Working with Adults with Attention Deficit/Hyperactivity Disorder

From an Adlerian Perspective

Presented to

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Abstract

Working with adults with AD/HD presents special challenges and opportunities for an Adlerian clinician. Successful psychotherapy and coaching for adults with AD/HD require a thorough understanding of the disorder, possible medications, how the symptoms differ from children to adults, and that each individual with AD/HD can be affected by in a variety of ways. The psychotherapist/coach and client must establish a relationship where the client feels that past behaviors are not judged and the goals they set together are realistic and attainable. The Adlerian psychotherapist, by uncovering the past through the process of lifestyle assessment, affords the client the opportunity to move from negative feelings about the past to optimism for the future. Coaching allows the client to establish practical skills to overcome the frustrations of disorganization, poor time management, and other challenges specific to each individual. With hard work and encouragement an adult with AD/HD can achieve success in all of the Adlerian life tasks.
Working with Adults with Attention Deficit/Hyperactivity Disorder from an Adlerian Perspective

Attention-deficit/hyperactivity disorder (AD/HD) has been recognized for over a century. In 1902 George Still theorized that there were some cortical differences in children who exhibited disruptive behavior. He believed that the symptoms were due to a lack of moral control as well as a personal failure on the part of the individual to conform to current behavior expectations. Fortunately, today most knowledgeable professionals accept the strong scientific evidence that AD/HD is, in most cases, a genetic disorder that affects the neurobiology of the frontal lobes (Faraone, 2004). Barkley (2010, p. 10) defines Attention Deficit Disorder as “a neuropsychiatric disorder that usually becomes apparent in early childhood. Its symptoms of hyperactivity, impulsivity, and/or inattention often persist across a lifespan.”

Research indicates that at least fifteen genes can contribute to the hereditary nature of AD/HD (Barkley, Murphy, & Fischer, 2008). While the triggers that cause the development of AD/HD remain unclear, Biederman, et al. (1995) found that 70% of children with AD/HD have parents with the disorder.

It is clear that AD/HD is not an insignificant disorder. It can cause serious disruption in the lives of the individuals who suffer from it. It can be a significant impediment to finding success in the Adlerian life tasks. Adler specified the three life tasks as work, love, and community (Oberst & Stewart, 2003). Work can be occupation, school, or a vocation. Love is a long term and emotional relationship with another individual. Lastly, community is being part of and contributing to a family, a community, or society. With the help of a team of knowledgeable and talented professionals as well as appropriate medication, psychotherapy, and coaching, AD/HD
can become a challenge to be successfully addressed in all of the life tasks rather than a prescription for disappointment and defeat.

AD/HD is currently described by the criteria set forth in the DSM-IV-TR, in the section of the manual reserved for disorders usually diagnosed in infancy, childhood, or adolescence. Those criteria were developed based on behavior of children (most often boys) for the diagnosis of children (Barkley, Murphy, & Fischer, 2008). Only in the last twenty years has AD/HD been recognized as a lifespan disorder: it appears in adults as well. It is almost always an inherited disorder often remaining undiagnosed, with symptoms varying with time and according to the individual’s age and life situation. The degree of impairment varies greatly and can be hidden or masked by a variety of maladaptive coping mechanisms (Tuckman, 2007).

For an individual with AD/HD all aspects of life can be challenged. The disorder is an insidious enemy that it is unseen to the world at large appearing to be behavior that is most easily explained as a lack of self-discipline or lack of self-control. Individual adaptation to AD/HD is often problematic for those who have had no assistance learning to cope with the disorder in healthy ways. An Adlerian approach looks at the entire individual, their lifestyle over time, rather than at the current discrete symptoms. Adlerian psychotherapists offer encouragement, assist in identifying mistaken beliefs, and work to clarify the private logic that can impede movement toward the development of a healthy lifestyle in an effort to achieve satisfaction in all of the life tasks.
AD/HD in Children and Adults

To best understand AD/HD in adults it is helpful to understand what it looks like in children and how it transforms as the individual grows from childhood to adolescence and then adulthood.

**AD/HD in Children**

AD/HD is the most researched and most commonly diagnosed psychiatric disorder in children. It is believed to be the neurobehavioral disorder often causing restlessness, inability to pay attention, and impulsiveness. No single cause of AD/HD has been identified, although, as noted above, research indicates a strong genetic link. Additionally, maternal smoking or substance abuse, premature birth, extreme stress during pregnancy, traumatic brain injury, and early exposure to lead are also possible contributors to AD/HD (American Psychiatric Association, 2009; Barkley, 2010). It is widely believed that low activity in the frontal area of the brain reduces the ability of children with AD/HD to inhibit behavior. These children experience difficulties with attention, impulse control, and activity level (Barkley, 2005). They show limited ability to inhibit responses to the world around them and to situations or events that are generally manageable to those without AD/HD. Barkley (2005) suggests that AD/HD might be defined as developmental *disorder of self-control*, due to the diminished ability of the orbital-frontal cortex of the brain to regulate impulse control. Research over the last two decades definitely contradicts the belief that those with AD/HD could regulate their behavior by self-control and free will (Barkley, 2005).
Diagnosis

Studies indicate that about 5-8% of school-age children have AD/HD. Boys are diagnosed at a ratio of 3 to 1 to girls. It is believed that girls may be under-diagnosed as a result of less aggressive behavior (Barkley, 2005). Because girls with AD/HD seldom cause disruption in a classroom setting their symptoms go unnoticed and as a result, untreated.

One of the challenges for both children with AD/HD and their parents is that the symptoms of AD/HD may change as the child grows. What is problematic for a seven year old may be entirely different at the age of fifteen. While the diagnosis of AD/HD remains, the demands of peer interaction, school, and family present new and often challenging situations which require an entirely new set of coping skills. As life becomes more complicated, with ever-increasing demands, the struggle to cope can become ever more taxing and children’s behavior is often misunderstood and judged as unacceptable.

There are a number of AD/HD rating scales which can be helpful in identifying symptoms. However, since each child is different, diagnosis should be done by a clinician with specific training in AD/HD and children (Wadsworth & Harper, 2007). Additionally, consistent with the DSM-IV-TR (2000), input must be garnered from parents, teachers, and other professionals who interact with the child regularly in order to assess behavior under various situations which may change as the child grows into adolescence and the adulthood (Brown, 2005).

Treatment

Currently the symptoms in children are best treated with a three pronged approach: using medications, psychotherapy, and coaching for both children and parents in an effort to establish a structured environment which gives order and understanding to an often chaotic world
(Weyandt, 2007). The support of school staff is also critical to the success of a student confronting AD/HD. A scheduled review process should be in place to identify issues as they become apparent.

