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CLINICAL MODULES

Adult ADHD: Clinical Practice Workbook

Neurodiversity-affirming tools for attention, activation, planning, emotion regulation, relationships, and sustainable support

DSM-5-TR · ICD-11 CLINICAL ALIGNMENT

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How to use this workbook

CLINICAL ORIENTATION

- Use the workbook collaboratively or independently as an adjunct to professional care; begin with the area causing the most meaningful difficulty.
- Complete short sections, use external reminders, and revisit reusable forms. Writing every answer is not required.
- Treat inventories as pattern-finding tools rather than diagnostic or severity tests.
- Test one environmental support or strategy at a time and evaluate fit in the person's real context.

Clinical considerations

- This workbook cannot diagnose ADHD. Diagnosis requires developmental and cross-setting history, impairment assessment, and consideration of sleep, mood, anxiety, trauma, substances, medication effects, learning differences, autism, and medical conditions.
- Use nonmoralizing language: executive-function difficulty is not laziness, lack of caring, or a character defect.
- Adapt tasks for disability, literacy, sensory needs, culture, finances, work conditions, caregiving, and access to technology or support.
- Impulsivity involving driving, substances, spending, aggression, sexual risk, self-harm, or other danger may require prompt individualized safety planning and professional care.
- Medication decisions belong with a qualified prescriber. Record benefits, side effects, adherence barriers, and questions without changing medication outside medical guidance.
- Mindfulness and body-focused exercises are optional and should be adapted or stopped if they increase distress, dissociation, pain, or sensory overload.

Whole-Person ADHD Pattern Map

Clinical aim: Identify functional patterns, contexts, strengths, and priorities without reducing the person to deficits.

ADHD-related differences can affect attention, activation, memory, organization, inhibition, restlessness, and emotion. Performance often changes with interest, novelty, urgency, structure, sleep, stress, and support.

How executive-function differences show up

Rate each area based on the past month, then add examples and contexts. Ratings support reflection and are not a diagnostic score.



Area	Rating 0–4	Example	Where/when easier	Impact
Sustaining or shifting attention				
Starting tasks				
Working memory/remembering				
Planning and sequencing				
Time awareness				
Organization and belongings				
Impulse control				
Restlessness/stimulation needs				
Emotion regulation				

Area	Rating 0–4	Example	Where/when easier	Impact
Completing and reviewing				

Which difficulties occur across settings?

Which emerged in childhood or adolescence?

Which might have another or additional explanation?

Strengths, conditions, and priorities

Record capabilities and the conditions under which they appear. The goal is to design support around the actual nervous system and environment.

Strength or successful condition	Example	What makes it possible	How to use it elsewhere
Interest			
Structure			
People/support			
Environment			
Personal strength			

What captures your attention naturally?

When do you initiate or finish effectively?

What strengths do others notice?

What accommodations or supports already work?

Which one functional problem would make the biggest difference if improved?

Goals, Values, and Activation

Clinical aim: Translate meaningful goals into small, supported actions.

Difficulty activating is not the same as lacking motivation. Interest, clarity, immediacy, novelty, reward, energy, and accountability can all change access to action.

Goal-to-action map

Choose one personally meaningful goal. Make the next step visible and small enough to begin, not merely a smaller version of the whole project.

Goal	Milestone	Next visible action	Start cue	Support/reward	Review date
Plan					

Why does this matter to you?

What would count as done?

What is the smallest visible next action?

What information or material is needed?

What cue will start the action?

What immediate reward, interest, novelty, or accountability can help?

Activation barrier plan

Identify the actual barrier rather than applying more pressure. Select a matching support and test it once.

- ☐ Task is vague
- ☐ Task feels too large
- ☐ First step is hidden
- ☐ Low interest or delayed reward
- ☐ Fear, shame, perfectionism, or uncertainty
- ☐ Low energy, pain, hunger, or poor sleep
- ☐ Materials or information are missing
- ☐ Environment is distracting or understimulating
- ☐ Competing demands exceed capacity
- ☐ No external cue or accountability

Barrier	Support to test	When/where	Result	Adjustment
Experiment 1				
Experiment 2				

Time Awareness and Time Estimation

Clinical aim: Improve awareness of actual task duration, transitions, and capacity.

