The Therapist's ADHD Session Guide

A Neurodivergent-Affirming Quick Reference for Moving From "That's the Thing" to "Let's Understand What's Happening"

When a client brings you an ADHD term, framework, metaphor, or piece of neurodivergent community language, you do not need to immediately decide whether the term is clinically "correct" or choose an intervention. Begin by getting curious about the experience the language is helping them describe.

The term is the beginning of curiosity, not the end of formulation.

The Clinical Curiosity Map

1. NAME | Start With Their Language

Begin with the term or description the client is already using. You do not have to adopt it as a clinical construct in order to understand what it means to them.

Try asking: *"You've been calling this Task Paralysis. What does that phrase capture for you?"*

Remember: Some ADHD language comes from established psychological constructs, some from clinicians and educators, some from neurodivergent communities, and some from metaphor. Start with the experience before deciding what to make of the terminology.

2. DESCRIBE | Make the Experience Specific

Move from the label toward what actually happens. Ask what the client thinks, feels, notices, does, avoids, or experiences in their body.

Try asking: *"If I could watch this happening, what would I see?"* or *"What does this actually feel like from the inside?"*

3. LOCATE | Find Where Access Changes

Slow the experience down. Look for the moment something becomes harder, unavailable, overwhelming, or stuck.

Try asking: *"Walk me through what happens from the moment you think, 'I need to do this.' Where does it start getting difficult?"*

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Think **access rather than ability**. A client may possess a skill without having reliable access to it under every condition.

4. CONTEXTUALIZE | Look at the Conditions

Ask what makes the experience more or less likely. Consider executive demands alongside the client's environment, body, relationships, history, and current capacity.

Explore factors such as **interest, novelty, ambiguity, working memory, transitions, sensory load, hunger, fatigue, sleep, urgency, perfectionism, shame, anxiety, autonomy, social context, environmental cues, cumulative stress, and the presence or absence of support.**

Try asking: *"When is this easier? What is different then?"*

Variability is not noise around the problem. It is clinical information.

5. UNDERSTAND | Ask What Is Actually Happening

Before choosing an intervention, consider what the pattern may reflect. Is the client encountering executive-function friction, cognitive overload, sensory overwhelm, difficulty shifting attention, anticipatory shame, anxiety, perfectionism, depleted capacity, perceived loss of autonomy, relational threat, or several things working together?

Try asking: *"What seems to make this hard, and what might your system be responding to?"*

Avoid forcing every experience into ADHD simply because the client has ADHD.

6. SUPPORT | Change the Conditions

Once you understand more about the friction, ask what might make access easier. Support may involve changing the task, environment, expectations, sensory conditions, relational context, or the amount of information the client is expected to hold internally.

Possibilities include **externalizing steps, reducing choices, visual cues, timers, body doubling, movement, sensory adjustments, transition buffers, written reminders, predictable routines, clearer starting points, restoring meaningful choice, co-regulation, pacing, or working therapeutically with shame, anxiety, perfectionism, attachment, trauma, or other emotional material.**

Try asking: *"What would make this easier to access rather than simply harder to avoid?"*

7. EXPERIMENT | Try Something Small

Choose one manageable experiment rather than designing an entirely new life-management infrastructure before the session ends.

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Try asking: *"What is one small thing we could change and see what happens?"*

Frame strategies as experiments rather than compliance tests. If something does not help, the client has not failed the intervention. You have gathered more information about the formulation.

8. REASSESS | Learn From What Happened

Return to the experiment together. Ask what changed, what did not, what surprised the client, and whether your understanding of the original problem needs to shift.

Try asking: *"What did we learn about how your system works?"*

Then adjust. ADHD support is often less about discovering the One Correct Strategy and more about developing a better working relationship with the variables.

What Might I Explore?

When the client describes...	Become curious about...	Possible directions
Difficulty starting	First-step clarity, sequencing, activation, overwhelm, perfectionism, shame, capacity	Clarify the entry point, reduce steps, externalize sequence, add support
Attention or motivation difficulties	Interest, novelty, stimulation, urgency, movement, feedback, environment	Body doubling, movement, timers, immediate feedback, environmental changes
Time or working-memory difficulties	Time perception, prospective memory, working memory, visibility	Visual time, external reminders, point-of-performance cues, environmental scaffolding
Transitions or decision paralysis	Set shifting, choice load, attention residue, cognitive overload	Reduce choices, create defaults, transition buffers, thought parking
Sensory or body-related difficulties	Sensory load, sensory seeking, interoception, movement, hunger, fatigue	Sensory adjustments, movement, body check-ins, recovery, environmental changes

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Difficulty with demands	Autonomy, overwhelm, anxiety, perfectionism, trauma, sensory or executive demand	Restore meaningful choice, reduce unnecessary pressure, clarify expectations
Emotional or relational distress	Regulation, rejection sensitivity, shame, attachment, communication, relationship history	Validate, contextualize, regulate, communicate, repair
Masking, collapse, or burnout	Compensation, cumulative load, recovery, environmental mismatch, capacity	Pacing, accommodations, recovery, reducing masking, replacement scaffolding

Before You Call It ADHD

ADHD may be part of the formulation without explaining everything the client experiences. When something does not fit neatly, widen the lens rather than forcing it into the ADHD drawer.

Depending on the presentation, consider whether **autism, anxiety, trauma, depression, OCD, dissociation, sleep, medication effects, medical factors, chronic stress, attachment experiences, environmental mismatch, or other contributors** may also deserve exploration.

The question is not simply *"Is this ADHD?"* A more useful question may be: *"What combination of factors best helps us understand what is happening for this person?"*

Check the Therapy Environment Too

Before deciding a client is struggling to engage in therapy, consider whether therapy itself is creating unnecessary access barriers.

Ask yourself whether your questions are too broad, whether you are relying heavily on verbal working memory, whether the client needs movement or different seating, whether sensory conditions are affecting attention, whether homework contains too many invisible executive steps, whether you are expecting immediate emotional identification, and whether written or visual supports might help.

Most importantly, ask the client directly:

"Is there anything we could change about how we do therapy that would make this space easier for your brain to access?"

Neurodivergent-affirming therapy does not require lowering expectations or assuming every difficulty needs accommodation. It means becoming curious about whether the current route is unnecessarily difficult before concluding the client cannot reach the destination.

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Keep These Four Principles Nearby

Access, Not Ability: Inconsistent access to a skill is not evidence that the skill, desire, or effort is absent.

Curiosity Before Correction: Understand what is happening before trying to change it.

The Term Is the Beginning of Formulation: Task Paralysis, RSD, Waiting Mode, Demand Avoidance, Brain Smoothie, and other terms tell us where to look, not necessarily what we will find.

Explanation Is Not Exoneration: Understanding why something happens can support responsibility, communication, repair, and change without requiring shame as the admission price.

A Final Clinical Reminder

The goal is not to become fluent in every ADHD term circulating through clinical practice and neurodivergent communities. New ones will inevitably appear while you are reading this sentence.

The goal is to know what to do when a client looks at you and says, **“There. That’s the thing.”**

Get curious about the thing.

That is where the work begins.

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