

ADAPTED SCHEMA THERAPY FOR ADULT ADHD

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Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is a lifelong, neurodevelopmental condition. Within the DSM-V, symptoms are clustered into three subtypes: inattentive, hyperactive/impulsive, and combined (see Table 1). Whilst randomised control trials may still be required, initial research indicates that schema therapy may be particularly well suited to the treatment of secondary problems, such as maladaptive patterns of coping and chronic negative self-perception, (Lücke, Lam, Müller and Philipsen, 2017; Philipsen et al. 2017; Kiraz and Sertçelik, 2021).

It is important to note, that within the neurodiversity paradigm, ADHD can be conceptualised as a naturally occurring variation in human neurology and cognitive functioning (Singer,

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1997; The ADHD Foundation: Neurodiversity Charity, 2023). Therefore, any psychological intervention should focus on the specific areas of difficulty or need identified by the individual client, such as emotional regulation or interpersonal functioning.

ADHD in the DSM-V	• Symptoms must have been present before age of 12 years and must have had a clinical significant impact on the client's life for at least 6 months • Several symptoms must be present in 2 or more settings • Symptoms must interfere with age-appropriate functioning in at least 2 areas (e.g., school/work, relationships, self-image, socialising) • Symptoms must not be better explained by another condition
Inattentive subtype	Children (up to age 16) experiencing 6+ or adults (age at least 17) experiencing 5+ of: • Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities. • Often has trouble holding attention on tasks or play activities • Often does not seem to listen when spoken to directly. • Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked). • Often has trouble organizing tasks and activities.

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	• Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework). • Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones). • Is often easily distracted • Is often forgetful in daily activities.
Hyperactive subtype	Children (up to age 16) experiencing 6+ or (adults age at least 17) experiencing 5+ of: • Often fidgets with or taps hands or feet, or squirms in seat • Often leaves seat in situations when remaining seated is expected. • Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless). • Often unable to play or take part in leisure activities quietly. • Is often “on the go” acting as if “driven by a motor”. • Often talks excessively. • Often blurts out an answer before a question has been completed. • Often has trouble waiting their turn. • Often interrupts or intrudes on others (e.g., butts into conversations or games)

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Combined subtype	• If enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months
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Table 1. DSM-V diagnostic criteria for ADHD (American Psychiatric Association, 2013)

Adaptations for clinical practice

Reviewing preliminary research against the existing ST framework, and drawing upon examples from clinical practice, the following three potential areas have been identified and adaptations outlined, summarised in Table 2:

- **Challenge 1:** Sensitivity to criticism and perceived rejection – ‘Rejection sensitive dysphoria’
- **Challenge 2:** Underachievement
- **Challenge 3:** Sensory processing difficulties

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ADHD challenges	Unmet core emotional needs (based on Young, Klosko & Weishaar, 2003)	Early maladaptive schemas	Possible coping response (based on Young, Klosko & Weishaar, 2003)	Implications for adaptations
Sensitivity to criticism and perceived rejection 'rejection sensitive dysphoria' (Beaton, Sirois & Milne, 2022)	Secure attachments to others (safety, stability, nurturance & acceptance)	Social Isolation (Kiraz & Sertçelik, 2021) Emotional deprivation (Philipsen et al., 2017) Subjugation (Philipsen et al., 2017) Defectiveness/shame (Philipsen et al., 2017)	Surrender "Fawning" by giving in to other's demands (e.g., "<i>Compliant Surrenderer</i>"); puts self down; selects emotionally depriving partner Over-compensate Becomes a social chameleon in groups; becomes controlling of others (e.g., "<i>Paranoid</i>" or "<i>Suspicious Over-controller</i>")	Transparency and congruence within the therapeutic relationship; use of supervision to process challenges/transference reactions; regular check-ins with client ("How are we doing?" "Is there anything we need to think about to help you feel safer here?")

