioral assessments. However, these observations or assessments are typically more difficult to complete with adult patients. Therefore, rating scales such as the BAARS-IV: Other-Report can be used to assess the degree of ADHD impairment across different settings such as home and work. Again, it must be underscored that to qualify for a diagnosis of ADHD, the adult must evidence some degree of functional impairment in at least one setting as well as a sufficient number of symptoms for the disorder.

smoke may be a risk factor for ADHD in children (Huang et al., 2021). Notably, findings from these research studies did not identify mechanisms to explain this association.

2.2.2 Environmental Toxins

The results from several studies indicated that some toxins and organic pollutants are associated with symptoms of ADHD, including prenatal exposure to polychlorinated biphenyls (i.e., manufactured compounds that are highly resistant to extreme temperature and pressure) and postnatal exposure to organophosphate pesticides and lead (Thapar et al., 2013; Yolton et al., 2014).

2.2.3 Food Additives/Dietary Factors

Systematic studies that examined food additives and dietary factors have only found associations, and not causal relationships, with ADHD. Specific nutritional deficiencies (e.g., iron, zinc, iodine, polyunsaturated fatty acids) and additives (e.g., sugar, artificial food colorings) have all been linked to ADHD (Del-Ponte et al., 2019; Thapar et al., 2013). Although some study findings suggest there may be dietary interventions that could reduce ADHD symptoms, research to date has not included randomized control trials to support any specific dietary intervention (Breda et al., 2022).

2.3 Psychosocial Adversity Factors

Psychosocial adversity factors have been demonstrated to increase the risk of ADHD or even exacerbate the severity of symptoms of the disorder. In a seminal investigation on this issue, Rutter and colleagues (1975) demonstrated that the aggregate of six risk factors within a family, rather than the presence of any single factor, contributed to psychopathology. Factors included marital discord, low social class, large family size, paternal criminality, maternal mental disorder, and foster care placement. In particular, SES and ethnic minority status have been associated with lower rates of treatment adherence (Fernandez & Eyberg, 2009). Moreover, in the MTA study, a significant association between economic difficulties and barriers to treatment adherence have been clearly demonstrated (Rieppi et al., 2002). Thus, in their work with disadvantaged clients, the practitioner must be acutely aware of the impact of SES on parent engagement with treatment and must take active initiatives to assist families in overcoming such treatment barriers.

Regarding racial and ethnic minority status, while no differences in prevalence rates have been demonstrated, there is some compelling evidence to suggest that African Americans and Latino individuals are identified as ADHD at lower rates and less likely to receive services relative to

3.1 Assessment Procedures

Obtaining collateral information is important for the assessment process

When conducting a comprehensive evaluation to determine whether an adult meets criteria for a diagnosis of ADHD, it is recommended that practitioners obtain as much collateral information as available from other people who know the client well, such as a partner, spouse, or caregiver. According to the *DSM-5*, to qualify for an ADHD diagnosis during adulthood, there must be a history of several hyperactive-impulsive or inattentive symptoms (prior to 12 years of age) during childhood. These criteria allow for the possibility of an individual reporting several symptoms of ADHD but no associated impairment during childhood to then meet diagnostic criteria for ADHD later in life.

Multimethod assessment of ADHD in an adult should include the following components: (1) a thorough developmental history that includes a focus on social, behavioral, and medical history; (2) clinical interviews with the client and if possible the client’s partner or parents; (3) rating scales or checklists completed by multiple informants for the purpose of capturing a broad perspective with regard to behaviors that may be associated with ADHD across settings (home, work, other activities); and (4) an evaluation of comorbid psychiatric diagnoses or learning disabilities.

Other assessment procedures that are more time intensive but may prove helpful in the diagnostic process include home or community observations and psychoeducational or neuropsychological testing for the purpose of assessing learning disabilities. Direct observations of the client’s behavior in the home or recreational settings can be useful because they provide a way for the clinician to gain information about symptom expression in naturalistic contexts. Moreover, they capture an array of behaviors that a single office visit may not reveal. Although this information clearly can be informative to the diagnostic process, many mental health professionals who work with adult clients do not find this activity to be feasible because of the significant time requirement and lack of reimbursement. While psychoeducational or neuropsychological testing does not identify ADHD, these assessments can be useful for identifying other cognitive comorbidities such as specific learning disorders. The tools discussed in the following sections do not represent an exhaustive list of all available ADHD assessment techniques: Instead, these sections examine critical components of an ADHD evaluation and highlight corresponding evidence-based assessment strategies. For a more thorough discussion of the assessment of adult ADHD, see Lovett and Harrison (2021).

