

# The Therapist's ADHD Field Guide

## 220 Clinical Antidotes for the Things Your Client Finally Has Words For

### A Neurodivergent-Affirming Companion for In-Session Intervention, Exploration, and Support

A client comes into session and says, “I finally figured out what this is called.” Maybe it is Time Blindness, Task Paralysis, Reply Paralysis, the Wall of Awful®, Waiting Mode, sensory overload, or one of the many other terms that have given neurodivergent people language for experiences they may have spent years struggling to explain. Sometimes finding the name brings enormous relief. Something previously understood as laziness, irresponsibility, oversensitivity, inconsistency, or simply being “bad at life” suddenly becomes something the client can observe with curiosity rather than only judge.

For therapists, however, recognition creates another question: **Now what do we do with it?**

That is where this guide begins.

This companion was created to sit alongside the client-facing *ADHD Field Guide: Terms for the Things You Thought Were “Just You.”* It follows the same 220 terms, but shifts the lens from recognition to clinical exploration. Rather than offering a predetermined treatment for each experience, every entry provides a possible **clinical antidote**, something you can explore collaboratively when that particular pattern walks into the therapy room.

In this guide, an **antidote is not a cure for ADHD**, nor is it an attempt to eliminate neurodivergent traits or make a client function more neurotypically. An antidote is a therapeutic response that may reduce friction, increase access, restore meaningful choice, support regulation, deepen understanding, strengthen relationships, or help the client develop a more workable relationship with what they are experiencing. Sometimes the antidote is behavioral scaffolding. Sometimes it is emotional regulation, environmental accommodation, sensory support, relational repair, acceptance, externalization, meaning-making, or a conversation with the part of the client that has been working extraordinarily hard to keep everything together. Occasionally, the most clinically appropriate antidote is recognizing that nothing about the behavior actually needs to be changed.

The interventions throughout this guide are intentionally **evidence-informed, integrative, and modality-flexible**. They draw from **established and widely used psychological and behavioral approaches**, including Acceptance and Commitment Therapy (ACT), Dialectical

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

Behavior Therapy (DBT), behavioral interventions, motivational interviewing, and executive-function scaffolding, while also incorporating relational and attachment-based work, humanistic/Rogarian therapy, narrative therapy, solution-focused therapy, existential approaches, parts-informed work, somatic and nervous-system-informed practices, and Jungian/depth-oriented exploration when clinically appropriate. These approaches do not all carry the same type or degree of empirical support, and they are not presented as though they do. The intervention should follow the client, the function of the experience, the clinical formulation, therapist competence, client preference, and the available evidence, rather than the other way around.

The same is true of the language itself. Some terms in this guide reflect established psychological or neuropsychological constructs. Others come from clinicians, educators, neurodivergent communities, or popular language that captures a lived experience unusually well. Recognition is meaningful, but recognition is not diagnosis. **The term is the beginning of formulation, not the end of it.** When a client says, “I have RSD,” “I think this is demand avoidance,” or “Apparently I live in Waiting Mode,” our job is not simply to confirm or correct the vocabulary. Our job is to become curious about what the language is helping that particular person describe.

Throughout the guide, that curiosity rests on a few recurring principles: **Access, Not Ability. Curiosity Before Correction. The Term Is the Beginning of Formulation. Explanation Is Not Exoneration.** Understanding why something happens does not erase its impact, just as acknowledging impact does not require us to interpret a neurodivergent difference as a character flaw. We can hold accountability alongside accommodation, acceptance alongside change, and clinical rigor alongside respect for the client’s lived experience.

Most importantly, these interventions are **experiments, not compliance tests**. If body doubling helps one client initiate a task and makes another client want to crawl out of their skin because being perceived is itself activating, that difference is clinically useful information. If a visual schedule becomes wallpaper, a planner becomes an expensive decorative object, or a grounding exercise makes someone feel less regulated rather than more, the client has not failed the intervention. We have learned something about the formulation.

You do not need to memorize all 220 entries. This is a field guide, after all. It is meant to be opened when something wanders into the therapy room and everyone would benefit from taking a closer look.

When your client says, **“There. That’s the thing,”** find the thing.

Then get curious about it.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

# Executive Dysfunction

## The Start Button, Steering Wheel & Brakes

### 1. Executive Dysfunction

**Clinical Antidote:** Identify the executive function before choosing the intervention.

**Try in session:** Take one current difficulty and break it into the executive processes it requires: initiating, sequencing, prioritizing, holding information in mind, inhibiting, shifting, monitoring, or completing. Ask, *“Which part becomes hardest to access?”* Treat “executive dysfunction” as the beginning of formulation rather than the explanation itself.

**Draws from:** Behavioral functional analysis, collaborative formulation, ACT, solution-focused therapy.

### 2. Task Initiation Difficulty

**Clinical Antidote:** Make beginning smaller than the brain expects beginning to be.

**Try in session:** Choose a task the client has been unable to start and ask, *“What is the smallest physical action that would count as contact with this task?”* Continue shrinking until the action feels almost absurdly manageable. Opening the document may count. Putting the envelope beside the door may count. Beginning does not have to impersonate meaningful progress.

**Draws from:** Behavioral activation, shaping, graded task assignment, solution-focused therapy.

### 3. Task Paralysis / ADHD Paralysis

**Clinical Antidote:** Regulate before mobilizing.

**Try in session:** Resist immediately turning paralysis into a productivity problem. Invite the client to notice what happens when they imagine beginning: body sensations, thoughts, urges, emotions, images, and impulses. Ask, *“Does this feel more like I can’t organize movement, I don’t know where to begin, everything feels too much, or some part of me is hitting the brakes?”* Let the answer determine whether the next intervention involves regulation, clarification, task reduction, emotional work, or action.

**Draws from:** Somatic tracking, DBT mindfulness, ACT acceptance, parts-informed work.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 4. Activation Gap

**Clinical Antidote:** Build a bridge between deciding and moving.

**Try in session:** Identify a task the client reliably intends to do but struggles to activate around. Explore what has helped intention become movement in other situations: music, another person, standing up, a countdown, putting shoes on, changing rooms, a timer, or touching the first object involved. Design a repeatable **activation bridge** that occurs immediately after the decision.

**Draws from:** Behavioral activation, implementation intentions, solution-focused exceptions, executive-function scaffolding.

## 5. Invisible First Step

**Clinical Antidote:** Turn abstraction into observable behavior.

**Try in session:** Write the task down and ask, *“If I were watching through a window, what would I see you physically do first?”* If the answer is still abstract, keep going. “Start the application” might become “find the website,” then “open the laptop.” Stop when the starting point becomes unmistakably visible.

**Draws from:** Behavioral task analysis, behavioral activation, collaborative problem-solving.

## 6. Too-Many-Steps Problem

**Clinical Antidote:** Get the task out of working memory and onto the table.

**Try in session:** Put every hidden step on separate cards, sticky notes, or pieces of paper. Let the client physically arrange them, combine them, eliminate unnecessary ones, identify where support is needed, and decide what “good enough” completion actually requires. Often the intervention is not teaching someone to tolerate thirty-seven steps. It is discovering that twelve of them never needed to exist.

**Draws from:** Behavioral task analysis, executive-function scaffolding, ACT values clarification, occupational adaptation.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 7. Task Fog

**Clinical Antidote:** Define the edges before asking for movement.

**Try in session:** Ask the client to describe what **done** would look like rather than how they should begin. What would be visibly different when the task was complete enough? Then work backward. If the client cannot identify the destination, difficulty initiating may be an information problem rather than a motivation problem.

**Draws from:** Solution-focused preferred-future work, behavioral specification, guided imagery.

## 8. Task Cliff

**Clinical Antidote:** Find what appears at the edge.

**Try in session:** Have the client imagine approaching the task without requiring them to do it. Ask them to tell you when the manageable task suddenly becomes a cliff. Then slow down: *“What just showed up?”* Look for uncertainty, anticipated effort, perfectionism, sensory discomfort, shame, fear of failure, boredom, previous criticism, or loss of autonomy. Treat the cliff as information about what requires support.

**Draws from:** ACT willingness, somatic tracking, behavioral chain analysis, experiential therapy.

## 9. Task Quicksand

**Clinical Antidote:** Stop using internal coercion as the extraction strategy.

**Try in session:** Externalize the voice saying, *You should have done this already. Just get up. Why are you still sitting here?* Ask what happens inside as that voice becomes louder. Explore where its language came from and what it believes pressure will accomplish. Then experiment with replacing command with curiosity: *“What is making movement difficult right now?”* Notice whether access changes when the internal relationship changes.

**Draws from:** ACT defusion, narrative externalization, parts-informed work, Rogerian compassion.

## 10. Activation Threshold

**Clinical Antidote:** Discover the conditions under which activation becomes available.

**Try in session:** Conduct an exception interview around several times the client began something more easily than expected. Look for recurring ingredients such as urgency, novelty, movement, another person, clear instructions, interest, sensory stimulation, rest, reward, or

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

reduced decision-making. Create a personalized **activation recipe** rather than assuming motivation should arise under identical conditions every day.

**Draws from:** Solution-focused exception finding, behavioral analysis, motivational interviewing.

## 11. Friction Point

**Clinical Antidote:** Intervene at the jam, not across the entire highway.

**Try in session:** Walk through a recurring task slowly and ask the client to stop at the exact moment the process becomes harder. The problem may turn out not to be “doing laundry” but carrying it upstairs, deciding where partially worn clothes belong, or folding. Design the intervention specifically around that junction.

**Draws from:** Functional behavioral analysis, solution-focused therapy, environmental modification.

## 12. Friction Tax

**Clinical Antidote:** Remove unnecessary gates.

**Try in session:** Take a recurring task and count every login, password, decision, search, phone call, transition, preparation step, object retrieval, or other tiny gate surrounding it. Ask, “*Which of these could disappear?*” Automate, duplicate, relocate, pre-decide, simplify, or eliminate wherever possible.

**Draws from:** Behavioral/environmental modification, executive-function accommodation, occupational adaptation.

## 13. Executive Drag

**Clinical Antidote:** Account for the invisible thirty-five minutes.

**Try in session:** When the client says, “*It is a five-minute task. Why does it take me forty minutes?*” become interested in the other thirty-five. Map what occurs before and around the visible action: thinking about it, avoiding it, remembering it, forgetting it, preparing, negotiating internally, worrying about doing it correctly, transitioning, or recovering afterward. The invisible labor often tells you what needs treatment or accommodation.