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			Avoid May use alcohol/substances to avoid negative thoughts and feelings (e.g., “ <i>Detached Self-Soother</i> ”); avoids intimate relationship (e.g., “ <i>Avoidant Protector</i> ”)	
Under-achievement (Kaiser et al., 2008; Arnold, Hodgkins, Madhoo, & Kewley, 2020)	Competence Realistic limits and self-control	Failure (Kiraz & Sertçelik, 2021) Insufficient self-control/Self-Discipline (Kiraz & Sertçelik, 2021) Defectiveness/shame (Philipsen et al., 2017)	Surrender Does tasks in half-hearted/haphazard manner; gives in to negative thoughts and beliefs; gives up easily (e.g., “ <i>Compliant Surrenderer</i> ”) Over-compensate Becomes defensive; works excessively hard to prove	Psycho-education; skills training; developing resources and strategies e.g., time managing/organisation skills. Direction, coaching and support to develop skills; negotiate flexible boundaries e.g., late arrival times/incomplete homework

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			themselves/over-achiever (e.g., “<i>Self-Aggrandiser</i>”); might seem over-prepared or paranoid (e.g., “<i>Perfectionistic</i>”, “<i>Paranoid</i>” or “<i>Suspicious Over-controller</i>”) Avoid Procrastination; avoids situations perceived to be too challenging (e.g., doesn’t go for promotion); avoids accepting responsibility; deflects/obfuscates; uses alcohol/substances to numb/suppress arousal (e.g., “<i>Detached Self-Soother</i>”)	tasks; collaborative problem solving; empathic confrontation
Sensory processing difficulties (Bijlenga,	Freedom to express valid	Subjugation (Philipsen et al., 2017)	Surrender	Psycho-education around sensory processing; validation

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Tjon-Ka-Jie, Schuijers, Kooij, 2017; Kamath et al., 2020)	needs and emotions	Defectiveness/shame (Philipsen et al., 2017)	Defers to perceived expectations; suppresses sensory needs (<i>"Compliant Surrenderer"</i>) Over-compensate Rebels against authority; appears 'defiant' (e.g., <i>"Angry Protector"</i>) Avoid Avoids situations that may trigger sensory overload; socially withdraws; avoids expressing valid needs; uses alcohol/substances to numb/suppress arousal (e.g., <i>"Detached Self-Soother"</i>)	of sensory needs; invitation to explore and meet sensory needs within and outside of session; support the development of self-advocacy
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Table 3. Summary of areas of impairment experienced by clients with ADHD, early maladaptive schemas, coping responses and possible adaptations

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Challenge 1: Sensitivity to criticism and perceived rejection – ‘Rejection sensitive dysphoria’

Research suggests a heightened sensitivity to criticism, sometimes referred to as ‘rejection sensitive dysphoria’ in adults with ADHD (Beaton, Sirois & Milne, 2022), likely reflective through the identified dominance of **Social Isolation, Emotional deprivation, Defectiveness/shame** schemas identified within this population (Kiraz and Sertçelik, 2021; Philipsen et al., 2017). This, in turn, points towards an increased need for secure attachment relationships that provide acceptance, transparency and interpersonal safety, to address underlying schemas and patterns of maladaptive interpersonal coping (Young, Klosko & Weishaar, 2003). The emotional needs, highlighted by rejection sensitivity, hold significant and multifaceted implications for the therapeutic relationship, which within ST is formulated as *the primary vehicle* for therapeutic change.

Firstly, therapists should be mindful that much of the existing language around ADHD and ST is inherently deficit-based, for example “disorder”, “deficit”, “maladaptive”, “treatment”, which may be perceived by clients as inherently critical. To illustrate, adult clients with ADHD have struggled to engage with ST terminology because, for example, the very concept of “Insufficient Self-Control” (Young, Klosko & Weishaar, 2003) was experienced as too shaming. Much groundwork is often needed to reframe and de-shame language that many Schema Therapists take for granted, before clients have been able to engage with the next phase of therapy.

In contrast to the deficit-driven medical paradigm, the neurodiversity paradigm sees neurological difference as part of natural human variation, which provides both psychological advantages (such as creative thinking) and disadvantage (such as disorganisation) (Singer, 1997; The ADHD Foundation: Neurodiversity Charity, 2023). Aligning with the wider social disability model, the neurodiversity paradigm locates disability within a wider social context: the individual might experience certain impairments (such as difficulties with working memory) but is *disabled by a society that fails to accommodate the needs of the individual*

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with the impairment (such as expecting that all workers can manage to navigate multiple and complex competing tasks). Chapman & Botha (2022) argue convincingly for therapists to adopt the neurodiversity paradigm, as a matter of dignity and respect for neurodivergent clients.

