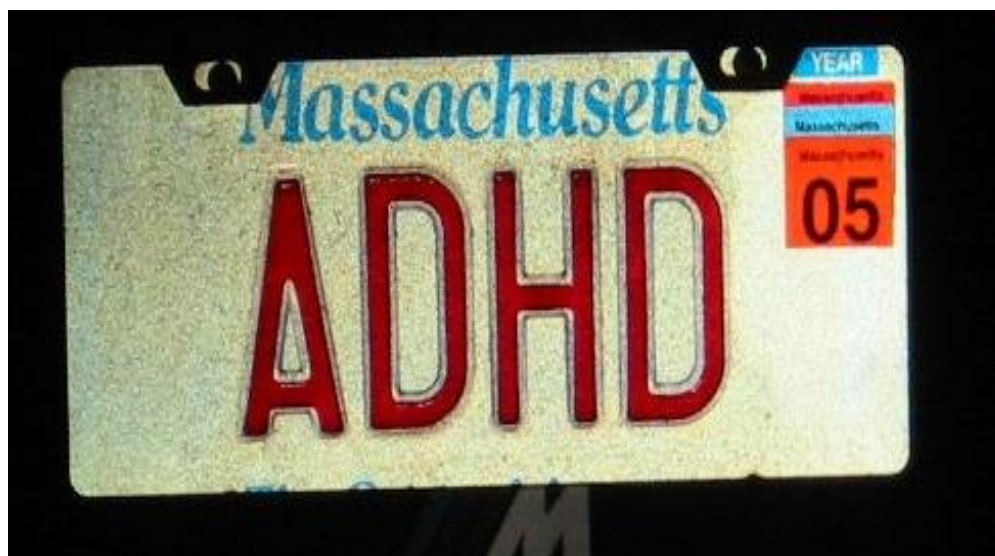




CBT and Psychosocial Treatment for ADHD

Aude Henin, Ph.D.

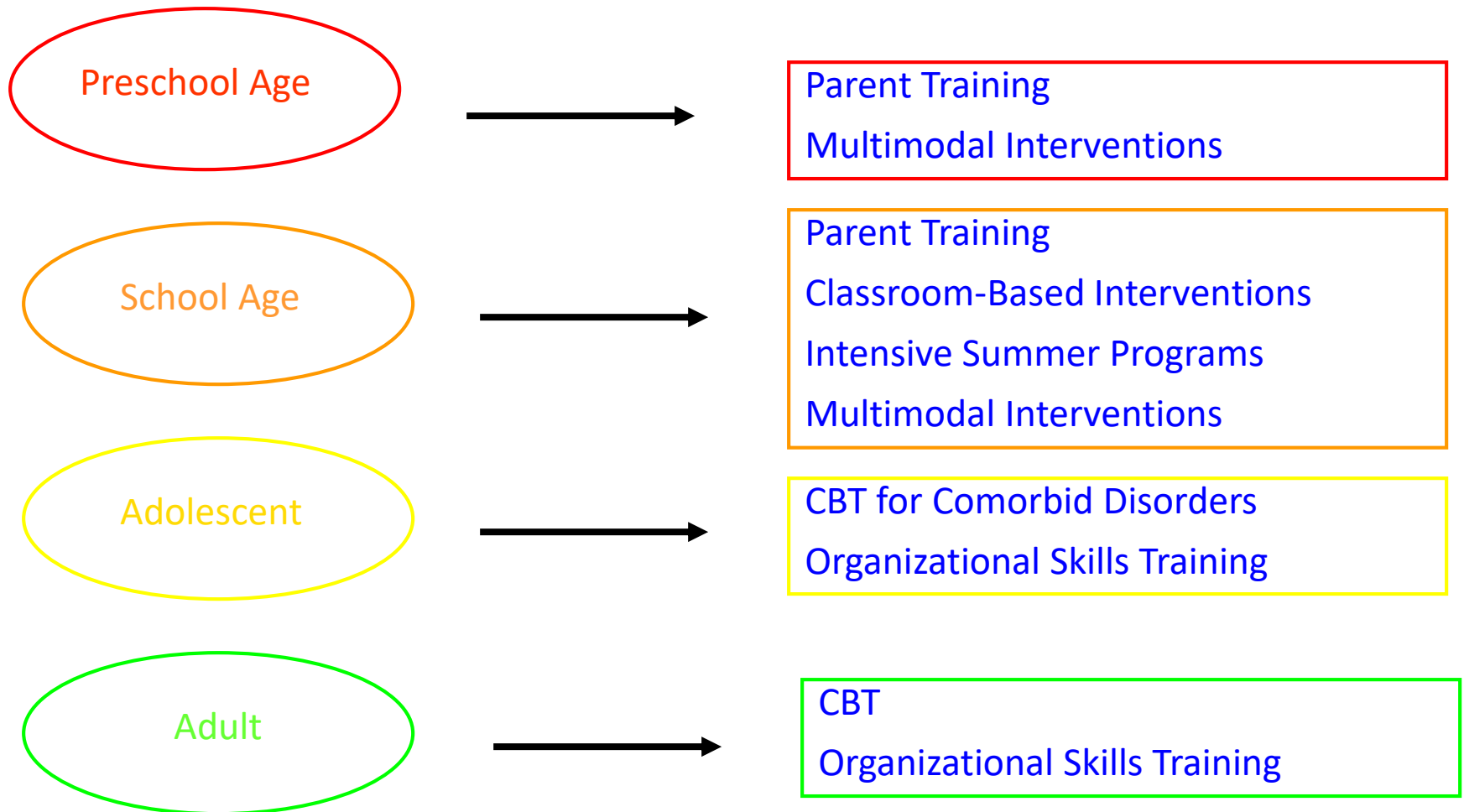


Disclosures

I have the following relevant financial relationship with a commercial interest to disclose:

Oxford University Press (Royalties)

Developmental Perspective on CBT Interventions



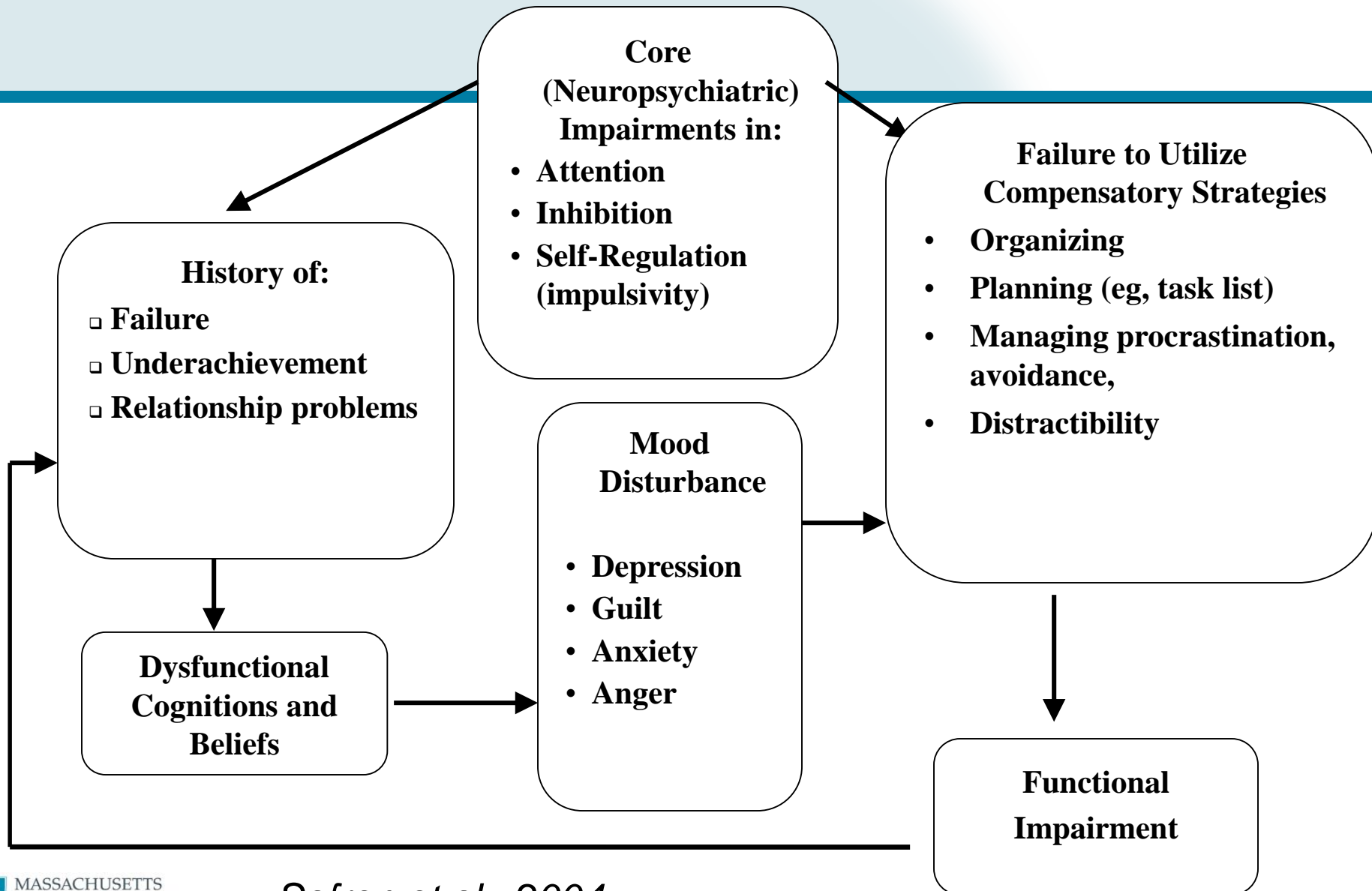
Why CBT if ADHD is a neurobiological disorder?