**Draws from:** Humanistic phenomenological inquiry, functional analysis, ACT, collaborative formulation.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

## 14. Threshold Brain

**Clinical Antidote:** Create rituals for crossing neurological doorways.

**Try in session:** Identify a recurring beginning or ending that feels disproportionately difficult and develop a brief transition ritual. It might involve changing lighting, making tea, playing one song, stepping outside, closing a notebook, moving rooms, stretching, or using a repeated phrase. The ritual becomes a sensory and symbolic marker: *we are leaving this state and entering another.*

**Draws from:** Behavioral cueing, somatic regulation, Jungian/depth-oriented ritual and symbolism, mindfulness.

## 15. Momentum Brain

**Clinical Antidote:** Protect useful momentum and plan stopping before momentum becomes captivity.

**Try in session:** Map what happens after the client finally gets moving. If continuation becomes easier than stopping, create both **entry supports and exit supports**. Identify natural stopping landmarks, body checks, transition cues, or external interruptions that protect momentum without allowing it to consume food, sleep, appointments, or tomorrow's capacity.

**Draws from:** Behavioral momentum, mindfulness, interoceptive awareness, pacing.

## 16. Invisible Load

**Clinical Antidote:** Make unseen executive labor visible enough to redistribute it.

**Try in session:** Choose one apparently ordinary responsibility and write down everything the client must remember, anticipate, monitor, decide, sequence, and cue themselves to do before anyone else sees the final behavior. Ask, "*Which of these pieces actually have to live in your head?*" Externalize, automate, delegate, or simplify what can be moved elsewhere.

This can also become important relational work when invisible executive labor is unevenly distributed or repeatedly mistaken for "doing nothing."

**Draws from:** Narrative externalization, behavioral task analysis, relational therapy, executive-function scaffolding.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 17. The Start Button Problem

**Clinical Antidote:** Develop a start cue that bypasses deliberation.

**Try in session:** Instead of relying on the client to repeatedly decide when to begin, pair the task with a stable cue: after coffee, when a particular playlist begins, immediately after sitting at the desk, when another person starts working, or after a specific alarm. Rehearse the cue-action pairing in session and make the first action tiny.

**Draws from:** Stimulus control, implementation intentions, behavioral conditioning, habit formation.

## 18. Task Temperature

**Clinical Antidote:** Warm the task before expecting full engagement.

**Try in session:** Ask what makes a “cold” task feel neurologically distant. Experiment with a two-minute warm-up that creates contact without requiring completion: preview the document, gather materials, talk through the problem aloud, doodle the idea, read the first question, or work beside someone. The goal is not yet productivity. It is increasing psychological and attentional proximity.

**Draws from:** Behavioral activation, graded exposure, motivational interviewing, ACT committed action.

## 19. Functional Friction

**Clinical Antidote:** Change the environment before concluding the person needs to change.

**Try in session:** Compare the objective task with the conditions under which the client is attempting it. Ask what would happen if the same task occurred at another time, in another place, with fewer sensory demands, clearer instructions, another person present, different tools, or fewer transitions. Experiment with changing one environmental variable.

**Draws from:** Person-environment fit, behavioral modification, neurodivergent-affirming accommodation, solution-focused experimentation.

## 20. Capacity Mismatch

**Clinical Antidote:** Match the demand to the nervous system that arrived today.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Try in session:** Ask the client to rate current capacity rather than motivation. Then explore what the task requires relative to what is available. Can the task be reduced, delayed, delegated, supported, or completed differently? This is particularly useful for challenging the belief that because something was accessible yesterday, it must be equally accessible today.

**Draws from:** ACT acceptance, pacing, disability-affirming practice, solution-focused scaling, somatic awareness.

## 21. Intention-Action Gap

**Clinical Antidote:** Separate wanting, intending, and accessing.

**Try in session:** Draw three columns: **I wanted to**, **I intended to**, and **I was able to access**. Use a recent difficulty to identify where the sequence broke down. Then ask what conditions might help bridge that specific gap. This can be especially powerful for clients carrying years of accusations that inconsistent action proves inconsistent caring.

**Draws from:** ACT values work, narrative reauthoring, behavioral formulation, humanistic therapy.

# Attention Regulation

**The Wandering, Sticky Spotlight**

## 22. Side-Questing

**Clinical Antidote:** Give curiosity somewhere to go without surrendering the original quest.

**Try in session:** Reconstruct a recent side quest from the original task through each attentional branch. Rather than treating every diversion as failure, identify what captured attention and why. Then create a **side-quest parking lot**, a visible place to record interesting-but-not-now tasks before returning to the original activity. Practice the sequence in session: notice, capture, return.

**Draws from:** ACT present-moment awareness, behavioral cueing, mindfulness, executive-function scaffolding.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

## 23. Side-Quest Cascade

**Clinical Antidote:** Interrupt the cascade at transition points rather than policing every thought.

**Try in session:** Map several branches of a recent cascade and identify what happened immediately before each switch. Develop a brief orienting question for those moments: *“What quest am I currently on?”* Pair it with a visible anchor such as the original task written on a sticky note or whiteboard.

**Draws from:** Behavioral chain analysis, DBT mindfulness, ACT attention flexibility.

## 24. Hyperfocus

**Clinical Antidote:** Preserve useful depth while building exits.

**Try in session:** Explore what hyperfocus provides before treating it as a problem. Then identify what becomes inaccessible while the client is deeply absorbed: time, hunger, movement, appointments, other responsibilities, or stopping. Collaboratively create external exit cues and body check-ins that protect the benefits of deep focus while reducing its costs.

**Draws from:** ACT, behavioral cueing, mindfulness, interoceptive awareness, pacing.

## 25. Hyperfixation

**Clinical Antidote:** Explore the function and meaning of intense interest rather than automatically regulating it away.

**Try in session:** Ask what the interest provides: pleasure, mastery, identity, predictability, regulation, belonging, escape, meaning, novelty, or intellectual stimulation. If it is creating difficulties, explore boundaries around time or resources without framing enthusiasm itself as pathological.

For some clients, the fixation may also become psychologically symbolic. *Why this subject? Why now? What does it awaken, represent, protect, or allow?*

**Draws from:** Humanistic therapy, ACT values, Jungian/depth exploration, behavioral boundary-setting.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 26. Attention Tunneling

**Clinical Antidote:** Build peripheral-awareness cues without destroying concentration.

**Try in session:** Ask what disappears from awareness once attention tunnels. Develop one external cue that periodically widens the field: a timer, change in lighting, another person checking in, music ending, or a visual prompt asking, “*Body? Time? Next obligation?*” Practice widening and returning rather than requiring sustained broad awareness.

**Draws from:** Mindfulness, behavioral cueing, somatic awareness, executive-function scaffolding.

## 27. Attention Pinball

**Clinical Antidote:** Reduce competing inputs before demanding sustained attention.

**Try in session:** Invite the client to identify everything currently competing for attention, including sounds, thoughts, bodily sensations, notifications, worries, visual clutter, and unfinished tasks. Externalize internal competitors and reduce environmental ones. Then experiment with focusing on one target for a deliberately short interval.

**Draws from:** DBT one-mindfulness, environmental modification, ACT present-moment awareness, sensory-informed work.

## 28. Rabbit Hole

**Clinical Antidote:** Give curiosity a container.

**Try in session:** Rather than telling the client to stop following interesting questions, develop a **rabbit-hole agreement**: capture the question, decide whether it serves the current task, and schedule exploration when it does not. For research-heavy rabbit holes, practice identifying the question the client is actually trying to answer and what would count as “enough information.”

**Draws from:** Behavioral boundaries, ACT values, metacognitive awareness, solution-focused therapy.

## 29. Task Magnetism

**Clinical Antidote:** Study attraction rather than moralizing preference.

**Try in session:** Compare a magnet task with a repellent task. Ask what the magnetic task contains: novelty, mastery, immediate feedback, clear boundaries, sensory pleasure, identity, urgency, or emotional safety. Then explore whether one or two of those conditions can be transferred to the less accessible task.

**Draws from:** Functional analysis, motivational interviewing, behavioral activation, solution-focused exceptions.

## 30. Cognitive Velcro

**Clinical Antidote:** Learn what makes attention stick.

**Try in session:** Identify several activities, thoughts, or problems that reliably hold attention and look for common ingredients. Use those patterns to understand the client's attentional ecology rather than treating strong engagement as evidence that they "can focus when they want to."

**Draws from:** Strengths-based formulation, behavioral analysis, solution-focused therapy, humanistic inquiry.

## 31. Cognitive Teflon

**Clinical Antidote:** Add traction rather than increasing self-criticism.

**Try in session:** Choose one task attention repeatedly slides away from. Experiment with changing one variable at a time: movement, novelty, social presence, visible progress, immediate feedback, location, challenge, or duration. Ask, "*What gives this task something for attention to grab?*"

**Draws from:** Behavioral experimentation, motivational interviewing, environmental modification.

## 32. Mental Velcro vs. Mental Teflon

**Clinical Antidote:** Replace "Why can't I focus?" with "Under what conditions does attention become accessible?"

**Try in session:** Put one Velcro task and one Teflon task side by side. Compare their sensory, emotional, cognitive, social, motivational, and environmental characteristics. Turn the differences into hypotheses the client can test rather than conclusions about effort or character.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Draws from:** Collaborative formulation, solution-focused exceptions, ACT curiosity, behavioral experimentation.

# Hyperactivity & Internal Restlessness

## The Outer Storm & Inner Storm

### 33. Tab Brain

**Clinical Antidote:** Close loops externally rather than demanding internal silence.

**Try in session:** Have the client name every mental “tab” currently open and place each one on paper. Sort them into **now, later, needs action, and can close**. Notice whether mental noise changes once the brain no longer has to keep every tab active to prevent losing it.

**Draws from:** Externalization, executive-function scaffolding, DBT mindfulness, narrative therapy.

### 34. Browser Brain

**Clinical Antidote:** Create a trusted place for new windows to land.

**Try in session:** Explore what happens when new ideas arrive. Rather than requiring the client to ignore them, develop one capture system that allows an idea to be saved without being pursued immediately. Practice capturing a thought and deliberately returning attention to the current conversation.