Alternative approaches to treatment include caffeine, biofeedback, specialized diets, and sensory integration training, to name a few. While they may prove helpful on an individual basis, their efficacy is not supported by scientific research (Weyandt, 2007). Due in part to the change in symptoms as children mature, the symptoms of AD/HD are varied, confusing, and often unrecognized. As a result of various psychosocial issues many children learn to mask symptoms as they negotiate their way through grade school, middle school, and high school often making an accurate diagnosis difficult.

Misdiagnosis presents a tremendous loss to children and adolescents. Underachievement in school, along with the frustrations associated with failure, lack of impulse control can lead to substance abuse, poor scholastic achievement, anger management issues, and other social problems stemming directly from diminished executive functions. Underachievement may be caused by problems with executive functioning, such as the inability to organize, plan, and fulfill goal-oriented tasks (Barkley, 2010). Comorbidity may include learning disabilities, anxiety disorders, conduct disorder, oppositional defiant disorder, and/or mood disorders. These conditions must be either ruled out in the diagnosis or treated in a hierarchical order to ensure the proper and complete care of the clients. This work is best done by a coordinated team of dedicated medical and psychological professionals as well as school and family members.

\textit{AD/HD in Adults}

According to Monastra, “…it is becoming clear that AD/HD is associated with specific abnormalities of at least four genes and that such abnormalities appear to be expressed in
anatomical differences in the frontal lobes, basal ganglia, corpus callosum, and cerebellum, as well as neurochemical and neurophysiological anomalies of the brains of individuals diagnosed with AD/HD” (Monastra, 2007, p.36). AD/HD is difficult to define as a single disease with a specific cause. Research indicates that “AD/HD appears to be associated with a dysregulation of the activation and interaction of multiple cortical and subcortical regions involved in various attentional functions, as well as the organization, regulation, and expression of behavioral response to situational demands” (Monastra, 2007, p.36).

**Diagnosis**

There is currently some debate on the implication of the term *executive function* and how it should be assessed relative to AD/HD and to other psychiatric disorders. According to one school of thought, assessment for AD/HD is best accomplished in a testing environment using various tools such as those examples in the meta-research by Nigg and colleagues (2005). Those tools were developed and are used to assess cognitive management functions for individuals with schizophrenia or traumatic brain injury particularly of the prefrontal lobe. However, if *executive function* is measured by these types of tests only approximately 30% of those diagnosed with AD/HD would emerge as having significant executive function impairment (Brown, 2006).

A second school of thought asserts that AD/HD cannot be measured precisely by neuropsychological instruments such as *The Wisconsin Card Sorting Test, the Rey-Osterreith, The Tower of Hanoi/London*, and others developed for the purpose of testing executive functions. Since AD/HD affects an individual in different ways at different times as circumstances vary, it must be evaluated by looking at daily life tasks over time and in various settings. As the definition of *executive function* continues to evolve, most researchers agree that executive function should be used to refer to brain circuits that prioritise, integrate, and regulate
other cognitive functions. It is the mechanism for self-regulation (Vohs & Baumeister, 2004). Brown (2005) presents a metaphor for executive function as “the conductor of a symphony.” No matter how well the musicians play their individual instruments, they will not produce good symphonic music without a skilled conductor to select what piece is to be played and to ensure the subtle, dynamic, intergrated functioning of the orchestra. Brown (2005) explains, “All neural networks are not created equal; some networks manage other networks. Certain neural networks—some in the prefrontal cortex, some in the limbic region, and others in the cerebellum—serve to coordinate and integrate cognitive functions of the brain.”

Because an objective test to verify a diagnosis of AD/HD may not exist (Torgersen, Gjervan, & Rasmussen, 2006), diagnosis in adults in some cases is based on previous childhood diagnosis. Another diagnostic challenge is a possibility of comorbid conditions. Comorbidity has been indicated in up to 34% of adult women with AD/HD and in 50% of men (Biederman, Faraone, Monuteaux, Bober, & Cadogen, 2004). Affective disorders, learning disabilities, obsessive-compulsive disorder, personality disorders, and drug or alcohol abuse are common comorbid disorders which share symptoms with the vast majority of adults diagnosed with AD/HD (Monstra, 2007). These conditions can obscure accurate diagnosis. Another challenge may be presented by medical conditions mimicking cognitive and behavioral symptoms of AD/HD. Individuals with hypoglycemica, certain allergies, and other metabolic or nutritional disorders may complain about inattention, impulsivity, and/or hyperactivity. Additionally, Torgersen et al. (2006) speculated that those adults not identified with AD/HD as children exhibit more severe symptoms of comorbidity.

The symptoms of AD/HD may seem normal to adults who have lived their lives attempting to meet the demands of everyday life tasks unsuccessfully. The immediacy of the
current anxiety and depression bother them more. Consequently the comorbid conditions can take precedence over the underlying AD/HD (Wadsworth & Harper, 2007).

Numerous assessments are available to determine the presence of AD/HD in an adult. The include Continuous Performance Tests (CTSs), developed to measure attention lapses, vigilance, and impulsivity (Woods, Lovejoy, & Ball, 2002), Stroop Tasks, The Trail Making test, and the Wisconsin Card Sorting Test, among many others. Woods et al. (2002) found that the most efficient and reliable assessment that differentiate adults with AD/HD from those with our are Stroop Tasks, verbal letter fluency, auditory-verbal list learning, and continuous performance tests (p. 28).

AD/HD in adults is indicated in three major symptom areas, hyperactivity, impulsivity, and inattention. Inattention appears to be the most persistent of the three moving into adulthood (Muller, Gimbel, Keller-Pliesnig, Sartory, Gastpar, & Davids, 2007). These areas of impairment can cause challenges and life disruptions in several key components of an adult’s life. Monastra (2007) refers to nine domains in which patients display atypical development: alerting, concentration, behavioral inhibition, affective control, socialization, memory, language processing, work retrieval, and fine and/or gross motor development. Adults diagnosed with AD/HD do not usually have impairments in all areas, they almost always have difficulty in at least three of the nine.

Symptoms of AD/HD present themselves differently in adults than in children. Hyperactivity becomes an inner restlessness; an adult who might have been considered hyperactive as a child will now appear as a workaholic. Poor time management becomes apparent. Family tension due to the constant need to be active becomes problematic. Lack of impulse control may manifest as intolerance to frustration, frequent job changes, difficulty with
relationships, lack of concern while driving, erratic temper, and a variety of addictions, including alcohol, drugs, gambling, or shopping (Barkley, 2005). In adults the symptoms of AD/HD of the Inattentive Type can result in lack of attention while reading, in meetings, or when completing paperwork. Procrastination can affect all areas of an adult life along with poor time management and lack of organizational ability (Barkley, 2005). The diminished ability of executive function becomes most problematic with adults as their lives become more complex, requiring working memory, self-regulation, and problem solving.