Time may be difficult to sense internally. Externalizing time and comparing predicted with actual duration creates more reliable planning data.

Predicted-versus-actual time audit

Track one representative day without trying to perform ideally. Include preparation, transitions, interruptions, breaks, and recovery.

Activity	Predicted time	Actual start/end	Transition time	Interruptions/context	Energy/focus 0–10
Morning					
Task 1					
Task 2					
Midday					
Task 3					
Evening					

Which tasks were consistently underestimated?

Where did transitions add time?

What was different when estimates were accurate?

Externalize time plan

Choose external time supports that fit the setting. Use enough structure to help without creating an unmanageable system.

- ☐ Visible clock or countdown timer
- ☐ Start and stop alarms with labels
- ☐ Calendar travel and preparation blocks
- ☐ Transition buffer
- ☐ Visual schedule
- ☐ Recurring reminders
- ☐ Accountability check-in
- ☐ End-of-task cue
- ☐ Planned recovery time

Time challenge	External support	Setup step	Test period	What happened
Support 1				
Support 2				

Priorities, Capacity, and Decisions

Clinical aim: Support realistic prioritization and reduce decision paralysis.

Priority is not only urgency. A workable plan also considers importance, consequences, capacity, energy, dependence on others, and what can be negotiated or released.

Capacity-aware priority matrix

Place tasks in the matrix, then estimate available capacity. Schedule fewer items than the maximum to leave room for transitions and unexpected demands.

Task	Important?	Time-sensitive?	Effort/energy	Do/schedule/delegate/negotiate/d efer	Next action
Task 1					
Task 2					
Task 3					
Task 4					
Task 5					
Task 6					

What can be removed or renegotiated?

What needs a deadline clarified?

What is the one priority that protects the most important outcome?

Good-enough decision worksheet

Choose a decision, set a reasonable information limit and deadline, then compare the most important factors. Good enough means adequately informed and aligned—not careless.

Option	Benefits	Costs/risks	Importance weight	Unknowns	First step if chosen
Option A					
Option B					
Option C					

What decision is required?

Is it reversible, partly reversible, or difficult to reverse?

What information is essential versus merely reassuring?

When will you decide?

What values or obligations matter most?

Task Breakdown and Completion

Clinical aim: Create a repeatable system for starting, sequencing, sustaining, and closing tasks.

A task becomes easier to access when its endpoint, first action, materials, sequence, and support are visible outside the mind.

Task launch map

Use one real task. Write actions as observable verbs and keep the first action small enough to begin within five minutes.

Step	Action	Materials/support	Estimated time	Done/next
1				
2				
3				
4				
5				
6				
7				
8				

What does done look like?

What is the first physical action?

What materials, files, people, or decisions are needed?

Where and when will you start?

What cue and accountability will help?

What will you do if you get stuck?

Focus-cycle and shutdown plan

Select a realistic work interval based on the task and your energy. Plan both breaks and a shutdown sequence so completion does not depend on memory.

- ☐ Save and label work
- ☐ Record the next action
- ☐ Return materials
- ☐ Capture unfinished items
- ☐ Set reminder/calendar block
- ☐ Mark progress or completion

Cycle	Focus target	Minutes	Break/recovery	Restart cue	Result
1					
2					
3					
4					

What interval supported focus without depletion?

What made restarting easier?

Attention and Environment Design

Clinical aim: Reduce avoidable friction and create the right level of stimulation.

Attention is shaped by environment. Some people need less stimulation; others focus better with movement, sound, novelty, or company. Supports should fit sensory and accessibility needs.

Distraction and stimulation audit

Observe one work period. Distinguish external interruptions, internal distractions, unmet body needs, and understimulation.

Distraction or need	External/internal/body	When it occurs	Impact	Possible design change
1				
2				
3				
4				
5				

Which interruption is preventable?

Which signal represents a legitimate need?

Is the environment overstimulating or understimulating?