**Draws from:** ACT defusion, behavioral scaffolding, mindfulness.

### 35. Brain Smoothie

**Clinical Antidote:** Separate the ingredients before trying to solve the mixture.

**Try in session:** When everything feels blended together, create categories on paper: **thoughts, feelings, body sensations, tasks, worries, sensory input, needs, and ideas**. Let the client distribute what is happening among them. Do not immediately problem-solve. First restore differentiation.

**Draws from:** DBT observe-and-describe, emotional granularity, narrative externalization, somatic work.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 36. Mental Popcorn

**Clinical Antidote:** Capture ideas without requiring every idea to become an assignment.

**Try in session:** Invite the client to rapidly list whatever is popping up for sixty seconds without organizing or evaluating it. Then ask which thoughts are actionable, interesting-but-not-now, emotional signals, or simply mental noise. This allows spontaneity without converting every kernel into a project.

**Draws from:** Mindfulness, cognitive defusion, narrative externalization, executive-function scaffolding.

## 37. Thought Traffic

**Clinical Antidote:** Direct traffic before choosing a destination.

**Try in session:** Externalize the competing thoughts and ask which ones are urgent, important, emotionally loud, repetitive, or merely present. Select one lane for the current session while visibly parking the others somewhere they can be returned to.

**Draws from:** DBT one-mindfulness, ACT present-moment work, executive-function scaffolding.

## 38. Open-Loop Hum

**Clinical Antidote:** Give unfinished business a trusted container.

**Try in session:** Create an open-loop inventory. For each item, decide whether it needs an action, a scheduled time, a reminder, delegation, deliberate postponement, or permission to be dropped. The therapeutic goal is not necessarily completing every loop. It is helping the brain believe it no longer has to hum continuously to keep the loop from disappearing.

**Draws from:** Behavioral planning, ACT acceptance, executive-function scaffolding, solution-focused therapy.

## 39. Background Brain

**Clinical Antidote:** Ask what attention is quietly protecting against forgetting.

**Try in session:** When a client cannot fully settle into rest or conversation, ask what part of their mind is still monitoring. Externalize those responsibilities before attempting relaxation. Sometimes “difficulty relaxing” is actually a nervous system refusing to relinquish information it does not trust anything else to hold.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Draws from:** Parts-informed work, ACT, executive-function scaffolding, somatic regulation.

## 40. Brain Static

**Clinical Antidote:** Reduce signal competition before asking for clarity.

**Try in session:** Pause content work and assess basic conditions: sensory load, sleep, hunger, movement needs, emotional activation, unresolved demands, and cognitive overload. Experiment with reducing one source of noise before asking the client to organize thoughts.

**Draws from:** Somatic work, sensory-informed intervention, DBT mindfulness, environmental modification.

# Impulsivity & Novelty Seeking

**The Brain That Moves Before the Committee Meets**

## 41. Dopamine Chase

**Clinical Antidote:** Identify the need beneath the chase.

**Try in session:** Rather than beginning with “*How do we stop this?*”, ask what the sought activity provides: stimulation, pleasure, relief, novelty, connection, escape, mastery, or emotional regulation. Then explore other ways of meeting the same need, especially when the current strategy carries consequences the client wants to change.

**Draws from:** Motivational interviewing, functional behavioral analysis, ACT values, harm-reduction principles.

## 42. Novelty Hunger

**Clinical Antidote:** Build renewable novelty into necessary routines.

**Try in session:** Identify an important routine that repeatedly becomes inaccessible once it is familiar. Brainstorm ways to vary **how** it happens without abandoning **what** needs to happen: location, order, music, tools, timing, challenge, companion, format, or reward.

Also explore whether the client experiences novelty as vitality, identity, possibility, or freedom. Sometimes the longing for “something new” carries existential information worth hearing.

**Draws from:** Behavioral activation, solution-focused creativity, existential therapy, ACT values.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

## 43. Dopamine Detour

**Clinical Antidote:** Create a pause between discomfort and diversion.

**Try in session:** Reconstruct a recent detour and identify what the original task felt like immediately before attention left it: boredom, confusion, anxiety, effort, shame, sensory discomfort, or low reward. Practice noticing that state and asking, “*What does this task need before I leave it?*” Sometimes the answer is stimulation. Sometimes it is clarity. Sometimes it is a break.

**Draws from:** Behavioral chain analysis, ACT willingness, DBT mindfulness, motivational interviewing.

# Motivation & Reward Regulation

Why Wanting To Is Not Always Enough

## 44. Deadline Gravity

**Clinical Antidote:** Move motivational pull closer without moving catastrophe closer.

**Try in session:** Ask what changes as the deadline approaches. Does the task become clearer? More real? Less optional? Does urgency eliminate competing choices? Once the mechanism is identified, recreate a smaller version earlier through milestones, appointments, accountability, or visible countdowns.

**Draws from:** Behavioral activation, implementation intentions, solution-focused therapy.

## 45. Deadline Rocket Fuel

**Clinical Antidote:** Borrow the useful properties of urgency without requiring emergency.

**Try in session:** Identify what crisis-level urgency gives the client that ordinary planning does not: narrowed attention, adrenaline, permission to ignore everything else, immediate consequences, or a clearly defined finish line. Design a structured sprint that recreates those conditions at lower intensity.

**Draws from:** Behavioral activation, environmental design, executive-function scaffolding.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 46. Artificial Urgency

**Clinical Antidote:** Use manufactured urgency intentionally rather than shamefully.

**Try in session:** Help the client design a deadline that has enough external reality to matter: a scheduled body-double session, sending something to another person, a timed challenge, or a calendar commitment. Discuss which forms feel activating versus coercive.

**Draws from:** Behavioral contracting, motivational interviewing, accountability structures.

## 47. Interest-Based Nervous System

**Clinical Antidote:** Work with motivational conditions without turning the framework into neurological destiny.

**Try in session:** Explore which conditions reliably increase engagement: interest, novelty, challenge, urgency, connection, creativity, or immediate relevance. Ask how these can be incorporated into responsibilities while still building tolerance for tasks that will never become fascinating.

**Draws from:** Motivational interviewing, behavioral activation, ACT committed action.

**Clinical note:** Treat this as a useful explanatory framework rather than a formal diagnostic model.

## 48. Interest Cliff

**Clinical Antidote:** Plan for the moment fascination leaves before it actually leaves.

**Try in session:** Examine projects the client abandoned after intense early engagement. Identify where novelty typically fades and what remains afterward. Develop a **post-interest plan** involving reduced scope, accountability, automation, delegation, scheduled completion, or consciously deciding that the project no longer deserves continued investment.

**Draws from:** Relapse-prevention style planning, behavioral shaping, ACT values clarification.

## 49. Dopamenu / Dopamine Menu

**Clinical Antidote:** Create intentional access to stimulation and regulation.

**Try in session:** Build a personalized menu of brief, moderate, and immersive activities that reliably provide pleasure, movement, connection, novelty, sensory input, or restoration. Include

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

options that require almost no setup for low-capacity moments. Use the menu as a choice aid rather than a prescription.

**Draws from:** Behavioral activation, pleasant-event scheduling, solution-focused therapy.

**Clinical note:** “Dopamine” is shorthand here. The menu is not literally dosing or measuring dopamine.

## 50. Motivation Bridge

**Clinical Antidote:** Add what the task is missing.

**Try in session:** Choose one low-access task and ask, “*What could we add without changing the actual requirement?*” Experiment with music, movement, companionship, competition, novelty, visible progress, reward, humor, or challenge. Let the client build bridges that match their nervous system rather than generic productivity advice.

**Draws from:** Behavioral activation, motivational interviewing, solution-focused experimentation.

## 51. Activation Energy

**Clinical Antidote:** Lower the energy required to make first contact.

**Try in session:** Identify everything that must happen before the task officially begins and reduce setup. Leave materials visible, pre-open the document, pre-decide the location, place needed objects together, or create a two-minute entry ritual. The intervention targets the energetic hill before the task, not merely the task itself.

**Draws from:** Behavioral environmental modification, stimulus control, executive-function scaffolding.

## 52. Low-Dopamine Day

**Clinical Antidote:** Treat the phrase as a capacity report rather than a neurochemical measurement.

**Try in session:** Ask what “low dopamine” means phenomenologically today: flatness, boredom, fatigue, low reward, difficulty activating, restlessness, low mood, or sensory understimulation. Then respond to the actual experience rather than the shorthand. If the pattern includes persistent loss of pleasure or mood change, widen the assessment.

**Draws from:** Humanistic phenomenological inquiry, behavioral activation, differential formulation.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Clinical note:** The phrase does not establish that dopamine is literally low.

## 53. Understimulation

**Clinical Antidote:** Add the right amount of input before demanding more effort.

**Try in session:** Experiment during the session. Invite standing, pacing, doodling, fidgeting, music without lyrics, chewing gum where appropriate, tactile input, or another safe form of stimulation while completing a small cognitive task. Compare attention before and after.

**Draws from:** Behavioral experimentation, sensory-informed intervention, somatic regulation.

## 54. Stimulation Seeking

**Clinical Antidote:** Help the client become intentional about stimulation rather than ashamed of needing it.

**Try in session:** Build a **stimulation profile**: what kinds organize, energize, soothe, overwhelm, or derail? Explore movement, sound, pressure, novelty, social contact, challenge, and sensory input. The aim is not “less stimulation.” It is more skillful matching.

**Draws from:** Sensory-informed work, behavioral self-monitoring, humanistic therapy.

## 55. Deadline Dependence

**Clinical Antidote:** Identify what the deadline has been doing for the client and replace the function gradually.

**Try in session:** Ask what would disappear if deadlines stopped producing panic. Would there still be clarity? Prioritization? Permission to focus? Activation? External accountability? Build those functions earlier rather than simply instructing the client to “stop procrastinating.”

**Draws from:** Functional analysis, behavioral activation, motivational interviewing, solution-focused therapy.

## 56. The Dopamine Door

**Clinical Antidote:** Identify the client’s preferred entrances into engagement.

**Try in session:** Create a short list of known doors: curiosity, movement, another person, novelty, challenge, urgency, music, competition, meaning, immediate feedback, or play. For a

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

stuck task, ask, “*Which door could we try?*” If it does not open, gather information rather than escalating force.