According to Barkley (2010) adults with AD/HD tend to experience cognitive impairments or deficits in executive functioning which result in such symptoms as disorganization, forgetfulness, failing to plan ahead, dependence on others for maintaining order and goal-direction, impulsive decision-making, and problems keeping promises and commitments to others. While these symptoms are found in other disorders, he adds, they are most frequently found in concert in clients with AD/HD.

Brown’s (2006) list of executive functions impaired by AD/HD is similar to Barkley’s however he defines six symptom clusters; activation, the ability to organize, prioritize, and initiate work; focus, the ability to sustain attention or effectively move from task to task; effort, the ability to regulate alertness; emotion regulation allows the individual with AD/HD to manage frustration and regulate emotions; memory, involves working memory and recall; action, refers to monitoring and self-regulating action. These symptom clusters operate “in rapidly shifting interactive dynamics, usually quite unconsciously,” as the individual attempts to perform a wide variety of daily tasks. The person “must regulate the self using attention and memory to guide action” (Brown, p.39).
Women. As mentioned earlier, women with AD/HD, present issues specific to gender. Women have a high rate of not being diagnosed as children or being misdiagnosed. AD/HD is frequently associated with the hyperactivity component most often seen in boys. In contrast, AD/HD in women frequently presents as forgetfulness, disorganization, internal anxiety/restlessness, and low self-esteem (Quinn, 2005). The symptoms of hyperactivity may more often appear as overly talkative or emotional reactivity as opposed to motor activity and may be misdiagnosed as bipolar disorder. Women with AD/HD of the inattentive type are often misdiagnosed with dysthymia (Quinn, 2005).

Women show variability in tolerance of symptoms depending on socioeconomic class, ethnicity, and culture. Those with psychological and academic difficulties along with low self-esteem, impaired social skills, and general demoralization may go unattended. Lack of diagnosis can lead to risky behaviors such as substance abuse, driving difficulties, promiscuity, and increased healthcare utilization (Quinn, 2005). Women more often that men experience greater psychological distress, including anxiety and depression along with lower self-concept. The difficulties presented by AD/HD are understood or endured differently in women than in men. Because they are frequently diagnosed later in life they develop strategies to mask their AD/HD related challenges. This behavior leads to feelings of shame, low self-esteem, and learned helplessness. Masking strategies exacerbates misdiagnosis. While men tend to externalize the difficulties they experience due to AD/HD, blaming outside sources, women internalize their frustration with AD/HD and often become socially withdrawn. They blame themselves, feeling inadequate and at fault for their symptomatic behavior. They tend to believe that nothing will ever be better (Waite, 2007).
Many women are not diagnosed before the age of 7 because their symptoms do not cause insurmountable problems until middle school, high school, college, or even into adulthood. At a young age the scope of their difficulties is not readily identified because coping at home or in relationships is often not considered significant enough to be addressed (Waite, 2007). There is research to indicate that boys react differently than girls to the dysfunction in neural pathways and insufficient amount of dopamine. Boys have an overproduction of dopamine receptors which might explain hyperactivity before puberty whereas girls appear to be protected until puberty. At that time additional estrogen generates an increase in dopamine receptors and consequently an increase in AD/HD symptoms. As male symptoms begin to abate the female chemistry can initiate more symptomatic behavior. (Taylor & Keltner, 2002). This is perhaps one of the reasons that diagnosis in girls is frequently missed and an explanation as to why the ratio of boys to girls with AD/HD is 3:1 in childhood and as adults the ratio becomes 1:1 (Taylor & Keltner, 2002).

The parenting skills of women with AD/HD are uniquely affected. Women tend to have difficulties with consistency, managing activities, setting limits, and establishing routines (Banks, Ninowski, Mash, & Semple, 2008). Additionally, mothers with AD/HD may be lax in parenting and then be over-reactive in expressing annoyance or irritation when children appear to be out of control. There may also be high levels of conflict within the family. As mothers with AD/HD perceive themselves as not possessing parenting skills, they accept parenting as having an external locus of control. This “giving up” presents an increased risk for the development of behavior problems in their children (Banks, Ninowski, Mash, & Semple, 2008). The research in the area of parents with AD/HD is limited and requires far more investigation.

Criteria for diagnosis. Although the models of Barkley and Brown are similar, Barkley believes that the overriding factor in AD/HD is the inability to inhibit behavior in the initial
response to an event, stopping an ongoing response, and the inability to focus or ignore
distraction. The ability to inhibit behavior in these three steps affords the other executive
functions to act. Brown looks at AD/HD as an inability to regulate any of the six cluster areas he
has identified without the initial inability to inhibit behavior component (Tuckman, 2007).

The DSM-IV-TR uses the same criteria for diagnosing children and adults. This is
problematic, since the symptomatology changes as adolescents move into adulthood. As
previously explained, the coping mechanisms of adults mean that they may not meet all of the
criteria required for a child. However, the lives of adults dealing with AD/HD present
considerable chaos in family life, career, and social relationships. Adding lost wages due to
underemployment, substance abuse, driving accidents, or broken relationships into the equation,
the net result is sadly immeasurable. According to Barkley (2005), criteria identified in the
DSM-IV-TR need updating and revision for adults. Symptoms need to be recognized as age
appropriate. The AD/HD-related behaviors specific to adults must be clarified. Impairment
thresholds should be defined differently for adults: 5 of 9 for individuals in their 20’s and 4 of 9
for those 30 or older (Barkley, 2005).

The indicators of AD/HD in adults vary widely. Barkley (2010) states that the
hyperactivity changes into an “inner restlessness” which manifests as excessively talking, being
overscheduled, or taking on more work than can be reasonably completed, and choosing, perhaps
wisely, a physically active career. In the area of impulsivity an individual may become easily and
inappropriately frustrated; there are often frequent job changes, troubled relationships, addictive
behaviors, and poor financial management. The inattentive aspect of AD/HD may present itself
in an adult as incapacitating procrastination, poor organizational skills, the inability to manage
time, as well as lack of attention during lectures, while doing paperwork, or reading (Resnick,
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2000). All of these problems can present seemingly insurmountable roadblocks for adults dealing with AD/HD. Although, as stated earlier, there is no single test to be used in diagnosing adult symptoms of AD/HD, the disorder must be recognized as having been present during childhood. It usually causes significant disruption in multiple areas of an adult’s life (Woods, Lovejoy, & Ball, 2002).