Environment experiment menu

Choose no more than two supports for a defined task and track the result.

- ☐ Dedicated or cleared work zone
- ☐ Headphones, ear protection, music, or ambient sound
- ☐ Phone/notification boundary
- ☐ Website or app limit
- ☐ Visible materials and visual cues
- ☐ Timer or checklist
- ☐ Standing, movement, fidget, or alternate seating
- ☐ Body doubling or coworking
- ☐ Natural light or adjusted lighting
- ☐ Single-task screen/layout
- ☐ Snack, hydration, medication-as-prescribed, or movement break
- ☐ Voice notes, mind maps, or alternate note-taking

Task	Support tested	Focus before/after	Completion effect	Keep/change/drop
Experiment 1				
Experiment 2				

Emotion Regulation

Clinical aim: Recognize emotion cycles, validate experience, and expand response options.

Strong or fast-changing emotions may reflect ADHD-related regulation difficulty, stress, shame, rejection sensitivity, trauma, mood concerns, or context. The task is to understand the chain rather than assume one cause.

Emotion event chain

Map one event in sequence. Include vulnerability factors such as poor sleep, pain, hunger, overload, conflict, or medication timing.



Vulnerability/context	Prompting event	Body/emotion + intensity	Thought/meaning	Urge/action	Consequence
Event					

What part of the response makes sense?

What early cue could create a pause?

Was repair needed afterward?

Regulation and repair plan

Choose responses that fit the intensity and situation. Evaluate effectiveness, not moral worth.

- ☐ Name and validate the emotion
- ☐ Reduce sensory input or step away safely
- ☐ Move, stretch, breathe comfortably, or orient to surroundings
- ☐ Meet a body need
- ☐ Ask for time or clarification
- ☐ Use a credible compassionate response
- ☐ Problem-solve after activation decreases
- ☐ Repair impact with acknowledgment and a specific next step
- ☐ Seek professional help if intensity, duration, or risk is concerning

Strategy	Best time to use	Intensity before/after	What helped	Adjustment
Practice 1				
Practice 2				
Practice 3				

Impulsivity and Safety

Clinical aim: Identify impulse chains and insert practical pauses in higher-risk situations.

Impulsivity may involve speech, spending, driving, substances, food, sex, conflict, digital behavior, or abrupt decisions. A nonjudgmental plan should match the actual level of risk.

Impulse chain review

Choose one recent episode. Record what increased vulnerability, the cue, early signals, action, and consequences.

- ☐ Racing thoughts
- ☐ Restlessness or stimulation seeking
- ☐ Impatience
- ☐ Interrupting or urgency to respond
- ☐ Strong emotion
- ☐ Narrowed attention
- ☐ Substance use
- ☐ Fatigue, hunger, pain, or overload
- ☐ Easy access to money, vehicle, app, substance, or other means

Vulnerability	Trigger	Early sign	Impulse/action	Immediate payoff	Later effect
Episode					

Where could a pause realistically enter the chain?

Does this pattern require additional safety or professional support?

Pause and friction plan

Add time, distance, or another person between urge and action. For immediate danger or inability to stay safe, use emergency or crisis supports.

Risk situation	Friction/barrier	Delay action	Support/contact	Review
Spending/digital				
Driving/substances				
Conflict/communication				
Other				

My pause phrase is...

I will delay for...

I will move away from or restrict access to...

I will contact...

A safer substitute action is...

My threshold for urgent professional help is...

Self-Talk, Shame, and Self-Compassion

Clinical aim: Replace global self-criticism with accurate, compassionate accountability.

Years of missed expectations or misunderstanding can produce shame. Forced positivity is rarely persuasive; credible compassion recognizes difficulty, context, responsibility, and capacity to learn.

From verdict to useful response

Choose one recurring self-critical statement. Separate facts from labels and write a response you can believe.

Self-critical verdict	Facts/context	Need or difficulty	Credible compassionate response	Constructive action
Example 1				
Example 2				
Example 3				

Whose standard or voice does this resemble?

What does the criticism attempt to prevent?

How can you acknowledge impact without attacking identity?