**Draws from:** Behavioral experimentation, motivational interviewing, ACT values, solution-focused therapy.

## 57. Interest-Importance Gap

**Clinical Antidote:** Stop asking importance to perform the job of activation.

**Try in session:** Put **Why this matters** and **What helps me engage** in separate columns. Let the client identify the values behind the responsibility without assuming values alone will create action. Then add the practical conditions that make engagement more accessible.

This distinction can be especially reparative for clients who have learned that difficulty acting on something important proves they do not care. Values tell us **why we want to move**. Executive and environmental supports may still determine **whether movement is accessible**.

**Draws from:** ACT values and committed action, motivational interviewing, behavioral activation, narrative reauthoring.

# Time Perception

**Welcome to the Elastic Clock**

## 58. Time Blindness

**Clinical Antidote:** Make time perceptible rather than asking the client to feel it more accurately.

**Try in session:** Choose one recurring activity and map how time actually behaves around it. Ask the client to estimate how long each stage takes, then compare those estimates with observed experience when possible. Introduce external representations such as visual timers, countdowns, clocks, or time blocks so elapsed and remaining time become visible rather than something the client must internally sense.

**Draws from:** Behavioral self-monitoring, executive-function scaffolding, environmental modification.

## 59. Temporal Myopia

**Clinical Antidote:** Bring the future close enough to become psychologically real.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Try in session:** Take one future obligation that feels distant and work backward until it touches today. Instead of “renew license next month,” identify the first present-tense action and place it somewhere visible. Ask, “*What would Future You need Present You to make easier?*”

**Draws from:** ACT committed action, prospective planning, behavioral scaffolding, future-self work.

## 60. Time Warp

**Clinical Antidote:** Use external landmarks when internal time changes shape.

**Try in session:** Identify activities during which time reliably disappears or stretches. Rather than asking the client to monitor time continuously, build landmarks around the activity: a playlist ending, scheduled check-in, meal, environmental change, timer, or another person’s arrival.

**Draws from:** Behavioral cueing, mindfulness, environmental scaffolding.

## 61. Time Accordion

**Clinical Antidote:** Plan with ranges rather than false precision.

**Try in session:** Have the client estimate a task three ways: best case, typical case, and difficult-day case. Use the range rather than the shortest estimate when planning. This helps loosen the assumption that variable duration represents poor discipline rather than variable access and conditions.

**Draws from:** Behavioral self-monitoring, behavioral planning, cognitive reframing, solution-focused therapy.

## 62. Now / Not Now

**Clinical Antidote:** Give “not now” a visible route back into “now.”

**Try in session:** Take one future task and create an external re-entry cue: calendar event, object placement, scheduled reminder, another person, or visible planning board. Ask, “*What will make this become real again without requiring you to remember that you need to remember it?*”

**Draws from:** Prospective-memory scaffolding, behavioral cueing, environmental design.

## 63. Future Fog

**Clinical Antidote:** Replace the vague future with concrete landmarks.

**Try in session:** Draw a simple timeline from today to the future event. Add preparation points, decisions, transitions, and deadlines. Keep the map visible and limited to what actually matters. Future fog often clears when time stops being an abstract cloud and acquires furniture.

**Draws from:** Visual planning, behavioral task analysis, solution-focused therapy.

## 64. Time Confetti

**Clinical Antidote:** Gather scattered minutes into usable containers.

**Try in session:** Explore where the client has fragments of time that feel too small to use. Rather than filling every gap with productivity, identify a few activities that genuinely fit five, ten, or twenty minutes, including rest. Create a small menu so the client does not spend the entire available window deciding what could fit inside it.

**Draws from:** Behavioral planning, choice reduction, pacing, solution-focused therapy.

## 65. Waiting Mode

**Clinical Antidote:** Externalize responsibility for the upcoming event.

**Try in session:** Build a concrete pre-event plan containing a **safe-to-start window**, transition alarm, preparation cue, and leave time. Ask what kinds of activities feel safe before an appointment and how long the client needs to disengage from them. The goal is to let the external system guard the appointment so the entire nervous system does not have to stand watch.

**Draws from:** Behavioral scaffolding, prospective-memory support, anxiety-informed work.

## 66. Future-Me Delegation

**Clinical Antidote:** Turn Future You from an imaginary employee into a person with finite capacity.

**Try in session:** When the client says, *"I'll do it later,"* ask them to describe what Future Them will actually be doing, feeling, and carrying at that time. Then ask, *"What could Present You do that would make that person's job easier?"* This is not about guilt-tripping the present self into productivity. It is about creating continuity between selves across time.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

**Draws from:** ACT values, self-as-context, future-self work, behavioral planning.

## 67. Time Optimism

**Clinical Antidote:** Replace imagined duration with observed duration.

**Try in session:** Choose a routine the client consistently underestimates and break it into its actual components. Include transition time, locating objects, preparation, parking, walking, and inevitable human moments. Compare prediction with observation over several repetitions and build planning estimates from the resulting data.

**Draws from:** Behavioral self-monitoring, estimate calibration, behavioral planning, executive-function scaffolding.

# Working Memory & Retrieval

The Thought That Was Here Three Seconds Ago

## 68. Calendar Amnesia

**Clinical Antidote:** Make checking the calendar part of another behavior rather than another thing to remember.

**Try in session:** Attach calendar review to something that already reliably happens, such as morning coffee, opening the laptop, lunch, or ending the workday. Rehearse what the client will look for and what action follows.

**Draws from:** Habit stacking, stimulus control, implementation intentions.

## 69. Brain Buffet

**Clinical Antidote:** Reduce simultaneous mental serving dishes.

**Try in session:** Ask the client to empty everything currently competing for working memory onto paper without organizing it first. Once visible, sort into **now, later, delegate, discard, and emotionally important**. Let prioritization happen after unloading rather than while the brain is still carrying the buffet.

**Draws from:** Cognitive offloading, DBT one-mindfulness, executive-function scaffolding.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 70. Working-Memory Drop

**Clinical Antidote:** Capture before switching.

**Try in session:** Practice a three-second capture ritual whenever the client must shift attention: jot a word, leave a visual marker, record a voice note, or state aloud what they were about to do. The intervention protects the intention before another stimulus displaces it.

**Draws from:** Cognitive offloading, behavioral cueing, metacognitive training.

## 71. Doorway Amnesia

**Clinical Antidote:** Carry the intention across the threshold externally.

**Try in session:** Experiment with keeping a physical or verbal cue active while moving between locations: carry the object associated with the task, repeat the intention aloud, put it in a phone note before standing, or use a location-based reminder.

**Draws from:** Context-dependent memory support, behavioral cueing, environmental scaffolding.

## 72. Thought Evaporation

**Clinical Antidote:** Protect fleeting thoughts without interrupting connection.

**Try in session:** Establish a session norm that allows the client to jot down a word when a thought appears while you are speaking. Practice saying, *“I want to keep listening, and I need to put this somewhere safe first.”* This can be especially useful for clients who interrupt because they know the thought may genuinely disappear.

**Draws from:** Working-memory accommodation, relational therapy, behavioral scaffolding.

## 73. Brain Buffering

**Clinical Antidote:** Give retrieval time without filling the silence for them.

**Try in session:** When the client pauses searching for a word or memory, resist immediately rescuing the silence. Offer permission: *“Take your time. We don’t have to make your brain retrieve this on demand.”* If needed, provide context cues rather than supplying the answer.

**Draws from:** Rogerian presence, humanistic therapy, memory retrieval support, disability-affirming practice.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 74. Retrieval Lag

**Clinical Antidote:** Separate delayed retrieval from absent knowledge.

**Try in session:** Normalize the difference between *not knowing* and *not retrieving right now*. Offer alternative routes such as describing around the word, drawing, writing, returning later, or using recognition choices. Notice whether performance pressure worsens access.

**Draws from:** Humanistic therapy, cognitive accommodation, anxiety reduction.

## 75. Out of Sight, Out of Mind

**Clinical Antidote:** Put important information where attention naturally lands.

**Try in session:** Choose one recurring forgotten responsibility and identify the exact location where action needs to occur. Place the cue there rather than somewhere conventionally tidy. Ask, *“Where would your eyes naturally encounter this when it becomes relevant?”*

**Draws from:** Point-of-performance cueing, environmental modification, behavioral design.

## 76. Reminder Wallpaper

**Clinical Antidote:** Restore novelty to cues that have become scenery.

**Try in session:** Audit the client’s reminder ecosystem. Remove redundant alerts, retire obsolete sticky notes, change cue location or format, and reserve intrusive reminders for genuinely important tasks. More reminders are not always more remembering.

**Draws from:** Stimulus control, habituation principles, environmental modification.

## 77. Alarm Blindness

**Clinical Antidote:** Give the alarm a specific behavioral meaning.

**Try in session:** Examine what currently happens when an alarm sounds. Replace vague alarms such as “appointment soon” with action-based cues such as **stand up now, put shoes on, or leave the house**. If alarms are routinely dismissed, change modality or connect the cue to a physical action.

**Draws from:** Behavioral cueing, implementation intentions, stimulus control.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

## 78. Point Retrieval Failure

**Clinical Antidote:** Leave breadcrumbs back to the original thought.

**Try in session:** When the client loses their point mid-story, use collaborative retrieval rather than pressure. Summarize the last few ideas and ask which one feels closest to the missing thread. In daily life, encourage one-word anchors during complex conversations, meetings, or writing.

**Draws from:** Relational attunement, working-memory scaffolding, narrative organization.

# Transitions & Switching

**Sometimes the Hard Part Is the Doorway**

## 79. Transition Tax

**Clinical Antidote:** Budget for switching as part of the task.

**Try in session:** Map the actual cost of moving between two activities: stopping, saving the current state, emotionally disengaging, moving locations, reorganizing materials, changing sensory environments, and orienting to the next demand. Build transition time into the plan rather than treating it as wasted time.

**Draws from:** Behavioral planning, pacing, executive-function scaffolding.

## 80. Task Inertia

**Clinical Antidote:** Use momentum intentionally in both directions.

**Try in session:** Explore whether the harder problem is starting, stopping, or both. For starting, create an entry cue. For stopping, establish a visible finish landmark before beginning. Help the client anticipate inertia instead of discovering it only after becoming trapped inside an activity.