Executive function difficulties often become more acute and complex as adolescents move into adulthood. These difficulties include challenges in working memory which could be indicated by the inability to schedule or manage time. Lack of self-regulation might present as laziness, low motivation, or procrastination. Deficits in planning problem solving relate to the lack of organizational skill and the inability to work toward a future goal (Barkley, 2005). There is some evidence that executive functioning is associated more with inattention-disorganization than with hyperactivity-impulsivity (Nigg, Starvo, Ettenhofer, Hambrick, Miller, & Henderson, 2005).

Areas of impairments and coping techniques

Each individual presents a unique picture of what AD/HD looks like. While there are, of course, identifiable features that present in AD/HD, each client is an individual with personality qualities, family situations, skills and talents, and a whole host of other situational experiences that make their impairments distinctive. For this reason each client deserves to be appreciated and accepted where they are currently in their lives. The Adlerian adage that everything can also be different (Ansbacher & Ansbacher, 1956) is important to remember at this juncture. Life for an adult with AD/HD has very often been fraught with frustration, self-doubt, and low self-esteem due to the general lack of understanding of AD/HD in adults. Many people believe that if these individuals would commit themselves to behaving in a moral and responsible manner, their
problems would go away. It is important that the psychotherapist consistently remind clients that they are not identified by the symptoms but rather they are individuals who happen to be coping with an identifiable and treatable disorder. They are not victims of AD/HD but rather survivors (Ramsay & Rostain, 2005). The clients must realize that their lives can be different; they can achieve success in the Adlerian life tasks. All areas of life of an individual are affected in some way, how they see themselves as people, their relationships with family, friends, in the community, and their work life (Carlson, Watts, & Maniaci, 2006).

A professional diagnosis as well as an understanding of the symptoms and the effects of AD/HD afford the client an opportunity to comprehend the multitude of ways in which they are affected by the disorder and what type of coping techniques will best serve to relieve symptoms. It is not a matter of willful poor choices but rather a picture of learning appropriate coping techniques. That same professional diagnosis can then afford the client knowledge about special compensations available in educational or work settings. The diagnosis must be completed carefully and it must address very specific criteria. Additionally, therapist and client must clearly understand that while medication will relieve or ameliorate symptoms, it will not change the self-image established over years of maladaptive coping, mistaken beliefs, and private logic. The client’s hesitating attitude will require the clinician’s patience and ability to give courage (Carlson, Watts, & Maniaci, 2006).

Education. When considering education after high school, it is important to consider the end goal: what is the best career option and what is required to reach that goal? Is it college, trade school, or some specialized vocational training option? Education is an area where individuals with AD/HD may feel particularly vulnerable. Clients need to be reminded again that AD/HD is not a measure of intellectual ability nor should it be used as an excuse for failure.
Adults with AD/HD (Tuckman, 2007). It is, however, a disability that may entitle a student to specialized compensations. For example it is important that the client becomes knowledgeable about what types of accommodations are available in their chosen institution. Barkley (2010) suggests choosing a college with class sizes that afford individualized attention; studying in groups with students who have good organizational skills; scheduling the most difficult classes early in the day when attention is best; reading difficult material, keeping one hand moving down the center of the page to maintain focus while leaving the other hand free for note-taking; alternating study between interesting and uninteresting material to maintain concentration; learning time-management skills, avoiding the typical student habits of staying up late and oversleeping in the morning. Taking advantage of extra faculty assistance; learning SQ4R for reading comprehension (Survey, Question, Read, Recite, Review, Reflect); identifying a mentor or coach; utilizing vocational or career counseling services well before graduation; and taking advantage of seminars offered by the college counseling center, including those on social and study skills.

Students must also take care to establish a reasonable and achievable academic schedule, keeping in mind possible challenges or roadblocks that will require extra effort. An understanding that an individual is both the picture and the artist (Ansbacher & Ansbacher, 1956) affords them the opportunity to visualize themselves as successful, to use the coping techniques most applicable to themselves, and to take an active role of developing beyond their disability.

**Relationships.** Adults with AD/HD are often acutely aware of their own social shortcomings. They frequently report difficulty in engaging others in conversation, maintaining tactfulness, and reacting in a manner appropriate to the situation. They are also ever watchful for
any social violation by others. Their relationships suffer because of their diminished capacity to pick up on the emotions of others – nor do they accurately describe their own emotional state. They frequently express surprise at the negative reaction of others to their behavior (Friedman, et al., 2003).

As mentioned previously, the parenting relationship can be strained due to lack of skills and the perception of an external locus of control. Mothers with AD/HD report reacting with hostility toward family members, often exhibiting high levels of annoyance, temper outbursts, and argumentativeness, all leading to strained family relationships. The AD/HD parent frequently has an expectation that they will be unable to be successful in the role of parent and they will derive little satisfaction from their role (Banks, Ninowski, Mash, & Semple, 2008). Although there is a need for more research in the area of parenting with AD/HD special attention should be given to this area of concern. The stress of wanting to do a good job may bring out the worst rather than the best in an adult with AD/HD if they are unaware of their own challenges and AD/HD-related roadblocks. Problems also stem from awkward and problematical experiences in childhood. A parent with good skills sees their child’s behavior as directly related to their own efforts while and parent with AD/HD sees the opposite. Their child’s behavior is outside of their control or influence. In a study done of expectant mothers with AD/HD and mothers (with AD/HD) of infants Ninowski et al. (2007) found lowered expectations of successful parenting and feelings of incompetence.

Because the skills of organizing, being consistent, managing behavior, setting limits, and establishing routines are challenging for a personal with AD/HD parenting is problematic on many levels. Inconsistency in all areas of parenting along with difficulty in the area of problem-solving creates a foundation for maladaptive coping (Banks, Ninowski, Mash, & Semple, 2008).
The symptomatic behavior including temper outbursts and argumentativeness are reflective of *disorder of self-control* described by Barkley (2005). In social settings, frequently, the individual with AD/HD is unable to clearly discern a situation before reacting inappropriately thus straining social interaction at home, at work, at school, and in the community. In one-on-one interactions it is also possible that an AD/HD client will react before taking the time to discern the meaning of the conversation (Barkley, 2005). Over a lifetime of feeling inadequate and misinterpreting social cues, the client often carries hypersensitivity into social settings and comes to inappropriate conclusions and mistaken beliefs about their place in that setting (Ramsay & Rostain, 2005).