Evidence of effort, learning, and strengths

Record concrete evidence, including partial progress and effective use of support. This is data collection, not self-persuasion.

Date/situation	Effort or strategy	Strength used	What I learned	What deserves acknowledgment
1				
2				
3				
4				
5				
6				

What progress have you dismissed because it was imperfect?

What support made success possible?

Relationships and Shared Systems

Clinical aim: Reduce blame and create explicit agreements, accommodations, and repair practices.

ADHD can affect attention in conversation, follow-through, household labor, time, emotional intensity, and intimacy. These patterns occur within a relationship system and do not establish intent or blame.

Relationship pattern inventory

Each person may complete this separately, then compare with curiosity. Do not use the worksheet to score or diagnose a partner.

- ☐ Attention drifts during conversation
- ☐ Interruptions or rapid topic shifts
- ☐ Commitments are remembered differently
- ☐ Tasks remain invisible until urgent
- ☐ One person carries more planning or reminding
- ☐ Time estimates create conflict
- ☐ Emotional escalation or shutdown makes repair harder
- ☐ Novelty, stimulation, or fatigue affects shared time
- ☐ Strengths and contributions go unrecognized

Pattern	My experience	Other perspective to ask about	Impact	Shared support
Communication				
Follow-through				
Labor/planning				
Time				
Emotion/repair				
Connection				

Shared agreement design

Choose one recurring problem and build an external system. Make ownership, timing, reminders, and repair explicit.

Agreement	Owner	Cue/system	Definition of done	Repair if missed	Review date
Shared plan					

What shared outcome do we want?

Who owns the task from noticing through completion?

What reminder system is acceptable?

What accommodation helps without turning one person into a manager?

How will we handle missed follow-through?

When will we review the agreement?

Mindfulness and Present-Moment Options

Clinical aim: Offer adaptable attention practices without presenting mindfulness as mandatory.

Brief present-moment practices can support noticing, shifting, and returning attention. Movement-based or externally focused options may fit better than stillness or internal focus.

Practice menu

Try one practice for 30 seconds to five minutes. Eyes may remain open. Movement, fidgets, sound, or a shorter duration are valid adaptations.

- ☐ Follow one comfortable breath or the feeling of exhaling
- ☐ Scan contact points or selected body areas
- ☐ Observe one object through available senses
- ☐ Label thoughts and let attention return
- ☐ Walk while noticing feet, movement, and surroundings
- ☐ Eat or drink one portion with deliberate attention
- ☐ Listen for near and far sounds
- ☐ Complete one routine action with full attention

Practice	Duration/adaptation	Attention before/after	Comfort	Fit/usefulness
Trial 1				
Trial 2				
Trial 3				

Which practice was easiest to return to after distraction?

Which should be adapted or avoided?

Pause before transition

Use this 30–60 second routine before switching tasks: stop, orient, capture the current next step, identify the destination task, and move deliberately.

Transition	What I captured	Next destination/action	Cue used	Result
1				
2				
3				
4				

Which transitions create the most lost time?

What physical or digital cue makes the pause easier?

Flexible Planning and Maintenance

Clinical aim: Integrate supports into a sustainable planning system and review care needs.

A useful planner protects capacity, makes priorities visible, includes transitions and body needs, and can recover after disruption.

The best system is one the person can return to.

Capacity-aware daily plan

Plan a realistic day using flexible blocks rather than filling every hour. Include appointments, transitions, care needs, and recovery.

Time/block	Appointment or focus	First action	Transition/buffer	Support/reminder	Done/carry forward
Morning start					
Block 1					
Block 2					
Midday					
Block 3					
Block 4					
Evening/shut down					

Top one to three priorities

Meals, hydration, medication as prescribed, movement, and rest

What can be dropped if capacity changes?

One completed action to acknowledge

Strategy and care review

Review strategies by fit, effect, and sustainability. Identify when additional diagnostic, medical, medication, therapy, occupational, workplace, or relationship support is needed.

Strategy/support	What improved	Cost or friction	Keep/change/stop	Next review
Planning				
Environment				
Activation				
Emotion				
Relationships				
Professional care				

What warning signs show that supports are slipping?