**Draws from:** Behavioral momentum, implementation intentions, mindfulness.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 81. Attention Residue

**Clinical Antidote:** Give the previous task somewhere to remain while attention leaves it.

**Try in session:** Before switching, have the client write three things: **where I stopped, what comes next, and what I do not want to forget.** Add a brief closing ritual before beginning the next task. The brain no longer has to keep rehearsing the unfinished activity to protect it.

**Draws from:** Cognitive offloading, behavioral closure rituals, mindfulness.

## 82. Momentum Theft

**Clinical Antidote:** Protect high-access periods from avoidable interruption.

**Try in session:** Identify what repeatedly breaks productive momentum and distinguish unavoidable interruptions from preventable ones. Experiment with boundaries, notification changes, communication agreements, environmental signals, or batching interruptions.

**Draws from:** Environmental modification, interpersonal effectiveness, behavioral planning.

## 83. Restart Cost

**Clinical Antidote:** Leave a re-entry ramp before walking away.

**Try in session:** Teach the client to stop a task by preparing its restart: leave the document open to the right place, write the next sentence fragment, position the materials, or leave a note saying exactly what happens next. Make tomorrow's first step before today's attention leaves.

**Draws from:** Behavioral cueing, implementation intentions, cognitive offloading.

# Planning, Prioritization & Decision-Making

**Everything Is Important and Therefore Nothing Is**

## 84. Decision Paralysis

**Clinical Antidote:** Replace the search for the perfect choice with criteria for a sufficient one.

**Try in session:** Identify what the decision actually needs to accomplish and choose two or three criteria that matter most. Once an option meets them, explore what makes committing

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

difficult. Often the work moves from decision-making into uncertainty tolerance, perfectionism, regret, or fear.

**Draws from:** ACT acceptance, CBT, solution-focused therapy, existential choice.

## 85. Decision Fatigue

**Clinical Antidote:** Preserve decision-making capacity for choices that deserve it.

**Try in session:** Inventory repeated low-value decisions and create defaults: meals, clothing combinations, appointment times, grocery lists, routines, or recurring purchases. Discuss which decisions express values and which are simply charging admission to get through Tuesday.

**Draws from:** Behavioral design, choice architecture, ACT values.

## 86. Choice Overload

**Clinical Antidote:** Reduce the menu before asking the client to choose.

**Try in session:** When the client presents ten viable options, collaboratively narrow them to two or three before comparing. If narrowing itself is difficult, establish elimination criteria first.

**Draws from:** Choice architecture, solution-focused therapy, behavioral decision-making.

## 87. Decision Tree Explosion

**Clinical Antidote:** Stop solving branches that do not exist yet.

**Try in session:** Draw the decision tree the client is mentally carrying. Circle only the branch that requires action now and cross out hypothetical decisions that can be made later if they actually occur. Ask, *“Which decision belongs to Today You?”*

**Draws from:** ACT present-moment awareness, cognitive defusion, behavioral planning.

## 88. Microdecision Fatigue

**Clinical Antidote:** Bundle tiny choices into systems.

**Try in session:** Identify a routine containing repeated microdecisions and convert them into a sequence, checklist, kit, preset, or default. The goal is not rigid routine for its own sake. It is preventing every ordinary activity from requiring a committee meeting.

**Draws from:** Behavioral chaining, environmental design, executive-function scaffolding.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 89. Priority Soup

**Clinical Antidote:** Separate urgency, importance, emotion, and visibility.

**Try in session:** Put competing tasks on cards and sort them according to what makes each feel important: actual deadline, consequence, value, anxiety, another person's demand, visibility, or simple loudness. Then prioritize using explicit criteria rather than whichever task is currently shouting.

**Draws from:** ACT values clarification, behavioral prioritization, DBT mindfulness.

## 90. Everything Is On Fire

**Clinical Antidote:** Triage before strategizing.

**Try in session:** Divide the situation into **actual fire, uncomfortable but survivable, can wait, and not mine**. Address immediate safety or true deadlines first. Regulate physiological urgency before constructing the larger plan.

**Draws from:** Crisis triage principles, DBT distress tolerance, behavioral prioritization.

## 91. Overwhelm Freeze

**Clinical Antidote:** Reduce incoming demand until movement becomes possible again.

**Try in session:** Stop adding solutions. Orient to the body, slow the pace, and externalize everything competing for attention. Ask, *"What could come off the table for the next hour?"* Once activation decreases, choose one manageable action.

**Draws from:** Somatic regulation, DBT distress tolerance, behavioral simplification.

## 92. Cognitive Traffic Jam

**Clinical Antidote:** Get the traffic out of the intersection.

**Try in session:** Have the client rapidly externalize every competing thought, obligation, question, and concern. Do not organize while unloading. Once the intersection is clear, sort and choose one lane.

**Draws from:** Cognitive offloading, DBT one-mindfulness, executive-function scaffolding.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

## 93. Pressure Paralysis

**Clinical Antidote:** Lower threat before increasing accountability.

**Try in session:** Explore what pressure communicates to the client's system: danger of failure, judgment, loss of autonomy, disappointing someone, being trapped, or proving inadequacy. Experiment with reducing coercive language while preserving the responsibility itself.

**Draws from:** ACT, motivational interviewing, parts-informed work, trauma-informed therapy.

# Completion & Follow-Through

The Last Ten Percent Has Teeth

## 94. Almost-Done Graveyard

**Clinical Antidote:** Explore what changes psychologically when creation becomes completion.

**Try in session:** Review several almost-finished projects and look for the recurring moment of abandonment. Does finishing introduce evaluation, permanence, boredom, exposure, grief, loss of possibility, or administrative cleanup? The last ten percent may contain a different psychological task than the first ninety.

For some clients, an unfinished project can remain perfect in imagination. Completion requires allowing the thing to become real, limited, and therefore imperfect.

**Draws from:** Behavioral analysis, ACT acceptance, Jungian/depth work, existential therapy, perfectionism work.

## 95. Completion Drop-Off

**Clinical Antidote:** Change the support when the task changes phases.

**Try in session:** Divide a project into **generation, development, and completion**. Identify which phase naturally provides stimulation and where engagement drops. Design different supports specifically for completion, such as accountability, shorter work periods, checklists, immediate reward, or another person handling administrative closure when appropriate.

**Draws from:** Behavioral shaping, executive-function scaffolding, solution-focused therapy.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 96. Last-Mile Paralysis

**Clinical Antidote:** Make “finished enough” explicit.

**Try in session:** Ask the client to define the minimum criteria for completion before returning to the task. Explore whether perfectionism, fear of evaluation, uncertainty, or tedious final steps are preventing closure. Practice deliberately submitting or finishing something at the agreed-upon standard rather than continuing refinement indefinitely.

**Draws from:** Exposure to imperfection, ACT willingness, behavioral completion practice, CBT.

## 97. Productive Procrastination

**Clinical Antidote:** Respect the productivity while naming the avoidance.

**Try in session:** Ask, “*What are you accomplishing instead, and what does that activity protect you from encountering in the original task?*” Validate that the substitute activity may genuinely need doing while remaining curious about why it suddenly became irresistible. Then choose whether to return to the original task, schedule it differently, or address the emotion beneath the detour.

**Draws from:** ACT experiential avoidance, motivational interviewing, behavioral functional analysis, narrative inquiry.

# Emotional Regulation, Rejection & Shame

**Big Weather, Fast Weather & Weather That Lingers**

## 98. The Wall of Awful®

**Clinical Antidote:** Work with the emotional history surrounding the task before trying to climb over it.

**Try in session:** Choose one task that has accumulated emotional weight and ask what experiences now seem attached to it: criticism, previous failures, disappointment, embarrassment, anxiety, conflict, or shame. Externalize the Wall and explore what it is built from. Rather than immediately asking how to get through it, ask, “*What does this wall remember?*” Then determine whether the client needs emotional processing, a smaller behavioral approach, support, self-compassion, or a corrective experience with the task.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

**Draws from:** Brendan Mahan's Wall of Awful® framework, narrative externalization, ACT acceptance, parts-informed work, behavioral shaping.

## 99. Emotional Dysregulation

**Clinical Antidote:** Increase options around emotion rather than making emotional intensity itself the enemy.

**Try in session:** Map a recent emotional episode through **trigger, body activation, interpretation, action urge, behavior, and recovery**. Identify where intervention might realistically help. Practice one skill at that point rather than giving the client an emergency suitcase containing fourteen regulation strategies they will understandably forget while dysregulated.

**Draws from:** DBT emotion regulation, behavioral chain analysis, ACT, somatic awareness.

## 100. Emotional Hyperarousal

**Clinical Antidote:** Help the nervous system come down before asking the cortex to conduct an investigation.

**Try in session:** When activation is high, temporarily reduce verbal analysis. Orient to the room, slow pacing, experiment with movement, grounding, temperature, pressure, breath if welcomed, or reduced sensory input. Once activation shifts, return to meaning-making.

**Draws from:** DBT distress tolerance, somatic regulation, mindfulness, trauma-informed stabilization.

## 101. Rejection Sensitivity

**Clinical Antidote:** Validate the sensitivity while creating space between cue and conclusion.

**Try in session:** Take a recent rejection cue and separate **what happened, what the client noticed, what their nervous system predicted, and what meaning they made of it**. Explore whether previous experiences make particular cues especially loud. The goal is not convincing the client that rejection never happens. It is increasing their ability to distinguish rejection, ambiguity, difference, conflict, and uncertainty.

**Draws from:** DBT check-the-facts, ACT defusion, attachment work, relational therapy.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 102. Rejection Sensitive Dysphoria / RSD

**Clinical Antidote:** Treat the experience as real without turning the label into the entire formulation.

**Try in session:** Ask what the client means specifically when they say “RSD.” Track trigger, intensity, bodily response, interpretation, urges, duration, and recovery. Explore ADHD history alongside attachment, trauma, anxiety, shame, perfectionism, and relational learning. Develop strategies around regulation and repair based on the actual pattern.

**Draws from:** DBT, ACT, attachment/relational therapy, collaborative formulation.

**Clinical note:** RSD is widely used ADHD-community language associated with psychiatrist William Dodson, but it is not a standalone DSM diagnosis.