These mistaken beliefs can lead to misunderstandings with co-workers and family members, in the community, and in other social situations. Friendships may be strained, marriages troubled, and jobs jeopardized as a result. Knowledge of their AD/HD can temporarily decrease their self-esteem. Due to their sensitivity to failure, there may be a tendancy to develop “magical thinking,” a belief that with medication and a few visits with the clinician all of the social inadequacies will be resolved (Ramsay & Rostain, 2005).

**Career.** Often therapists give little attention to the difficulties faced by individuals with AD/HD at work, leaving that forum to career counselors and coaches. There are few therapists who have firsthand knowledge of career development and few career counselors who understand the dynamics of AD/HD and what kind of assistance an adult with AD/HD needs in making career choices that provide the best chance for success.

It is at this time in an adult’s life that they are both the picture and the artist (Ansbacher & Ansbacher, 1956) of their own future. With the help of medication, psychotherapy, and coaching and with continued effort an individual can find success. It is not that the career field is
limited, it is the ability of the individual to identify strengths and see where challenges are most likely to occur. It is an individual process, a client with AD/HD cannot be lumped into a category of interest or ability.

With AD/HD comorbid conditions should be addressed in order for an individual to be successful. They must also deal with the past feelings of self-doubt and disappointment. Also, as individuals progress from childhood to adolescence and into adulthood the symptoms of AD/HD change. Some problems abate while others morph and become more difficult to manage. Poor time management can lead to missed deadlines, lack of organizational skills can result in poor work quality, the inability to prioritize can cause work to go unfinished. All of these can jeopardize any job no matter how high the interest level seems to be.

There are successful adults with AD/HD in every field. Most successful adults with AD/HD have some skills and abilities in common. Nadeau (2005) addresses internal and external resilience factors. Internal resilience factors include the ability to develop a focus on being in control of their life, the desire to be successful, to have a clear goal, to acknowledge that AD/HD is a disability but to recognize personal strengths, and the ability to be persistent, to give the extra effort needed to achieve success.

The external goals include finding the right fit, identifying the job that fits their own personal interests and strengths. Successful individuals with AD/HD build a supportive social network that understands the challenges of AD/HD and can offer encouragement. Also, it is important that individuals with AD/HD allow others to offer guidance. Successful adults with AD/HD don’t hope that good career options will come along they take an active role in making choices that further their careers (Nadeau, 2005).
Not every client needs extensive testing or evaluation, what they do need is a clinician who is aware of their challenges as they pertain to career development and to be questioned when they make career choices without considering how to address AD/HD as a factor. A careful and thorough examination of past employment experiences, both positive and negative, what symptoms of AD/HD are most troublesome, and specific interests are key factors to be considered for career development.

While each client must be treated as an individual there are some criteria that apply to all adults with AD/HD. When identifying a career path Nadeau (2005) talks about “goodness of fit.” These criteria include finding a balance between the job requirements and the strengths of the client, an assessment of the job’s stress level and the client’s stress tolerance, being able to identify what structure is offered to help the client stay on track, and recognizing if the career path offers what is needed to hold the interest of the client.

Nadeau (2005) suggests that the clinical interview should be career focused rather than the more typical initial interview, addressing current workplace concerns and career goals. A past history can reveal roadblocks and challenges that resulted from AD/HD. Neurocognitive testing may be necessary in order to obtain educational and workplace accommodations. Any comorbid conditions that come to light through psychological evaluation can be addressed to alleviate undue distress. Personality testing such as the Myers-Briggs Type Inventory (MBTI) can help to identify the type of environment that would best suit the client as well as help in understanding their own personality in contrast to that of others. The Strong Interest Inventory is useful for identification of interests however, if interests and career choice are not a good match the client and therapist must work collaboratively to find possibilities that are a match. It is important to remember that concrete problem solving in conjunction with addressing
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pschotherapeutic issues are necessary for the client to understand that AD/HD is only one part of who they are as a whole person.

Adlerian lifestyle. Lifestyle in Adlerian terms is the meaning a person gives to their life. It refers to the way an individual meets their tasks in life in the categories of work, friendship, and intimacy (Kutchins, Curlette, & Kern, 1997). Life for an adult with AD/HD can seem chaotic. In addition to the difficulties already mentioned in the areas of education and career, the person frequently faces challenges with legal issues, substance abuse, and in finances. All of these problems create an unhealthy and self-defeating lifestyle. Research (Barkley, Murphy, & Fischer, 2008) indicates an increased rate of drug abuse as well as some social challenges for individuals with AD/HD. These maladaptive behaviors point to diminished inhibition and developmental disorder of self-control (Barkley, 2005). An overall reduced regard for future consequences results from diminished executive function and negative expectations developed over a lifetime of impulsive behavior (Barkley, 2005).

Each adult with AD/HD presents a unique lifestyle, challenging the therapist to be open to the circumstances and ready to meet the client with acceptance. White (2005) indicates that although career is part of lifestyle it is seldom considered by a psychotherapist as part of their area of expertise nor does a career counselor consider Adlerian lifestyle when assisting an individual while examining career choices. Incorporating Adlerian lifestyle assessment information including early recollections, the consequences of useful and useless behavior, family constellation, and “The Question” “What would you be doing if you were doing well?” all present a picture that allows the client to see what best suits them (White, 2005). For an adult with AD/HD all aspects of lifestyle should be addressed in an effort to offer the best choices
while also identifying the challenges of each choice. Being able to see the past and have hope for the future allows the client to embrace the idea of change.

_Treatment_

At this time there is no cure for AD/HD. Treatment for AD/HD commonly includes a multi-modal approach including medication, education about AD/HD, psychotherapy, and coaching. It might also include academic support services, vocational counseling, and support groups. The medication should be closely monitored by a physician; the coaching and psychotherapy should be done by someone who is familiar with the vast array of difficulties that AD/HD presents.

Adults, both those who were diagnosed as children and those who were not, often find themselves in relationship failures, employment difficulties, or perhaps legal issues and consequently are forced to examine the nature of the problems. Just as sports teams watch films of their opponents and individual athletes have coaches to help them see their sports-related challenges, individuals need to see themselves and understand the opponent, AD/HD, in order to effectively meet the challenges they will face every day.

Adults with AD/HD should be evaluated by a professional who specializes in Attention Deficit/Hyperactivity Disorder and the possible associated comorbid disorders. After the diagnosis, the clinician’s obligation should include offering the client information about what AD/HD is, the ways in which it can affect one’s life, and the various treatment options currently available. The landscape of information on adult AD/HD is changing quickly as new research becomes available. Research has shown that the position held not too long ago that AD/HD belonged in the realm of child or adolescent disorder is incorrect and today it is understood that 50-70% of children diagnosed with AD/HD carry the symptoms into adulthood (Ramsay &
Adults with AD/HD (2007). There is new research available continually and it is incumbent on the therapist to stay current. As mentioned earlier women who have difficulty running a household and managing families often are underserved as a result of lack of familiarity of adult AD/HD symptoms by clinicians. Care must be taken to meet the individual needs of each client.