- Although medications help, they do not teach compensatory skills that individuals with ADHD may not have learned
- Medications help turn the volume down on symptoms
 - But a “responder” in medication trials = 30% reduction in symptoms
 - 20-50% of patients are “non-responders” in first line medication trials



References for psychopharmacology studies: Wender, 1998; Wilens et al., 1998, 2002

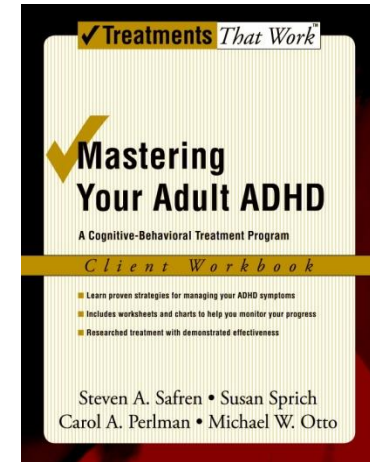
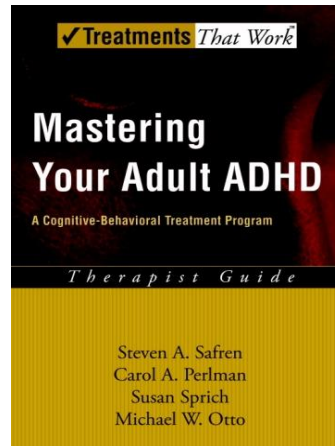
Cognitive-Behavioral Model of ADHD



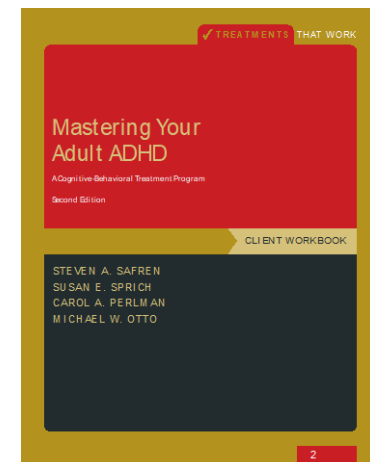
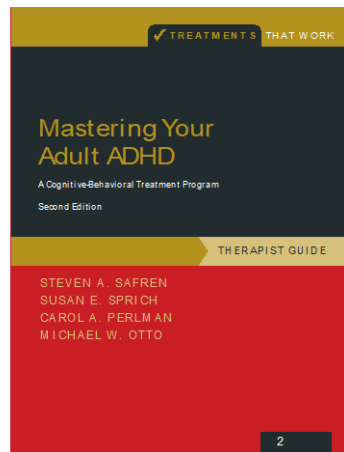
Safren et al., 2004

MGH Treatment Program

1st Editions, published in 2005:



2nd Editions, published in 2017:



Treatment Modules

1. Organizing and planning
2. Coping with distractibility
3. Cognitive restructuring

optional

4. Application to procrastination
5. Involvement of significant other

MODULE 1: ORGANIZING AND PLANNING



Module 1: Orientation To The Treatment

- Each session has an agenda – like taking a course
- Review of previous modules and symptoms every session
- New skill almost every session
- Not all skills can be learned at once – makes it harder
- Practice makes perfect – need to practice long enough for it to be habitual
- Adherence to treatment – **plan for attention and distractibility during sessions**



Module 1: Begin Calendar and Task List System

- Calendar – develop and agree on a system (no such thing as the best system, but need a workable one)
- Task list – notebook, app on phone
- Consolidate **EVERYTHING** into calendar and task list/notebook – no loose papers, appointment slips, etc.
- Use this system long enough to become a habit



Managing Multiple Tasks

- Organization of multiple tasks (A,B,C)
- Managing overwhelming tasks: breaking large tasks into multiple do-able steps
 - 1. Choose a complex task from to-do list.
 - 2. List the steps you must complete.
 - 3. Make sure each step is manageable. (e.g.,
If task is “buy house” it will never get completed.
If it is “look up realtors in town” it is much more likely to get completed)
 - 4. List every individual step on your daily to-do list.



Prioritizing Tasks

- **“A” Tasks:** most important
- **“B” Tasks:** less important, long-term
- **“C” Tasks:** lowest importance
 - May be easiest to complete & therefore most attractive to client
- **Careful not to rate all as A’s**
- **Complete “A” items first before moving on to “B” items, and so on**



Module 1: Five Steps in Problem-Solving

- 1. Articulate the problem.
- 2. List all possible solutions.
- 3. List pros and cons of each solution.
- 4. Rate each solution.
- 5. Implement the best option.



Problem Solving Form: Selection of Action Plan

Possible Solution	Pros of Solution	Cons of Solution	Overall Rating of Solution (1-10)

MODULE 2: DISTRACTIBILITY



Module 2: Coping with Distractibility

- Decide on a reasonable length of time that patient can expect him or herself to focus on a difficult or unpleasant task
- Distractibility delay (Apply “chunks” from problem solving that coincide with the length of one’s attention span for difficult or boring tasks and set your timer)
- If distractions occur during this time, write them down and go back to task at hand
- Check in with distractions when timer goes off



Module 2: Coping with Distractibility

- Modifying the environment:
 - Look for distractions in environment and eliminate or reduce them in advance to “set the stage” for success

Using Reminders & Alarm Device

- Set alarm on phone or computers to go off at regularly scheduled intervals (every half hour)
- “Am I doing what I am supposed to be doing or did I get distracted?”