## 103. Shame Spiral

**Clinical Antidote:** Interrupt shame’s attempt to turn an event into an identity.

**Try in session:** Write the triggering event separately from the conclusions the client drew about themselves. Externalize the shame voice and ask what it wants the event to prove: *I forgot* becomes *I am irresponsible*; *I was late* becomes *I do not care about people*. Help the client construct an account that includes responsibility without converting behavior into character.

**Draws from:** Narrative therapy, ACT defusion, compassion-focused work, humanistic therapy.

## 104. Should Storm

**Clinical Antidote:** Investigate the authority behind the “should.”

**Try in session:** Select several recurring should-statements and ask, “*According to whom?*” Explore family expectations, cultural scripts, productivity norms, previous criticism, internalized ableism, perfectionism, or genuine personal values. Then sort each should into **chosen value, practical responsibility, inherited rule, or unnecessary demand**.

**Draws from:** ACT values clarification, narrative deconstruction, existential therapy, parts-informed work.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 105. Failure Echo

**Clinical Antidote:** Help the nervous system distinguish this attempt from every attempt that came before it.

**Try in session:** Ask what earlier experience the current task seems to awaken. Identify similarities and, importantly, differences between then and now: skills, support, environment, autonomy, knowledge, capacity, or stakes. Develop a present-tense experiment small enough to provide new information.

**Draws from:** Narrative reauthoring, corrective emotional experience, ACT, behavioral experimentation.

## 106. Anticipatory Shame

**Clinical Antidote:** Make room for the predicted judgment without letting it decide the next action.

**Try in session:** Ask the client to complete: *“If this goes badly, I am afraid it will mean...”* Follow the meaning rather than debating probability. Once the feared identity conclusion becomes visible, use defusion and values work to ask, *“What would you want to do here if you did not have to eliminate the possibility of embarrassment first?”*

**Draws from:** ACT willingness and defusion, exposure principles, existential therapy, compassion-focused work.

## 107. Demand Static

**Clinical Antidote:** Reduce the number of expectations the nervous system is continuously monitoring.

**Try in session:** Externalize every unresolved demand currently hovering in the background. Sort them into **needs action, scheduled, belongs to someone else, optional, and can be released**. Then notice what happens in the body when the demands no longer have to remain mentally active.

**Draws from:** Cognitive offloading, DBT mindfulness, ACT, executive-function scaffolding.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

# Organization & Daily-Life Systems

**Every Object Is a Tiny Unfinished Decision**

## 108. DOOM Pile

**Clinical Antidote:** Treat the pile as accumulated decisions rather than evidence of failure.

**Try in session:** If clinically appropriate, use a photo or imagined pile and identify what kinds of decisions are hiding inside it. Create only a few categories, such as **belongs here, belongs elsewhere, needs action, unsure, and leave alone**. Reduce decision density before increasing organizational expectations.

**Draws from:** Behavioral task analysis, environmental modification, executive-function scaffolding.

## 109. DOOM Box

**Clinical Antidote:** Give temporary containment an expiration pathway.

**Try in session:** Do not shame the box. It may have solved an immediate problem. Instead ask what would make reopening it accessible. Schedule a brief review, label contents visibly, or divide the box into smaller decision groups. Temporary containment can be useful; invisible permanent containment is where archaeology begins.

**Draws from:** Behavioral shaping, solution-focused therapy, environmental design.

## 110. DOOM Closet / DOOM Room

**Clinical Antidote:** Shrink the territory before approaching it.

**Try in session:** Do not assign “clean the room.” Choose one bounded area that can be completed in a short period: one shelf, one square of floor, one category, or one bag. Establish a stopping point before beginning so organizing does not become an all-day punishment.

**Draws from:** Graded task assignment, behavioral activation, pacing.

## 111. Clutter Blindness

**Clinical Antidote:** Change the environment enough for perception to notice it again.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

**Try in session:** Explore which areas have faded into visual background. Rather than relying on remembering to notice them, experiment with environmental contrast, scheduled resets, photographs, temporary relocation, or another cue that makes the space perceptually new again.

**Draws from:** Stimulus control, habituation principles, environmental modification.

## 112. Clutter Threshold

**Clinical Antidote:** Intervene before the environment crosses from manageable to neurologically expensive.

**Try in session:** Help the client identify early signs that clutter is approaching their threshold. Define a small reset that occurs before full overwhelm, ideally one requiring very few decisions. The goal is not maintaining a magazine-ready home. It is preserving functional access to the space.

**Draws from:** Behavioral prevention planning, sensory-informed work, solution-focused therapy.

## 113. Horizontal Storage

**Clinical Antidote:** Understand what visibility is doing before replacing it with concealment.

**Try in session:** Ask why objects live on horizontal surfaces. Often the answer is not laziness but visibility, unfinished action, proximity, or fear of forgetting. Design vertical, transparent, open, labeled, or point-of-performance storage that preserves the function the countertop was providing.

**Draws from:** Environmental accommodation, behavioral design, occupational adaptation.

## 114. Point-of-Performance Storage

**Clinical Antidote:** Put the support where the behavior actually happens.

**Try in session:** Choose one repeatedly inconvenient item and ask where it is used, not where convention says it belongs. Move storage to the point of performance whenever feasible.

**Draws from:** Behavioral environmental design, executive-function accommodation.

## 115. Launch Pad

**Clinical Antidote:** Make leaving require less prospective memory.

**Try in session:** Design one departure location containing the objects the client repeatedly needs. Keep the system deliberately simple and visible. Rehearse the evening or arrival behavior that replenishes the launch pad so it does not become another aspirational basket.

**Draws from:** Behavioral chaining, prospective-memory support, environmental design.

## 116. Landing Zone

**Clinical Antidote:** Give frequently carried objects an easy first destination.

**Try in session:** Identify what naturally happens when the client enters the home. Place the landing zone along that existing behavioral path rather than where it looks most elegant. Build organization around actual movement patterns.

**Draws from:** Habit design, environmental modification, behavioral observation.

## 117. Duplicate Infrastructure

**Clinical Antidote:** Use redundancy strategically when searching and remembering cost more than duplication.

**Try in session:** Identify inexpensive objects repeatedly transported, forgotten, or lost. Consider whether keeping duplicates at points of use reduces enough executive friction to justify the cost. Discuss this as accommodation rather than organizational failure.

**Draws from:** Environmental accommodation, behavioral economics, executive-function scaffolding.

## 118. Visibility-Based Organization

**Clinical Antidote:** Design for remembering, not for hiding.

**Try in session:** Ask which objects disappear cognitively when stored out of sight. Experiment with clear bins, open shelving, labels, hooks, visual inventories, or photographs. Balance sensory needs around visual clutter with the need for retrievability.

**Draws from:** Environmental modification, sensory-informed design, executive-function accommodation.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

## 119. ADHD Tax

**Clinical Antidote:** Reduce recurring costs without turning consequences into shame.

**Try in session:** Identify one repeated financial, temporal, or practical cost and conduct a compassionate systems review. Could the payment be automated? Could cancellation reminders happen earlier? Could duplicates prevent replacement purchases? Treat the tax as a design problem where possible.

**Draws from:** Behavioral problem-solving, environmental modification, harm reduction.

## 120. Convenience Tax

**Clinical Antidote:** Evaluate cost against accessibility rather than against an imaginary ideal.

**Try in session:** When the client feels guilty about paying for convenience, compare the actual outcomes of the “cheaper but inaccessible” option with the more usable one. Include wasted food, missed tasks, exhaustion, time, and emotional cost in the calculation.

**Draws from:** ACT values, behavioral economics, disability-affirming practice.

## 121. Executive-Function Tax

**Clinical Antidote:** Identify where ordinary systems are demanding unnecessary executive labor.

**Try in session:** Choose one recurring responsibility and ask which parts require memory, sequencing, initiation, transitions, decisions, or inhibition. Modify the system around the most expensive functions rather than repeatedly training the client to endure the same friction.

**Draws from:** Functional analysis, environmental accommodation, collaborative problem-solving.

## 122. Laundry Limbo

**Clinical Antidote:** Give the in-between category an actual home.

**Try in session:** Instead of arguing with the existence of partially worn clothing, design a legitimate category for it: hooks, basket, rack, shelf, or designated section. The intervention accepts the behavior’s logic and gives it architecture.

**Draws from:** Behavioral/environmental design, acceptance-based problem-solving.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 123. The Chair

**Clinical Antidote:** Find out what job The Chair has been hired to perform.

**Try in session:** Ask what actually lands there and why. Is it holding partially worn clothes? Things that need attention tomorrow? Objects without homes? Transition items? Once its function is understood, decide whether The Chair needs replacement systems, boundaries, or perhaps formal recognition as a perfectly functional staging area.

**Draws from:** Functional analysis, solution-focused therapy, environmental design.

## 124. Dish Threshold

**Clinical Antidote:** Keep the task below the point where quantity changes its psychological meaning.

**Try in session:** Identify the point at which dishes shift from manageable to overwhelming. Design a reset that occurs earlier, reduce dish inventory if helpful, use smaller washing intervals, or temporarily simplify food preparation during low-capacity periods.

**Draws from:** Behavioral prevention, environmental modification, pacing.

## 125. Bag Archaeology

**Clinical Antidote:** Create a low-decision reset rather than demanding continuous perfect organization.

**Try in session:** Develop a brief recurring bag reset with only a few categories: trash, stays in bag, goes home, requires action. Keep frequently needed items duplicated or permanently housed there when feasible.

**Draws from:** Behavioral routines, choice reduction, environmental design.

## 126. Duplicate Purchase Phenomenon

**Clinical Antidote:** Make ownership and location externally searchable.

**Try in session:** For frequently duplicated or expensive items, experiment with designated visible homes, simple inventory notes, photographs, or searchable lists. For inexpensive essentials, consider whether intentional duplication is actually the more functional system.

**Draws from:** Cognitive offloading, environmental design, harm reduction.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 127. Open-Loop Clutter

**Clinical Antidote:** Resolve the action represented by the object, not merely the object.

**Try in session:** Pick one visible item and ask, *“What unfinished action is this reminding you about?”* Complete, schedule, externalize, delegate, or intentionally abandon that action before deciding where the object belongs.

**Draws from:** Behavioral completion, narrative externalization, executive-function scaffolding.

## 128. Halfway Home

**Clinical Antidote:** Study where the journey repeatedly stops.

**Try in session:** Trace the object’s route toward its official home and identify the point where effort becomes too expensive. Consider moving the home closer, creating an intermediate home, or accepting the halfway location if it functions perfectly well.