Medication. There is some controversy in the scientific research over the medication option and the effectiveness of stimulants for all AD/HD adults. Stimulants have proven to be ineffective or are not well tolerated by approximately 30% of adults diagnosed with AD/HD (Wadsworth & Harper, 2007). Although this is valuable and cautionary information, it does not mean that stimulants should not be used. On the contrary, if rewritten it states the 70% of adults find stimulants to be effective and helpful in the treatment of AD/HD in adults.

Research illustrates the importance of considering medication as a strong line of defense against AD/HD. It should be understood that while medication is effective in treating the symptoms of AD/HD, it is not a cure. Thomas Brown, an expert in AD/HD, referred to medication as being a bit like wearing glasses: while the wearer has them on they improve vision; however, when the glasses are off, poor vision remains problematic (Brown, 2005).

Tuckman (2007) explains the two types of stimulants most commonly used for treating AD/HD are methylphenidate in the Ritalin family and mixed salts amphetamine which are in the Adderall family. There are a variety of formulations within each family of drugs, which formulation is best for the individual client is determined between the client and the physician. Additionally, there is a new amphetamine on the market, Vyvanse. Although it is new it the results look promising (Tuckman, 2007).

Stimulant medication first became noticed by Bradley in 1937, when his research indicated a marked improvement in the behavior of hyperactive children who were given
Regularity use of stimulants for children and adolescents became routine about 25 years ago (Barkley, 2010). Stimulants are the most frequently used treatment and are available in two categories, amphetamines and methylphenidate (MPH). They are similar but not the same, and in different patients one may be tolerated better than the other. There is no way to determine the success of one or the other without trial and error. According to Barkley (2010),

Methylphenidate blocks the reuptake of dopamine and to a lesser degree, norepinephrine, thereby increasing the availability of the neurotransmitters in the synapse. Amphetamines block reuptake of norepinephrine and dopamine as well as promoting additional release of dopamine and norepinephrine from the presynaptic neuron. This action increases synaptic dopamine and norepinephrine. Methyphenidate and amphetamines are rapidly absorbed into the brain and act on nerve circuits that modulate attention and reward. Behavioral effects occur in one to three hours for immediate release preparations.

These stimulants affect the nerve circuitry of the brain, which allows more alert attention as well as appropriate responses to outside stimulation, giving an adult with AD/HD the opportunity to feel like they are in control.

In addition to stimulants, there are two nonstimulant medications that have had some success: Straterra (atomoxetine) and Wellbutrin (bupropion). Straterra is approved for children, adolescents, and adults for the treatment of AD/HD. It is a highly selective, norepinephrine reuptake inhibitor (Barkley, 2010). Antidepressants (Wellbutrin) are sometimes used for treating AD/HD although they are not approved for that use. For patients dealing with anxiety, depression, or drug abuse as comorbid conditions, desipramine and bupropion have been useful (Barkley, 2010).
Medication for AD/HD treatment in adults is very individual. Careful tracking of positive and negative effects is imperative in order to provide the the best option for each patient. Clear expectations along with clarification of symptom modification must be monitored in an effort to keep the patient aware of the possible changes or side effects (Brown T. E., 2006). Tracking allows appropriate alterations in dosage or type of medication to be made. The goals of medication should be defined between the client and the physician (Brown T. E., 2006). It is essential for the client with AD/HD to understand that medication may alleviate symptoms but it does not improve skills nor erase the negative perceptions of life developed over years of dealing with the repercussions of AD/HD.

While first starting on medication or when adjusting medication the client should be able to identify the ability to stay alert, maintaining steady energy for projects, maintaining focus and being able to return to a task if distracted, reducing hyperactivity and impulsiveness, and reducing stimulation overload (Soldern, 2005). Tuckman (2007) clarifies the effects of medication by indicating a clarity in thinking, the ability to calm the mind, and enhancing the ability to focus on one issue at a time.

*Psychotheraphy.* An elementary part of treatment then becomes educational. Having the most current research available, knowing what the resources are, and through education gaining an understanding of how AD/HD affects one’s life are important components of treatment. Every adult AD/HD client should understand that the range of symptoms and effects is wide. Also, how individuals respond to medication may vary and consequently require some fine tuning. A portion of the educational process starts with professional diagnosis which includes a process of ruling out possible alternative disorders as well as acknowledging possible comorbid conditions.
A thorough investigative interview with the client will reveal how their life has been affected by the disorder. The client and even the family are greatly empowered by understanding both the practical aspects of AD/HD and the emotional components that may have developed over time. Often family members are able to identify AD/HD behaviors while the client remains unaware of past difficulties. An understanding of the various ways in which AD/HD can present and how medication along with psychotherapy and coaching can affect each client are essential to both the client and the professionals involved.

Ramsay and Rostain (2007) indicate that medication alone is not always sufficient in treating adults with AD/HD, psychotherapy also plays an important role. Adults with AD/HD, by and large, have been overwhelmed by the symptoms of AD/HD for their entire lives. Knowledge of the enemy, AD/HD, doesn’t mean that the damage has been erased or that there are no psychosocial battles left to fight. The client’s overriding attitude is vital to achieving positive change. There must be an understanding that the locus of control is internal (Watts & Carlson, 1999). With the assistance of appropriate resources and a commitment on the part of the client, positive change is possible.

Although there might be little disagreement about the goals of therapy for a client with AD/HD, sources vary in identifying the right type of therapy. Tuckman (2007) and Barkley (2010) advise an open approach, suggesting that a client with AD/HD is not always suited to a single therapeutic approach due to impulsivity and attention difficulties; therefore, treatment should be flexible enough to incorporate what works best for that particular client.

The four Adlerian elements of therapy apply to treatment (Oberst & Stewart, 2003). The first is *joining* which includes meeting the client where they are, accepting, active listening, and offering encouragement. The second element is *assessment*, which is achieved through careful
Adults with AD/HD and thoughtful lifestyle investigation. Third is the insightful review of the lifestyle information, working collaboratively with the client, and lastly is reorientation, offering new ways of reframing mistaken beliefs and private logic in an effort to improve life for the client. Often the four elements overlap, there is no clearcut line separating one from another. As new information becomes apparent it must be incorporated into the assessment, interpretation, and reorientation while continually strengthening the bond between client and professional.