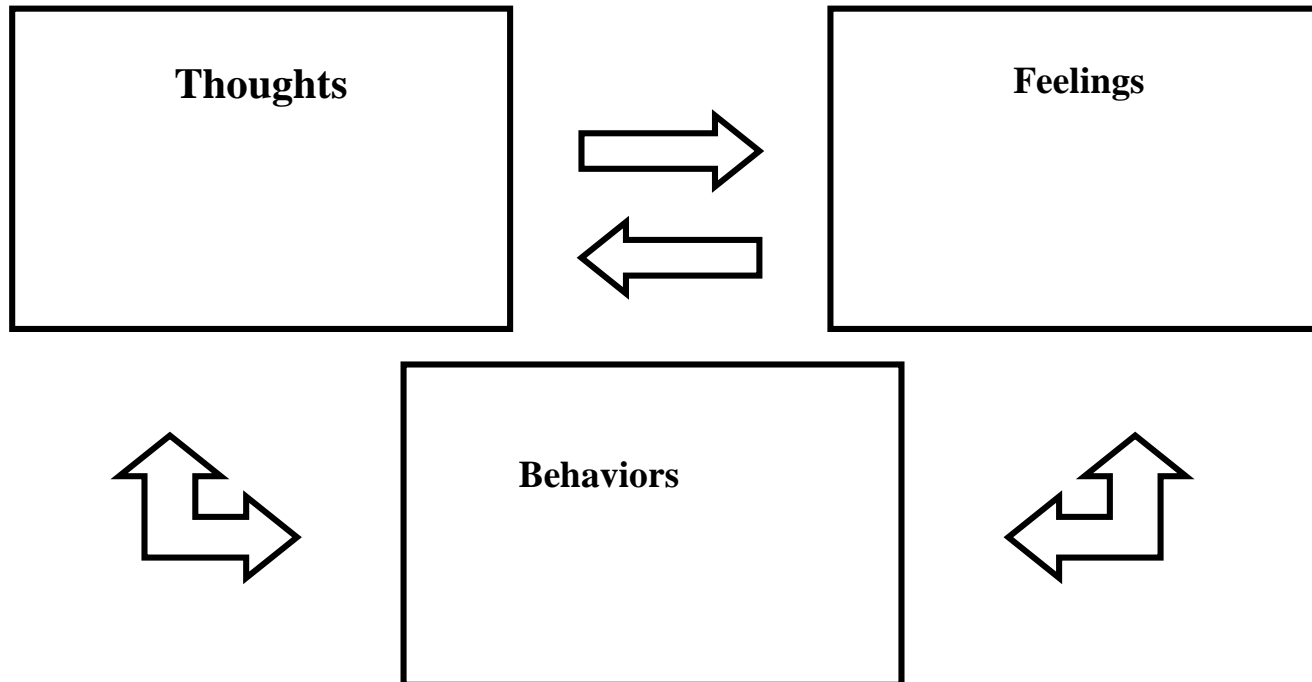


Keeping Track of Important Objects

- Ask client to think of difficulties keep track of important objects (keys, wallet, notebook, phone)
- Find specific place in house where these objects will be kept
 - Stress the importance of placing item in its appropriate place immediately
- Involve other family members



MODULE 3: COGNITIVE RESTRUCTURING



Cognitive Restructuring

Time and Situation	Automatic Thoughts	Mood and Intensity	Thinking Error	Rational Response
<p><i>Preparing a report for work</i></p>	<p><i>I have to do all of this today</i></p> <p><i>I must do this perfectly.</i></p> <p><i>If I do not finish my boss will be upset.</i></p> <p><i>If the project is not perfect and my boss is upset, I will lose my job</i></p> <p><i>I am worthless</i></p>	<p><i>Overwhelmed (80)</i></p> <p><i>Anxious (75)</i></p> <p><i>Depressed (60)</i></p>	<p><i>All or nothing thinking</i></p> <p><i>Jumping to conclusions (mind reading)</i></p> <p><i>Jumping to conclusions (fortune telling),</i></p> <p><i>Catastrophizing</i></p>	<p><i>I can probably get through this if I break it down into steps, and take breaks.</i></p> <p><i>Nobody is perfect, I have done similar tasks, though they were hard, and they were okay</i></p>

Overly Positive Thinking Can Have Negative Consequences...

- “Red Flag” Thoughts:
 - “I don’t need to worry about this.”
 - “It will all work out because I’m a good person.”
 - “I can get one more thing done before I leave.”
 - “I HAVE to do this interesting thing RIGHT NOW.”
- Can precipitate:
 - Avoidance of skill use
 - Failure to consider realistic consequences
 - Impulsive responding
 - Negative reinforcement of overly positive thinking via immediate distress reduction