**Draws from:** Behavioral task analysis, environmental accommodation, solution-focused therapy.

# Communication & Relationships

## The Story Has Branches

## 129. Verbal Traffic Jam

**Clinical Antidote:** Reduce the demand to organize and communicate simultaneously.

**Try in session:** Let the client pause, write keywords, draw connections, or speak pieces out of order before organizing them. Reflect what you are hearing without demanding polished chronology. Ask, *“Would it help if we sorted this after you get it out?”*

**Draws from:** Rogerian attunement, cognitive accommodation, narrative therapy.

## 130. Story Branching

**Clinical Antidote:** Preserve associative thinking while keeping a path back to the trunk.

**Try in session:** When a story branches, collaboratively name the main thread and park side branches visibly. You might say, *“I want to hear that piece too. Can we put it here so we can*

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

*come back after we finish this branch?"* The intervention provides structure without communicating that the client's natural storytelling style is wrong.

**Draws from:** Narrative therapy, relational attunement, executive-function scaffolding.

## 131. Parenthetical Speech

**Clinical Antidote:** Help context become selectable rather than compulsory.

**Try in session:** Ask what the client fears would be misunderstood if the context were omitted. Practice telling the same story in a long version and a short version, not because one is superior, but to build flexible communication choices across different situations.

**Draws from:** Communication skills training, ACT flexibility, narrative therapy.

## 132. Interrupt Urgency

**Clinical Antidote:** Protect the thought so listening does not require losing it.

**Try in session:** Develop a mutually agreed method for capturing thoughts during conversation: one-word notes, raised finger, visual marker, or brief verbal signal. Then practice returning attention to the speaker knowing the thought has somewhere safe to wait.

Also explore relationally how interruption is experienced by others without equating impact with malicious intent.

**Draws from:** Working-memory accommodation, DBT interpersonal effectiveness, relational therapy.

## 133. Context Dumping

**Clinical Antidote:** Understand what all that context is trying to protect.

**Try in session:** Ask, *"What are you worried I would misunderstand if I didn't know this part?"* The answer may reveal previous experiences of being misread, fear of judgment, precision needs, anxiety, or genuine complexity. Help the client distinguish contexts where detail serves connection from contexts where summarizing may serve them better.

**Draws from:** Humanistic inquiry, narrative therapy, attachment/relational work, communication training.

## 134. Friendship Time Blindness

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

**Clinical Antidote:** Externalize connection cues without moralizing frequency.

**Try in session:** Explore what friendship means to the client and how much contact they genuinely want, rather than importing a universal standard. If they want more consistency, create gentle external cues for reaching out and normalize reconnection after gaps.

**Draws from:** ACT values, relational therapy, behavioral scaffolding.

## 135. Out-of-Sight Relationship Drift

**Clinical Antidote:** Make valued relationships easier to retrieve.

**Try in session:** Identify relationships the client wants more access to and experiment with visible or scheduled cues: photos, recurring reminders, shared activities, standing calls, or keeping conversations where they are easier to encounter. Frame this as supporting memory, not manufacturing affection.

**Draws from:** Prospective-memory scaffolding, ACT values, relational therapy.

## 136. Reply Paralysis

**Clinical Antidote:** Break the delay-shame-avoidance loop with a deliberately imperfect repair.

**Try in session:** Map the cycle: message arrives, thoughtful response feels effortful, response is postponed, time passes, shame increases, and reopening becomes harder. Compose a **minimum viable reply** together, such as, *“I saw this and meant to respond sooner. I don’t have a thoughtful answer yet, but I didn’t want the silence to keep growing.”* Practice tolerating the discomfort of sending something imperfect.

**Draws from:** ACT willingness, graded exposure, DBT interpersonal effectiveness, narrative shame work.

## 137. Message Debt

**Clinical Antidote:** Replace relational accounting with repair and choice.

**Try in session:** Externalize the sense of “owing” replies and sort unanswered messages into **want to reconnect, needs practical response, no longer relevant, and permission not to answer**. Explore the belief that delayed communication requires increasingly elaborate repayment. Often a simple repair is enough.

**Draws from:** Narrative therapy, ACT values, interpersonal effectiveness, self-compassion.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

## 138. Social Hangover

**Clinical Antidote:** Include recovery in the cost of social engagement.

**Try in session:** Map what the client spends during social interaction: attention, sensory processing, language, masking, emotional monitoring, movement suppression, uncertainty management, and executive effort. Build decompression into social planning rather than treating recovery as evidence that the interaction went badly.

**Draws from:** Pacing, sensory-informed work, ACT acceptance, humanistic therapy.

## 139. Conversation Hyperfocus

**Clinical Antidote:** Preserve relational absorption while maintaining access to time and body.

**Try in session:** Explore what makes certain conversations deeply absorbing and whether the client wants any boundaries around them. Develop subtle cues for time, hydration, meals, other commitments, or stopping. If the intensity is relationally significant, explore what being deeply met in conversation means to the client rather than treating the experience only as attentional dysregulation.

**Draws from:** Mindfulness, interoceptive awareness, attachment/relational therapy, humanistic and existential exploration.

# External Supports & Co-Regulation

## Sometimes My Brain Works Better Beside Yours

## 140. External Brain

**Clinical Antidote:** Move information out of working memory and into the environment.

**Try in session:** Ask the client what they are currently trying to remember through sheer mental vigilance. Choose one recurring piece of information and give it an external home: calendar, whiteboard, notebook, visual cue, smart speaker, app, checklist, object placement, or another trusted system. The best external brain is usually the one the client will actually encounter, not the one with the prettiest dashboard.

**Draws from:** Cognitive offloading, behavioral scaffolding, environmental modification, executive-function accommodation.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 141. Externalizing Executive Function

**Clinical Antidote:** Identify which executive job needs an assistant.

**Try in session:** Rather than broadly recommending “more structure,” determine whether the client needs external support for initiation, sequencing, prioritization, memory, time, stopping, decision-making, or accountability. Design the support around that function. A timer cannot solve a sequencing problem merely because timers have excellent public relations.

**Draws from:** Functional analysis, behavioral intervention, executive-function scaffolding, collaborative problem-solving.

## 142. Visual Memory Scaffolding

**Clinical Antidote:** Let seeing become remembering.

**Try in session:** Identify something important that repeatedly disappears from awareness. Ask where a visual cue would naturally intersect with the behavior. Experiment with transparent storage, written prompts, objects placed intentionally in the path, visual schedules, or color/shape cues while remaining attentive to sensory clutter.

**Draws from:** Environmental modification, prospective-memory support, behavioral cueing.

## 143. Body Doubling

**Clinical Antidote:** Use another person’s presence as intentional scaffolding rather than evidence of dependence.

**Try in session:** Experiment with five minutes of an avoided task while you quietly remain present. Afterwards, ask what changed: initiation, accountability, emotional regulation, time awareness, sustained attention, or simply the feeling of not doing something alone. Help the client identify when body doubling is useful and how they might access it outside therapy.

**Draws from:** Behavioral activation, co-regulation, social facilitation, relational support.

## 144. Parallel Play / Parallel Working

**Clinical Antidote:** Allow connection without requiring continuous interaction.

**Try in session:** Explore whether the client regulates well when sharing space with someone while each person independently engages in something else. For clients who experience conventional social interaction as demanding, consider how parallel connection might support relationships, work, creativity, or regulation.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Draws from:** Relational therapy, neurodivergent-affirming practice, co-regulation, humanistic therapy.

## 145. Borrowed Regulation

**Clinical Antidote:** Use co-regulation intentionally while helping the client recognize what is being borrowed.

**Try in session:** During a moment when your presence helps the client settle, gently bring attention to what is happening. Is it your slower pace, predictable tone, lack of urgency, structure, warmth, rhythm, or willingness to remain with uncertainty? Naming the regulating ingredient can help the client seek or recreate it elsewhere.

**Draws from:** Attachment theory, relational therapy, somatic co-regulation, Rogerian presence.

## 146. Borrowed Executive Function

**Clinical Antidote:** Provide temporary scaffolding without confusing support with incapacity.

**Try in session:** When the client is overwhelmed, offer to temporarily hold one executive function: “I’ll keep track of the options while you decide,” or “Let me write these steps down while you talk.” Afterwards, identify what became easier and whether some version of that support can be externalized outside therapy.

**Draws from:** Collaborative scaffolding, relational therapy, executive-function support, guided participation.

## 147. Accountability Spark

**Clinical Antidote:** Use relational commitment as activation without turning it into surveillance.

**Try in session:** Ask whether telling someone about an intention changes its accessibility. If so, create a small, consent-based accountability experiment with clear expectations. Explore what kind of accountability feels supportive versus controlling or shame-producing.

**Draws from:** Behavioral contracting, motivational interviewing, relational accountability, solution-focused therapy.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 148. Witness Effect

**Clinical Antidote:** Explore what becomes possible when effort is witnessed without judgment.

**Try in session:** Invite the client to complete a small avoided action while you remain quietly present. Afterwards ask, *“What was different because someone safe knew you were doing it?”* The answer may involve accountability, co-regulation, reduced loneliness, validation, or protection from shame.

**Draws from:** Humanistic therapy, relational therapy, behavioral activation, attachment-informed work.

## 149. Thought Parking

**Clinical Antidote:** Give the thought somewhere safe to wait.

**Try in session:** Keep paper or a visible note available during therapy. When a side thought appears, help the client capture only enough information to retrieve it later. Then explicitly return to the current thread. This is particularly useful when “just let the thought go” translates neurologically into “accept that this thought may never be seen again.”

**Draws from:** Working-memory accommodation, ACT defusion, DBT mindfulness, cognitive offloading.

## 150. Borrowed Momentum

**Clinical Antidote:** Use environmental and interpersonal energy as a legitimate ignition source.

**Try in session:** Identify situations in which seeing another person move, clean, work, exercise, or begin helps the client activate. Deliberately recreate that cue through shared work periods, videos, music, routines, or another person’s presence.

**Draws from:** Behavioral activation, social facilitation, environmental cueing.

## 151. Nervous-System Negotiation

**Clinical Antidote:** Replace “Why won’t I?” with “What would make this more accessible?”

**Try in session:** Take one stuck behavior and conduct a negotiation with the client’s system. Ask what it seems to be asking for: clarity, movement, stimulation, reduced demand, rest, another

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

person, sensory change, smaller scope, reassurance, or meaningful choice. Test one request rather than assuming resistance must be overcome.