Finally, as Ramsay & Rostain (2015) note, many of the core symptoms and features of ADHD, such as forgetfulness and disorganisation, pose a challenge to therapists, discussed further in the next section (Underachievement). Relevant to the current section are ‘treatment complicating behaviours’ (TCBs), conceptualised by the authors as “compensatory strategies or attempts to deal with ADHD that are ultimately self-defeating and disrupt treatment” (Ramsay & Rostain, 2015, p.172). According to the authors, common examples of TCBs in adult ADHD may include: lying (either by omission or commission); criticism or hostility towards the therapist; resistance and ‘oppositional attitudes’; and externalisation of blame onto others.

Within ST these compensatory strategies can be compassionately conceptualised as coping modes, which need to be formulated collaboratively with the client and *empathically confronted*. To do this effectively, it is vitally important to have processed our own negative reactions in supervision. To illustrate, one client expressed open hostility towards the therapist. Ongoing attempts to manage feelings of intense vulnerability can provoke feelings of anxiety and frustration in the therapist that need to be processed in supervision before the therapist can work constructively with these challenges.

Adaptations for Challenge 2: Underachievement

Research suggests ADHD negatively effects long-term education outcomes and employment, and is generally associated with underachievement across multiple domains (Kaiser, et al., 2008; Arnold, Hodgkins, Madhoo, & Kewley, 2020). Many of the core features of ADHD, such as attentional regulation, executive dysfunction, impulsivity, and emotional

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regulation, may make the classroom and typical work environment hostile to the needs of children and adults with ADHD. Recently, the notion of ‘educational trauma’ has been used to conceptualise the emotional and psychological impact of “systemic practices perpetuated by educators and school staff that often have harmful long-term effects on students,” (Drummond-Bey, 2021). These experiences are likely to have contributed to the development of some of the UMS identified above, most notably **Failure** (Philipsen et al., 2017; Kiraz and Sertçelik, 2021) and **Defectiveness/Shame** (Philipsen et al., 2017). It is therefore of critical importance these issues are fully addressed in therapy, with the therapist striving to support the client’s unmet needs for **competence** and **realistic limits** – that is, limits that are *developmentally appropriate* to the needs of the client.

Here, it is also worth reflecting on the way in which adult clients with ADHD may view the therapist; particularly one who takes a more didactic approach when it comes to interventions such as psychoeducation, formulation, and homework setting. Clients with adult ADHD often seem to have great difficulty engaging with these aspects of therapy unless approached collaboratively. To illustrate, often clients describe viewing the therapist as being “like a teacher”; something given their early educational experiences is understandably off-putting and needs to be actively addressed. As therapy progresses, clients can be supported to decide their own homework activities, based on the work completed within the session. It can then be agreed for the therapist to send out an email summary of what was decided as a reminder. If handled with sensitivity, the therapeutic relationship can provide a ‘corrective experience’ in relation to perceived authority, more broadly, supporting the development of agency and autonomy.

As Ramsay & Rustain (2015) identify, adults with ADHD may require additional support when it comes to a range of organisational skills, such as arriving promptly to sessions and homework completion. This perhaps speaks to the prevalence of the **Insufficient Self-Control** schema (Kiraz and Sertçelik, 2021). Therapists should consider explicitly negotiating more flexible boundaries at the outset of therapy, with a view to providing

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coaching and skills training as part of the work. To illustrate, with one client it was agreed that the therapist would send a reminder the evening before a session. Whilst *empathic confrontation* was used to challenge late attendance, the therapist was careful to avoid the client experiencing this as punitive. On occasions when feelings of shame were activated by the therapist setting boundaries, this was actively addressed and worked through collaboratively. Again, use of supervision was vital to allow the therapist to process feelings of disappointment and frustration, and as therapy progressed, tighter boundaries were (re)negotiated, reflective of the client's developing confidence and skills.