What is the simplest restart plan?

What questions should be brought to a clinician or prescriber?

What accommodations or advocacy steps remain important?

2026 Clinical Alignment

DSM-5-TR (including Sept. 2025 update) · ICD-11 CDDR / 2026 MMS

Classification status

- DSM-5-TR: Attention-deficit/hyperactivity disorder · recognized
- ICD-11 CDDR: 6A05 Attention deficit hyperactivity disorder · recognized
- A title, checklist, or completed activity never establishes a diagnosis.

Pages requiring the updated interpretation

- The audit identified source pages 2, 3, 4, 5, 8, 10, 12, 19, 22, 23, 26, 29, 30, 36, 37, 38. The statements below supersede incompatible diagnostic, scoring, safety, or resource wording on those pages.

Diagnostic and differential limits

- A symptom checklist or self-rating cannot establish diagnosis. Any diagnostic discussion must address clinically significant distress/impairment, required course or duration where applicable, developmental and cultural context, substance/medication and medical causes, comorbidity, exclusions, and reasonable differentials without reproducing copyrighted criteria.

Document-specific corrections

- Use the current formal classification identified for Adult ADHD; avoid treating the workbook title, a checklist, or a total score as sufficient to establish that diagnosis.
- Where Adult ADHD discusses symptoms, add the missing diagnostic frame: clinically meaningful distress/impairment, relevant course or duration, exclusions, developmental and cultural context, substance/medication or medical causes, and plausible differentials.
- Supersede diagnostic-sounding scoring on pages [2, 3, 4, 22, 30]: disclose whether each tool is validated or author-created, remove unsupported thresholds, and separate symptom monitoring from diagnosis.
- Clinically review medical or treatment statements on pages [2, 22, 23, 37, 38]; remove prescriptive medication advice, clarify coordination with licensed medical care, and update contraindications or urgent warning signs for the specific topic.
- Replace crisis wording on pages [2, 26] with the current U.S. 988 call/text/chat pathway, 911 or nearest emergency department for immediate danger/medical emergency, and a direction to use verified local services outside the United States.

Measures, scoring, and permissions

- Pages [2, 3, 4, 22, 30] contain named, implied, or author-created screening/rating content . These scores are not diagnostic unless the exact instrument, version, validation population, administration, and interpretation are established. Identify provenance for every item set and scoring rule. Obtain publisher permission/license when required; otherwise remove cutoffs and label it as a nonvalidated reflection checklist, or replace it with a properly licensed measure without altering its wording/scoring.

Intervention scope and contraindications

- Use Adult ADHD activities as psychoeducation and structured reflection, not diagnosis or a stand-alone treatment plan. Adapt or stop any exercise that worsens distress, functioning, conflict, pain, or dissociation, and escalate care according to the actual presentation.
- ADHD diagnosis requires a full developmental, psychiatric, psychosocial, and cross-setting assessment; a worksheet or rating form alone is insufficient.

Crisis and current resources

- For Adult ADHD, use: ·If there is immediate danger or a medical emergency, call 911 or go to the nearest emergency department. In the U.S., call or text 988 or use 988lifeline.org for 24/7 crisis support. Outside the U.S., use verified local emergency and crisis services. · Verify all topic-specific agencies and links at publication.

Authoritative references

- <https://www.psychiatry.org/psychiatrists/practice/dsm/updates-to-dsm/updates-to-dsm-5-tr-criteria-text>
- <https://www.psychiatry.org/getmedia/b68a5776-f88c-45c7-9535-fd219d7aa5cb/APA-DSM5TR-Update-September-2025.pdf>

2026 Clinical Alignment

DSM-5-TR (including Sept. 2025 update) · ICD-11 CDDR / 2026 MMS

- <https://icd.who.int/browse/2026-01/mms/en>
- <https://www.who.int/publications/i/item/9789240077263>
- <https://www.samhsa.gov/mental-health/988>
- <https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care>
- <https://988lifeline.org/>
- <https://www.nice.org.uk/guidance/ng87/chapter/recommendations>