3.1.1 General Considerations

Spouses, family members, or close friends may have different viewpoints regarding ADHD symptoms

The diagnostic process ultimately must include assessing whether or not the adult meets criteria according to *DSM-5-TR* or *ICD-10* diagnostic criteria. There are several important issues for clinicians to consider prior to conducting an evaluation of an adult suspected of having ADHD. First, some adults with ADHD, like their younger counterparts, may have limited awareness of their difficulties and the resulting impairment and therefore may even

Table 2 FDA-Approved Medications for the Management of ADHD Symptoms					
Type	Class	Brand name	Form		Common side effects
			Short-acting	Long-acting	
Stimulant medications	Amphetamine	Adderall	✓		Loss of appetite, weight loss, sleep difficulties, irritability, tics
		Adderall XR		✓	
		Adzenys ER		✓	
		Adzenys XR-ODT		✓	
		Desoxyn		✓	
		Dexedrine	Intermediate		
		Dyanavel XR		✓	
		Evekeo	✓		
		Evekeo ODT	✓		
		Mydayis		✓	
		ProCentra	✓		
		Vyvanse chewable		✓	
		Vyvanse capsule		✓	
		Zenzedi	✓		
	Methylphenidate	Adhansia XR		✓	
		Azstarys		✓	
		Aptensio XR	Intermediate		
		Concerta		✓	
		Cotempla XR-ODT		✓	
		Daytrana patch		✓	
		Focalin	✓		
		Focalin XR		✓	
		Jornay PM		✓	
		Metadate CD	Intermediate		
		Metadate ER		✓	
		Methylin chewable	✓		
		Methylin ER	Intermediate		

4.1.4 Psychosocial and Psychological Therapies

The research related to psychosocial and psychological treatments for adults with ADHD is more limited than research related to pharmacological approaches for treating adult ADHD. Findings from a recent meta-analysis of the long-term efficacy of psychosocial treatments for adults with ADHD revealed that treatment groups evidenced greater improvement than control groups in self-reported total ADHD symptoms, inattention, and hyperactivity/impulsivity, and on a measure of global functioning, and these gains were generally maintained for at least 12 months (López-Pinar et al., 2018). The most employed and studied psychosocial and psychological therapies for adults with ADHD include coaching and CBT, metacognitive therapy (e.g., time-management and organizational-skills training), and supportive and family therapy. Also reviewed below are neurofeedback and cognitive-enhancement therapies (see Section 4.1.8) given their increasing use for treating ADHD among young people and adults. Finally, aspects of psychoeducation (Section 4.1.9), which should always be a component of ADHD treatment, are described.

Psychosocial and psychological treatments may be useful for adults with ADHD

4.1.5 Coaching and CBT

Coaching and CBT, which can be delivered in individual and group formats, share many components in that both modalities seek to provide structure for the adult suffering with ADHD and focus on teaching coping and problem-solving skills for identified problems. When working with an adult with ADHD, the following coaching and CBT strategies may be used as part of a treatment plan: (1) helping the client to gain acceptance of the disorder; (2) strengthening their time-management skills; (3) setting realistic goals; (4) improving their organizational skills across settings; (5) addressing difficulties in interpersonal relationships; (6) develop behavioral goals for starting and completing tasks; and (7) helping clients to better understand the association between their emotional reactions and ADHD (Kooji et al., 2010). Strategies more directly associated with CBT include helping clients identify and modify negative cognitions associated with avoidance of tasks (“As usual, this is too hard to do”), lack of motivation (e.g., “I am too lazy”), and negative affect (e.g., “I am no good”) (Safren et al., 2005). Therapists then assist the client in challenging these dysfunctional cognitions with the goal of diminishing hopelessness as well as improving motivation. A systematic review of psychosocial treatments of ADHD in adults concluded that CBT was the most effective treatment modality for reducing symptoms of ADHD as well as comorbid symptoms of anxiety and depression (Vidal-Estrada et al., 2012). A recent systematic review and meta-analysis indicated that the available evidence supports a recommendation for CBT for adults (Tourjman et al., 2022). For an in-depth review of CBTs for adults with ADHD, see Knouse (2015).

Case Vignettes

Julie (college student)

Julie is a 19-year-old Caucasian student in the second term of her first year at college. Although she reported expending a great deal of effort in her coursework, Julie had received failing grades on her midterms in two history courses. She made an appointment at the counseling center on campus to discuss her academic difficulties. Julie had always been interested in history and had been considering a career in academia but, after her struggles with her history classes, she wondered whether she needed to change her major and professional plans. Julie described an active social life and has felt the strain of competing academic and social pressures.

During elementary school, junior high, and high school, Julie consistently struggled in class with inattention, distractibility, and disorganization of materials. She would often daydream during class and her teachers needed to frequently redirect her attention back to the course material. Fortunately, Julie attended a small private school with a low student–teacher ratio, so her teachers were able to provide her with a significant amount of support for staying focused and engaged during class. Julie was always seated next to a peer that could help her stay on task and repeat instructions that she missed.

Julie reports having ongoing difficulties with organization. She noted trouble keeping track of important papers, and often losing clothing or other items. Julie’s mother was very involved in her life during the elementary and secondary school years. Julie reports that her mom helped her maintain a daily assignment book, organize her class materials, clean her room, and complete homework. Without her mom’s daily support, Julie found the first term of college to be much more challenging than high school, and her academic performance in college has been a disappointment to her. However, during her initial term, she attended the college’s freshman seminar program, and received quite a bit of individual attention, which she says was quite helpful. During the current term, she is enrolled in two large lecture classes and two smaller seminar classes. Although some of the material from lectures is accessible in the textbooks, Julie feels she has a difficulty time maintaining her attention during the lectures and it is difficult taking adequate notes. She feels competent during small interactive classes and has received high grades for her assignments in these classes but has failed the multiple-choice tests that comprise a major portion of her grade in both courses. Julie is especially