Ramsay and Rostain (2007) suggest that the wide variability of symptoms as well as symptom severity make psychotherapy critical. In a combined effort at coaching and psychotherapy they suggest seven features for clinicians to bear in mind: active involvement of the therapist, the restorative power of the therapeutic relationship, reasonable ground rules for therapy, psychoeducation, problem-solving focus, case conceptualization, and strategies for living with AD/HD. Psychosocial treatment of AD/HD has a twofold purpose, to help the client understand the relationship between their symptoms and functioning as well as to assist them in developing appropriate coping behavior (Waite, 2007).

Reframing is important for the client with AD/HD. For example, how will they see themselves in the future? How will they resolve their past? How will they approach new skill building? The past cannot be changed; however, with new information the future can be vastly different. Brown (2007) proposes four steps to reframing for the client with AD/HD: recognizing AD/HD as a disability, accepting AD/HD as well as other strengths and weaknesses, understanding the implications of having AD/HD, and making a conscious choice to address the limitation that AD/HD brings.

Ratey (2008) and Tuckman (2007) stress the importance of finding balance in all aspects of lifestyle. Discerning how each life task is affected and what can be done to alleviate the
symptoms, as they create challenges, must be a collaborative effort in both psychotherapy and coaching. In any given life task the disruption may seem more severe than in another; however, every area needs to be addressed in an effort to find balance in all areas.

Clients with AD/HD often doggedly pursue skills or new techniques with a single-minded focus in an effort to obtain relief from a specific problem or obstacle and to feel better about themselves. It is important that the therapist encourage balance, teaching the client to understand that they are both the picture and the artist (Oberst & Stewart, 2003), in charge of their own success or failure, and that it is necessary to develop skills and techniques to cope with all of the life tasks that are adversely affected by AD/HD. It takes time and patience to develop and grow into the new and successful picture. A new lifestyle (Oberst & Stewart, 2003) brings the possibility of seeing oneself in a new light, as capable, attentive, and less impulsive.

It is important that the therapist request feedback from the client to ensure that they are working collaboratively. This will enable both individuals to assess what is working and what obstacles are interfering with success, as well as to create a sense of normalcy around the symptomatic behaviors caused by AD/HD (Ramsay & Rostain, 2005). Feedback reinforces the bond between client and clinicial and clarifies that progress is not achieved without hard work and some missteps, allowing for the Adlerian acceptance of imperfection.

When dealing with change, Stoltz and Kern (2007) propose integrating the Adlerian lifestyle approach with Prochaska’s Transtheoretical Model (TTM) which includes six stages, they are pre-contemplation, contemplation, preparation, action, maintenance, and termination. The first TTM stage, pre-contemplation coincides with the joining and assessment phase of Adlerian therapy (Stoltz & Kern, 2007). It affords the client and therapist to get to know and
trust each other, the client shares information in an effort to explore what in life, now and in the past, has led to the current need for assistance.

The second TTM phase, contemplation (Stoltz & Kern, 2007) is parallel to the Adlerian insight phase. Adlerian lifestyle assessment uncovers mistaken beliefs and private logic that is often surprising to the client. The unique qualities revealed in lifestyle assessment can be used to set in motion the process of change. The two theories complement and enhance each other offering the client the opportunity to recognize hesitating or safeguarding behaviors (Carlson, Watts, & Maniacci, 2006) and how maladaptive coping or useless behavior can get in the way of progress. Review of the information gained from the lifestyle assessment presents possibilities, offering the client and therapist the opportunity to collaborate in identifying private logic, mistaken beliefs, and recognizing the value of useless and useful behaviors. This is the time when the Adlerian question “What would be different in your life if you didn’t have your symptoms?” (Carlson, Watts, & Maniacci, 2006, p. 278), becomes relevant.

The TTM preparation phase (Stoltz & Kern, 2007) allows the client to move from the Adlerian insight to reorientation. The client can begin to prioritize, decide what steps to take first. The client is encouraged to test the waters and to allow for mistakes. A client with AD/HD may be fearful that mistakes equate with being a failure, encouragement and understanding are part of the therapeutic process within both theories.

The TTM action phase (Stoltz & Kern, 2007) is congruent with Adlerian reorientation, practicing new behaviors, changing feelings of inferiority to acceptance and feelings of self-worth. Developing success in life tasks and developing social interest are part of the Adlerian reorientation and the TTM maintenance phase. The client is learning that they are in control, reworking techniques that are not successful and reinforcing those changes that do work. The
ability to see that setbacks do occur and new strategies can be initiated. Here, both models are very closely related.

The expectation for success recognizes the necessity to terminate the alliance between the client and therapist. Termination is an identified phase in TTM (Stoltz & Kern, 2007). While Adlerian theory doesn’t give the act of ending the therapeutic relationship a name the process is defined. The client reaches the understanding of their own lifestyle and knowledge of AD/HD so that they are able to meet their life tasks successfully. They can leave the therapeutic setting with the courage to face the future with the caveat that if new situations or circumstances present roadblocks the therapist will welcome the opportunity to again work collaboratively, with the client, to find solutions.

With AD/HD come a number of possible comorbid conditions which need to be addressed. It can be assumed that one or more comorbid conditions do exist unless proven otherwise (Tuckman, 2007). It is the job of the therapist to determine which condition is primary in the development of a treatment plan (Carlson, Watts, & Maniaci, 2006). Whatever treatment is initiated, it is important to remember that there may have been several therapeutic failures in the past that can color a client’s attitude toward success at that juncture (Weiss, Hechtman, & Weiss, 1999). Adlerian encouragement is an essential element, as there are a number of factors that may impede or interfere with progress. Ramsay and Rostain (2005) report that clients can experience decreased self-esteem after a diagnosis of AD/HD and initial therapy, as they recognize lost opportunities. As skill building and coping techniques improve self-esteem is likely to follow. Whatever type of therapy is chosen an adult with AD/HD is best served by a clinician who is willing to take a step by step approach to dealing with the myriad of issues that require attention. Each individual’s experience is different, requiring thoughtful attention to
uncovering heretofore unrecognized habits developed to compensate for feelings of inferiority. The Adlerian tenets of social interest do much to promote success for an adult who has an invisible disability that, even today, is often mistaken for poor self-control and lack of moral character.

*Coaching.* As an individual matures from childhood to adolescence and then to adulthood, the character of the symptoms resulting from AD/HD change to meet the more sophisticated demands of life (Barkley, Murphy, & Fischer, 2008). Coaching, like psychotherapy, requires that the client be met where they are in their life at the present moment. Handle first any crisis and then address the current tasks of daily living. For psychotherapists who also do coaching there is an interesting and delicate balance between the two. Adults with AD/HD experience difficulties very specific to the disorder. Unless the therapist/coach has a clear understanding of AD/HD they should defer to others better able to understand the challenges that the client must face.