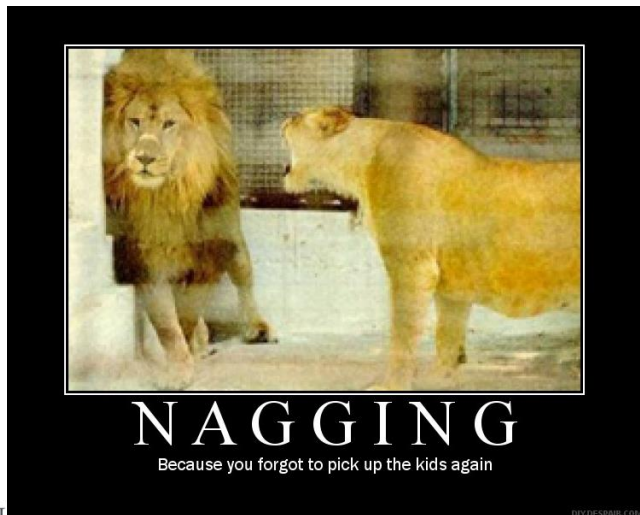


Managing Procrastination

- Using skills learned earlier in treatment and applying them to topic of procrastination
- Identifying triggers for procrastination
 - Is the task too large?—break it down into smaller chunks
 - Are you unsure where to start?—use problem-solving worksheet
 - Unhelpful cognitions?—use thought record to identify and challenge negative thoughts
- Use MI approach (short/long term pros & cons)
- Develop plan for coping with procrastination

Optional Module: Session with Significant Other

- Discuss family member role (reminders, “coaching” but not nagging)
- Overview of the treatment
- Making a plan as to how family member can support the patient in their treatment



Application to Adolescents

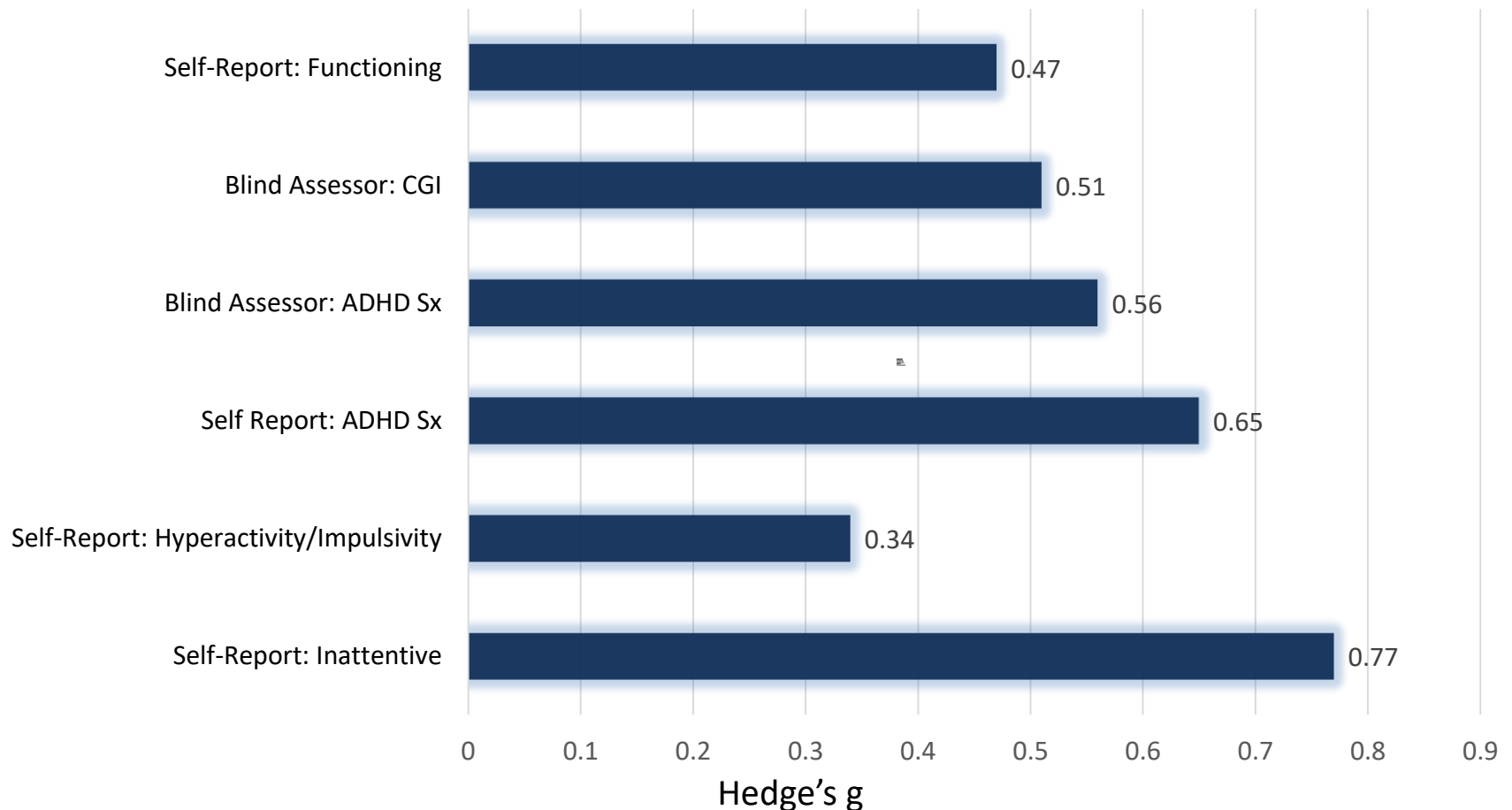
- We adapted our treatment program for use with adolescents aged 14-18
- Greater involvement of parents
- Increased emphasis on use of technology
- Decreased emphasis on traditional cognitive therapy
- Use of examples relevant to adolescents (school, homework, interpersonal issues)