A further implication of the neurodiversity paradigm, however, is the importance of those ADHD characteristics that may be regarded as a strength at both an individual and societal level. Champ et al. (2021) proposed that deficit-based treatment models for ADHD may be limited in their capacity to identify and support positive psychological factors for well-being and growth. Crook & McDowall (2023) identified a number of such strengths that adults with ADHD perceived themselves as bringing into the workplace. These strengths included: spontaneity, linking of ideas, a different perspective, empathy, a sense of fairness and justice, hyperfocus, physical and mental energy, a sense of humour, altruism, and resilience. Schippers et al. (2020) highlight the importance of strength recognition in helping individuals with ADHD to accept or embrace their diagnosis and make educational and occupational choices that fit them well. Given the high prevalence of the **Defectiveness/Shame** schema identified within this population, a strengths-based approach seems of critical importance. As one ST colleague put it, "We celebrate every success and cheerlead all the way through".

Adaptations for Challenge 3: Sensory processing difficulties

Recent research has suggested that sensory processing differences may be considered a core feature of adult ADHD, especially in women (Bijlenga, Tjon-Ka-Jie, Schuijers, Kooij, 2017; Kamath et al., 2020). Sensory differences may present themselves in childhood in the

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form of sensory-seeking behaviours, such as needing to touch and ‘fiddle’ with objects, or sensory over-responsiveness, such as agitation or distress at having to have hair brushed. Without a framework for understanding these differences, sensory sensitivities may prove challenging for parents and teachers to manage, resulting in them dismissing, coercing, or punishing children into the **Subjugation** (Philipsen et al., 2017) of their legitimate sensory needs and **emotional inhibition** (Kiraz and Sertçelik, 2021). Children may come to feel ashamed of their sensory differences and to see themselves as **Defective**; and are likely to develop enduring patterns of coping to manage their needs.

It is therefore essential that therapists invite a dialogue with clients about their sensory experiences and think collaboratively with clients about how to meet their sensory needs within and outside the session. Within the session this might mean attending to distracting or distressing environmental triggers, such as noise, heating, or light level. Clients might be invited to bring fidget toys or to get up and move around during the session, rather than being expected to sit still for the 50-minute duration. Perhaps the therapy session could take place outside, for example “Walk and Talk” therapy (Greenleaf, Williams, Leibsohn, & Walther, 2023).

Outside the therapy session, clients might be invited to keep a record of environmental triggers and to problem solve ways of managing these. Coaching around self-advocacy may be an important antidote to the **Subjugation** schema, as clients become more in touch with their sensory needs and increasingly able to negotiate these needs to be met, both within and beyond the therapy space.

Finally, it’s important to remember that with sensory sensitivity may come a greater capacity to feel all emotions. Redshaw & McCormack (2022) found that participants reported experiencing “a childlike access to joy”, associated with an uncommon degree of energy, optimism, adventurousness, and curiosity. In line with the earlier discussion about celebrating neurodivergent strengths, recognising and prising sensory differences may be key to undoing feelings of chronic shame and defectiveness.

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Intersectional considerations

Recent research suggests that women and girls with ADHD may often mask or internalise their struggles and are more likely to receive a diagnosis of comorbid affective disorders, such as depression and anxiety (Blair & Kim, 2023), and eating disorders, such as bulimia (Quinn, 2008). Morgan (2023) argues that delayed diagnosis for many women may contribute to cumulative psycho-social impact across multiple domains, including school, work, and interpersonal relationships, increasing the risk of mental health difficulties which may be, for some, “deeply traumatic”.

Considering the intersections between race and gender, Agyei (2022) talks persuasively about the additional pressures and social stigma Black women experience that may impede diagnosis and timely support, forcing women to mask their difficulties and struggle through. Emerging qualitative findings by Baig & Kahya (2024) support Agyei’s account, highlighting the experience of racially marginalised women who may feel a social pressure to ‘mask’ their cultural expression *as well as* their ADHD, placing them under intense and ongoing emotional stress.

Given the underdiagnosis of women, girls, and racially or culturally marginalised groups, schema therapists should be alert to the signs of ADHD within these populations and ready to consider exploring an ADHD-informed formulation and adaptations, such as those outlined in the current paper.

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