It must be remembered that a coach who is not a psychotherapist must take great care not to slip into a therapeutic role. A coach has the role of a guide, one who can offer suggestions and demonstrate techniques to alleviate specific problems caused by the AD/HD symptoms. However, it is not the job of a coach to carry the load or do the work for the client. There is no quick-fix or easy resolution to the challenges of adults with AD/HD. Coaching may entail a discovery process for the client, for perhaps the first time in their lives clients are asked to analyze their personal goals and determine how to achieve these goals through managing their Attention Deficit/Hyperactivity Disorder in practical ways (Ratey, 2008).

Adlerian psychotherapy and coaching have strong parallel attributes. Both Adler and Dreikurs were very practical in their approach to assisting others, helping clients recognize and
resolve the issues that stood in the way of successfully achieving the tasks of daily living with
the hope for a better future. They held the belief that the client deserves to be considered as an
individual striving for success in all areas of life. Their positive encouraging approach is
consistent with the coaching approach (Davidson & Gasiorowski, 2006). Davidson and
Gasiorowski (2006) cite goals to be considered in coaching. They are (a) to help the client
clearly define what they want to achieve, (b) to assist the client in clarifying their commitment to
the goal, (c) define with the client what steps will be necessary to achieve the goal, (d) identify
possible external support to help facilitate success and (e) take action, do the work necessary to
achieve success.

Redefining self, based on habits of success, is part of the therapy/coaching process. Recognition
that past failures were due, in large part, to inability as a result of neurological
difficulties is an important first step. Time and retraining will be necessary to change the habits of
a lifetime and to develop skills that better serve the client. It is important to address each of the
Adlerian life tasks (Ansbacher & Ansbacher, 1956) individually. While adults with AD/HD are
affected in similar and predictable ways, each client is affected in ways unique to him or her.
Experience indicates that it is best to start with small changes that offer the client a chance for
immediate success (Tuckman, 2007). Success is encouraging. It is, however, important to
remember, in coaching or psychotherapy, that AD/HD is a brain disorder. It is the responsibility
of the coach to be aware of what may be accomplished, the role of medication, and to challenge
clients with the awareness that some failures may be due to the disability and not to lack of effort
on the part of the client.

The goals of treatment with medication, psychotherapy, and coaching often overlap.
Adults with AD/HD have developed their mistaken beliefs and private logic (Oberst & Stewart,
based on their experiences and the reactions to life by themselves and those around them. There are a lot of “I shoulds…” the client has been unable to accomplish. “I should be able to get my work done.” “I should be able to pay attention.” I should not interrupt.” “I should not act impulsively.” The list is seemingly endless, and learning to redefine and reframe self without shame and guilt requires assistance in many different ways. After identifying the problem, the next step is to persuade the client that this is a battle that requires team effort including physician, psychotherapist, coach, and the support of those who are willing participants in the client’s life.

The Adlerian phases of therapy are similar to coaching. In joining (Carlson, Watts, & Maniacci, 2006) with the client the coach develops and trusting open relationship, one free of judgement. Active listening as the client relates the problems of daily living and offering encouragement help to cement the relationship. An in-depth educational component can help the client understand why things like procrastination, time management, impulsivity, and distractibility cause disruptions in all areas of their lives.

The assessment phase (Carlson, Watts, & Maniacci, 2006) allows the client and coach to understand how and where difficulties develop for each individual. Giving the client the opportunity to fully disclose problem areas and frustrations without embarrassment helps to clarify the scope of the problems to be addressed. Together they can determine what practical skills will best meet the client’s needs.

Reorientation is when the real work begins. Once goals are determined it is the attention to details, planning, prioritizing, and organization that afford the opportunities for success (Oberst & Stewart, 2003). Here the coach can play an active role in helping the client develop practical coping mechanisms for everyday operations. Structure around everyday responsibilities paves
the way for small successes which in turn expand the possibilities for the future. Ratey (2008), an acknowledged expert in AD/HD coaching, suggests an approach she refers to as A-N-S-W-E-R. A is for acknowledging AD/HD and determining just what it means in the life of the client. N is for narrowing the focus, identifying where the client gets off track and clarifying the behaviors that can undermine efforts for change. S is for strategizing, putting together a plan to stay on course and developing techniques to manage situations that have caused problems in the past. Also, this is where the client can learn to recognize and capitalize on personal strengths. W is for working the plan, keeping the future in mind. Working requires action, doing nothing is not an option. Change is never easy, it requires hard work and accountability. E is for evaluating. What parts of the new plan worked and what didn’t? What needs to be fine-tuned to achieve success? It is important to remember that change happens slowly, allow time for the new strategies to work. Lastly, R is for repeating the process and reinforcing new behaviors. Don’t allow shortcuts to derail the plan. Remembering that AD/HD is not going away and maintaining good habits is imperative for success (Ratey, 2008).

Coaching adults with AD/HD is not easy. The challenges of daily living change constantly, it is easy for an adult with AD/HD to slip back to useless habits. The coach must remember to clarify for the client the negative effect of useless behaviors as well as continue to help identify traps and distractions. Also, the coach can assist the client by helping to set realistic goals for change, selecting only one or two of the most difficult roadblocks and then working to eliminating the negative thoughts that sabotage success in those areas (Ratey, 2008). An Adlerian coach will remember to offer encouragement and proclaim mistakes as an important and positive part of the learning process.
Conclusion

AD/HD is the most researched disorder diagnosed in children (Barkley, 2005). While it is widely accepted that AD/HD is a disorder that covers a life span, research on adults with AD/HD is still limited. There is work on gender differences (Nadeau, 2005, Quinn, 2005, Soldern, 2005). Frequently the research suggesting concern for “adults with AD/HD” means college students, ignoring adults past the age of 20-something. As clinicians become more aware of what to look for they need to be sensitive to the possibility of identifying AD/HD in adults into the ages of 50 or 60 and beyond. The baby boomer population is growing at a rapid rate and will be living and working well into their 80s. As individuals retire the structure of their lives will change, unstructured free time that initially looks wonderful can present the challenges of disorganization, moving from task to task without completing any single task, or impulsive behavior which can lead to financial, relational, or legal problems. Psychotherapists and coaches will need to be able to offer understanding as well as practical approaches to solving the issues arising from changing lifestyle. It is never too late to learn skills and adaptive measures to improve lives.

Clearly Adlerian tenets direct clinicians and coaches to respect and encourage individuals throughout their entire lifespan. Affording adults the opportunity for success in all life tasks at any age and under varying circumstances should be the goal of all Adlerians.
References