Meta-analysis of CBT for Adults with ADHD

- 32 studies met inclusion criteria
 - 18 controlled trials (one with 2 active treatment conditions)
 - 12 open trials (two with 2 treatment groups)
 - 2 controlled trials with effect sizes only pre-to-post

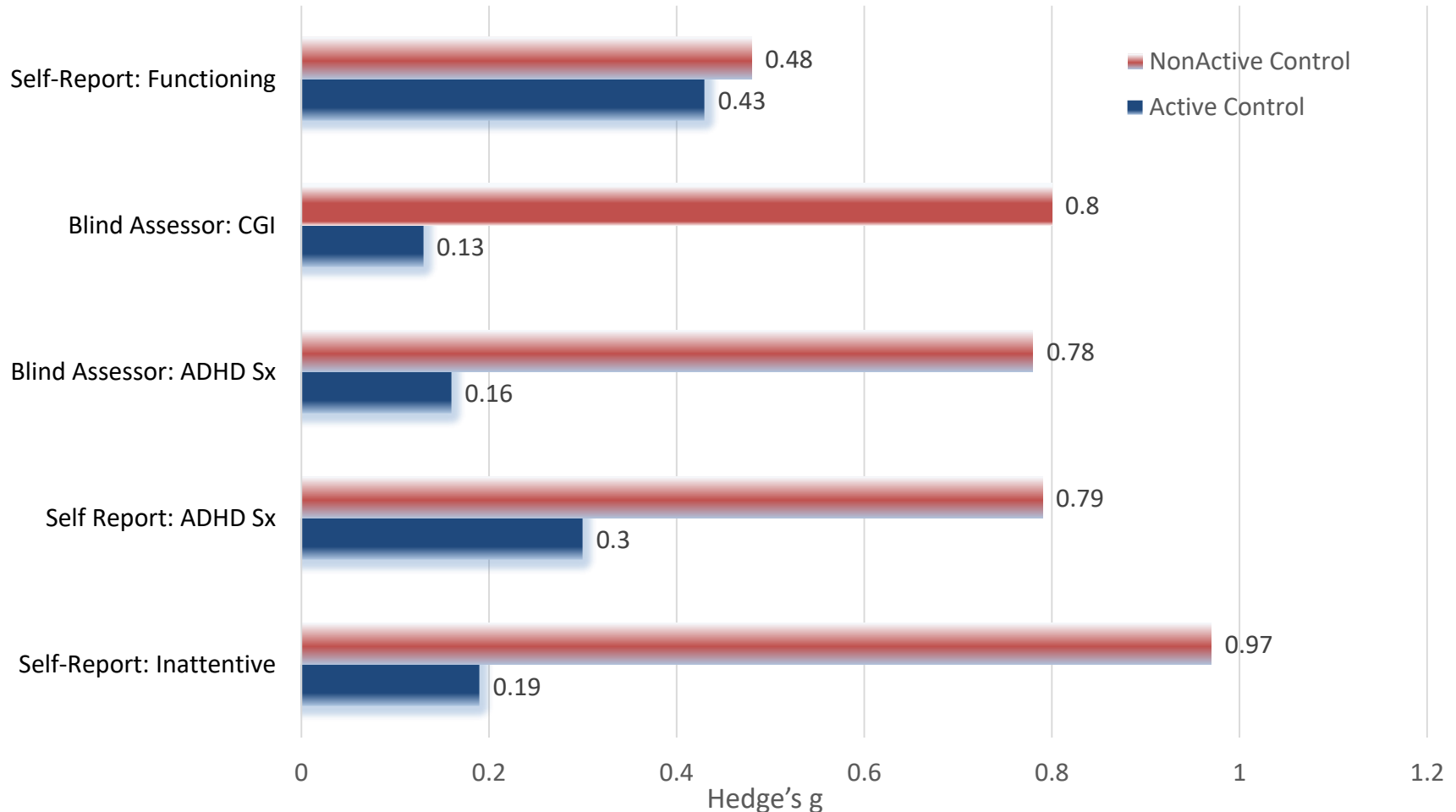
Knouse et al., 2017, JCCP 85(7): 737-50

Effect Sizes for Treatment vs. Control



Knouse et al., 2017, JCCP 85(7): 737-50

Effect Sizes for Moderator Analysis: Type of Control Condition



Knouse et al., 2017, JCCP 85(7): 737-50

Study Results



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Behaviour Research and Therapy 43 (2005) 831–842

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Cognitive-behavioral therapy for ADHD in medication-treated adults with continued symptoms

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Received 26 February 2004; received in revised form 6 July 2004; accepted 9 July 2004

Cognitive Behavioral Therapy vs Relaxation With Educational Support for Medication-Treated Adults With ADHD and Persistent Symptoms

A Randomized Controlled Trial

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Context Attention-deficit/hyperactivity disorder (ADHD) in adulthood is a prevalent, distressing, and impairing condition that is not fully treated by pharmacotherapy alone and lacks evidence-based psychosocial treatments.

Objective To test cognitive behavioral therapy for ADHD in adults treated with medication but who still have clinically significant symptoms.

Design, Setting, and Patients Randomized controlled trial assessing the efficacy of cognitive behavioral therapy for 86 symptomatic adults with ADHD who were already being treated with medication. The study was conducted at a US hospital between November 2004 and June 2008 (follow-up was conducted through July 2009). Of the 86 patients randomized, 79 completed treatment and 70 completed the follow-up assessments.

- Study 1 (2005): Pilot RCT (N=31) comparing CBT to Continued Psychopharmacology alone

- Study 2 (2010): Full scale efficacy trial (N=86) comparing CBT to Relaxation With Educational Support Published in JAMA

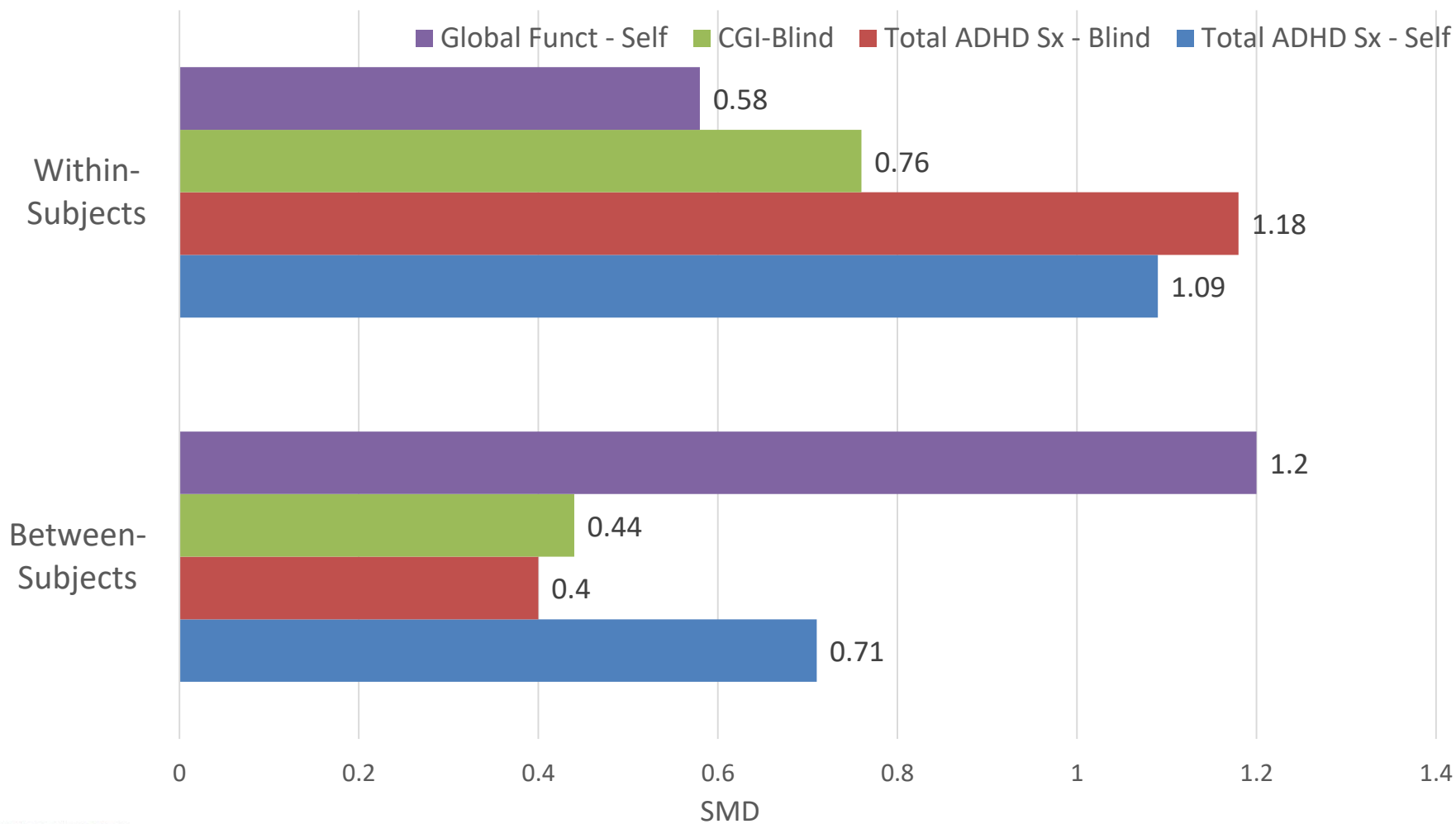
Efficacy Trial (Safren et al., 2010)

- 86 Participants
- Randomly assigned to CBT or Relaxation with Educational Support (RES)
- All participants on stable medication
- 12 week manualized CBT or RES
- Lower IE rated ADHD Symptom Severity and CGI in CBT group
- More responders in CBT group
- Results maintained at follow-up

Metacognitive Therapy for ADHD (Solanto et al, 2012, American Journal Of Psychiatry)

- 12-week manualized group therapy for time management, organizing, and planning
- N=86, stratified by medication use
- Compared to supportive psychotherapy groups
- Significantly greater improvement on self report, IE ratings of symptoms, and collateral report in MCT group
- Greater proportion of responders in MCT group than supportive psychotherapy

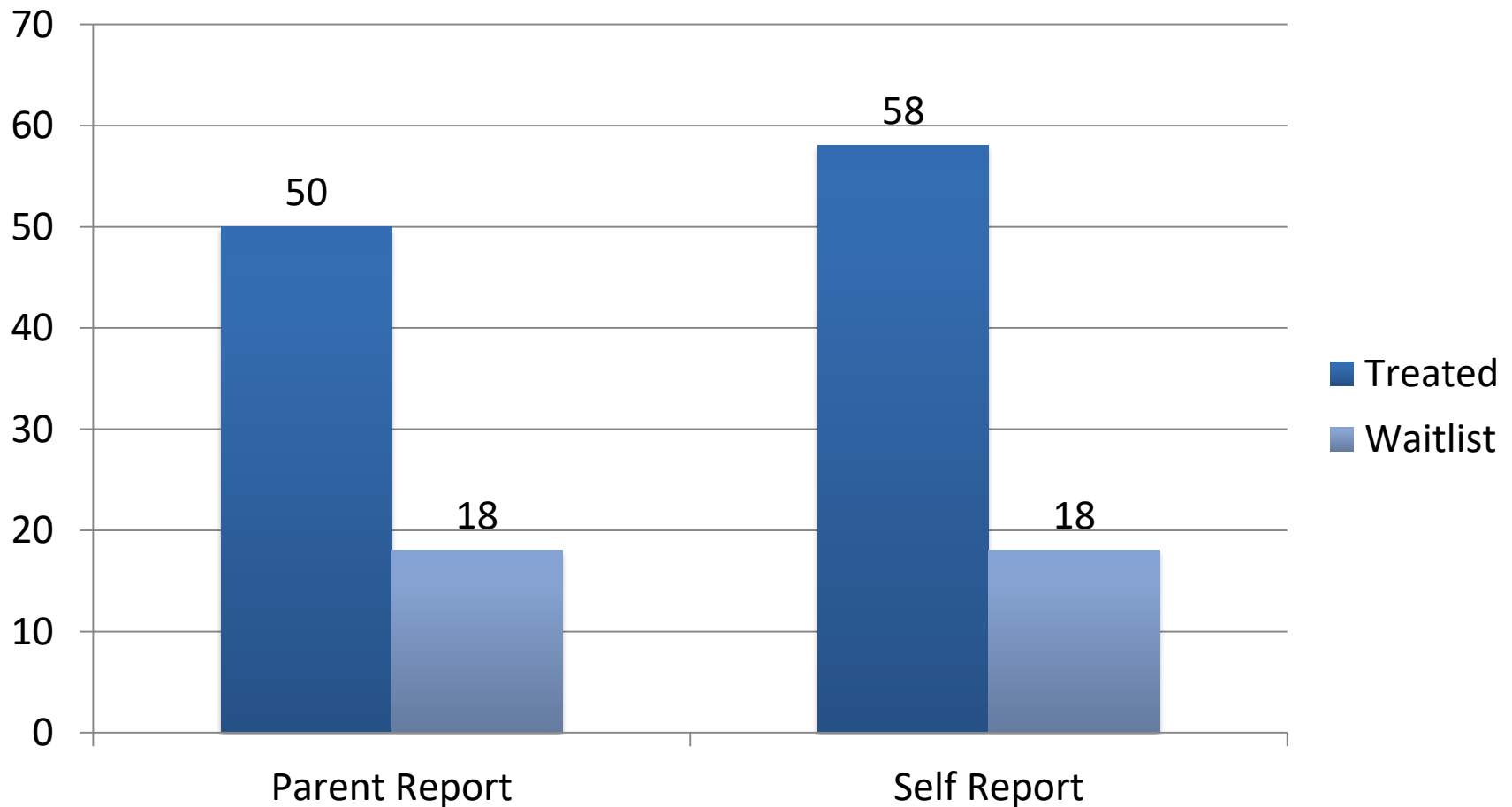
12-Month Outcomes of CBT for Adult ADHD (N=680)



A randomized controlled trial of cognitive behavioral therapy for ADHD in medication treated adolescents (Sprich, et al., 2016, Journal of Child Psychology and Psychiatry)

- 46 adolescents with ADHD on medication for ADHD
- Randomly assigned to CBT or wait list in a crossover design
- 12 sessions (2 with parents) plus 2 optional parent-only sessions
- Participants who received CBT had significantly lower scores on ADHD rating scale by IE-rated parent and adolescent report
- Significantly greater proportion of responders in CBT than wait list by parent and adolescent report
- Results demonstrate initial efficacy for CBT for medication-treated adolescents with ADHD

Results of Adolescent Study: Responder Status ($\geq 30\%$ decrease on ADHD Rating Scale)



Conclusions

- CBT has documented efficacy for adult ADHD
- Preliminary results are promising for adolescent ADHD
- More work is needed in adolescent populations using larger sample sizes, with individuals who are not on medications and comparing CBT to attention matched control groups

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