**Draws from:** ACT, motivational interviewing, parts-informed work, somatic inquiry, collaborative problem-solving.

# Masking & Compensation

## How Nobody Knew

### 152. ADHD Masking

**Clinical Antidote:** Make therapy a place where performance is optional enough to notice what the performance costs.

**Try in session:** Ask what the client consciously monitors or suppresses around other people: movement, tangents, forgetfulness, emotional intensity, processing time, sensory needs, eye contact, organization, or conversational style. Explore what masking protects them from and where, if anywhere, they would like to experiment with doing less of it.

Do not make unmasking another assignment.

**Draws from:** Humanistic/Rogarian therapy, ACT authenticity and values, narrative therapy, relational therapy.

### 153. Overcompensation

**Clinical Antidote:** Respect the scaffolding before loosening it.

**Try in session:** Identify a rigid or effortful strategy and ask, “*What would you be afraid might happen if you stopped doing this?*” Explore the history that made overpreparation, excessive checking, rigid routines, or overwork necessary. If the strategy is costly, build replacement support before reducing it.

**Draws from:** Parts-informed work, ACT, narrative therapy, behavioral scaffolding.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 154. Anxiety as Executive Function

**Clinical Antidote:** Do not remove the alarm system before installing another reminder system.

**Try in session:** Map what anxiety currently accomplishes. Does it wake the client early, prevent forgetting, create urgency, drive preparation, or maintain vigilance? If anxiety treatment begins reducing that activation, deliberately replace its executive functions with calendars, reminders, routines, accountability, and environmental cues.

**Draws from:** Anxiety treatment, behavioral scaffolding, ACT, collaborative formulation.

## 155. Perfectionism as Prosthetic

**Clinical Antidote:** Replace perfectionism's executive job before challenging its standards.

**Try in session:** Ask what perfectionism prevents: forgetting, criticism, missed details, embarrassment, disorganization, or uncertainty. Identify the support hidden inside the perfectionistic strategy. Then create a less punishing alternative and practice completing something at a deliberately sufficient standard.

**Draws from:** ACT willingness, exposure to imperfection, behavioral scaffolding, compassion-focused work.

## 156. Crisis Competence

**Clinical Antidote:** Identify what crisis temporarily provides that ordinary life does not.

**Try in session:** Compare a crisis in which the client functioned exceptionally well with a routine task they struggle to complete. Look for narrowed priorities, immediate feedback, clear stakes, permission to ignore competing demands, urgency, stimulation, and defined roles. Ask how ordinary tasks might borrow some of that clarity without requiring a metaphorical building to catch fire.

**Draws from:** Functional analysis, solution-focused exceptions, behavioral activation, strengths-based therapy.

## 157. Compensation Fatigue

**Clinical Antidote:** Calculate the cost of appearing effortless.

**Try in session:** Invite the client to describe everything they consciously do to produce an outcome others may assume is automatic. Ask what happens when those strategies are

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

unavailable. Explore accommodations, simplification, disclosure where safe and desired, reduced masking, or environmental changes that decrease the amount of continuous compensation required.

**Draws from:** Humanistic therapy, disability-affirming practice, ACT values, pacing, narrative therapy.

## Energy, Capacity & Recovery

### Same Brain, Different Battery

#### 158. Focus Hangover

**Clinical Antidote:** Treat recovery as part of concentration rather than what happens after concentration.

**Try in session:** Map what follows periods of intense focus: cognitive fog, irritability, hunger, headache, sensory sensitivity, exhaustion, or reduced executive capacity. Build breaks, hydration, food, movement, and decompression around predictable periods of intense concentration.

**Draws from:** Pacing, interoceptive awareness, behavioral planning, somatic work.

#### 159. Productivity Borrowing

**Clinical Antidote:** Put tomorrow's capacity into today's cost calculation.

**Try in session:** When evaluating a high-output day, ask not only *"How much did you accomplish?"* but *"What did it cost the next twenty-four hours?"* Help the client distinguish sustainable productivity from productivity financed with tomorrow's nervous system.

**Draws from:** Pacing, ACT values, behavioral self-monitoring, energy accounting.

#### 160. Boom-and-Bust Productivity

**Clinical Antidote:** Practice stopping while some capacity remains.

**Try in session:** Map the client's boom-and-bust cycle and identify the point where productive engagement becomes overextension. Develop an experiment in stopping before exhaustion rather than when the body forces cessation. Explore emotional barriers to stopping, including urgency, scarcity, guilt, or fear that productive capacity will never return.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Draws from:** Pacing, behavioral self-monitoring, ACT willingness, somatic awareness.

## 161. Sprint Brain

**Clinical Antidote:** Design around bursts where possible and build recovery between them.

**Try in session:** Explore whether the client genuinely functions better in shorter concentrated periods. Experiment with structured sprints and deliberate recovery rather than assuming sustainable functioning must look like uniform output across long periods.

At the same time, distinguish preferred rhythm from crisis-driven sprinting that repeatedly causes harm.

**Draws from:** Behavioral scheduling, pacing, strengths-based practice, solution-focused therapy.

## 162. Brain Weather

**Clinical Antidote:** Describe conditions before assigning character.

**Try in session:** Begin tracking the variables associated with different cognitive-weather days: sleep, hormones where relevant, stress, sensory load, illness, demands, interest, food, movement, social effort, emotional state, and recovery. Ask, “*What kind of weather are we working with today?*” Then plan accordingly.

**Draws from:** Mindfulness, self-monitoring, ACT acceptance, narrative externalization.

## 163. Capacity Weather

**Clinical Antidote:** Build flexible plans for different levels of access.

**Try in session:** Develop three versions of a day or recurring responsibility: **high-capacity, ordinary-capacity, and low-capacity**. Identify what is essential, optional, supported, or postponed in each. This gives the client alternatives before low capacity arrives rather than requiring improvisation from an already depleted brain.

**Draws from:** Pacing, solution-focused planning, behavioral adaptation, ACT flexibility.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 164. Good-Brain Day / Crunchy-Brain Day

**Clinical Antidote:** Use playful language to describe variability without creating a hierarchy of worthy and unworthy selves.

**Try in session:** Explore what “crunchy” means for this client. Is attention noisy? Language slower? Sensory tolerance lower? Initiation harder? Emotions closer to the surface? Identify what support fits that version of the day while challenging the idea that reduced access means reduced worth.

**Draws from:** Narrative therapy, humanistic therapy, ACT self-as-context, capacity-based planning.

# Sensory Processing & Regulation

## When the World Has Its Volume Turned Up

## 165. Sensory Sensitivity

**Clinical Antidote:** Believe the sensory experience before trying to increase tolerance.

**Try in session:** Ask the client to identify sensory inputs that consistently increase effort or distress. Explore intensity, predictability, controllability, duration, and recovery. Collaboratively test accommodations before assuming exposure or habituation is the appropriate goal.

**Draws from:** Sensory-informed practice, environmental modification, somatic awareness, humanistic validation.

**Clinical note:** Sensory sensitivity is not unique to ADHD and should be understood within the client’s broader neurodevelopmental and clinical context.

## 166. Sensory Overload

**Clinical Antidote:** Reduce incoming information before demanding higher-level regulation.

**Try in session:** When overload appears, reduce verbal complexity, lighting, sound, eye-contact expectations, decision-making, or other unnecessary input where possible. Develop a personalized early-warning map and an exit or reduction plan for common environments.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Draws from:** Environmental modification, somatic regulation, DBT distress tolerance, sensory-informed practice.

## 167. Sensory Seeking

**Clinical Antidote:** Add organizing input intentionally rather than suppressing the need for it.

**Try in session:** Explore which forms of input help the client feel more organized or alert: movement, pressure, texture, sound, chewing, strong flavors, temperature, rhythm, or repetitive motion. Experiment safely in session and notice what improves access.

**Draws from:** Sensory-informed intervention, behavioral experimentation, somatic regulation.

## 168. Sensory Avoidance

**Clinical Antidote:** Distinguish protective accommodation from fear-driven restriction.

**Try in session:** Choose one avoided sensory experience and explore what actually happens when the client encounters it: pain, distraction, overwhelm, disgust, panic, exhaustion, or anticipated loss of control. Determine whether the clinically appropriate response is accommodation, increased predictability, graded exposure, regulation support, or simply permission not to endure unnecessary discomfort.

**Draws from:** Functional assessment, ACT willingness, exposure principles when appropriate, sensory accommodation.

## 169. Sensory Filtering Difficulty

**Clinical Antidote:** Reduce the number of stimuli competing for equal billing.

**Try in session:** Conduct an environmental scan together. Ask the client what they are noticing that you may be filtering automatically. Experiment with headphones, seating position, reduced visual clutter, lighting, white noise, closed doors, or other modifications and observe whether cognitive access changes.

**Draws from:** Environmental modification, attention regulation, sensory-informed practice.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 170. Sensory Load

**Clinical Antidote:** Include sensory processing in the capacity budget.

**Try in session:** Map the client's day not only by tasks but by sensory environments. Identify periods of noise, crowds, driving, screens, fluorescent lighting, touch, smells, temperature, or constant conversation. Explore whether apparent "random" depletion becomes more predictable once sensory expenditure is counted.

**Draws from:** Pacing, sensory-informed formulation, behavioral self-monitoring.

## 171. Sensory Debt

**Clinical Antidote:** Plan recovery after tolerating unavoidable sensory strain.

**Try in session:** Identify situations the client can endure but pays for later. Ask what recovery actually requires: silence, darkness, pressure, movement, solitude, familiar sensory input, sleep, or reduced conversation. Build recovery into the plan instead of treating the delayed cost as inexplicable irritability or dysfunction.

**Draws from:** Pacing, somatic regulation, environmental accommodation, nervous-system-informed work.

**Clinical note:** "Sensory debt" is useful metaphorical language, not a formal diagnostic construct.

## 172. Stimming

**Clinical Antidote:** Protect regulation unless the behavior is harmful, unwanted, or creating a problem the client wants help addressing.

**Try in session:** Ask what the stim does. Does it regulate emotion, organize attention, provide sensory pleasure, discharge activation, support thinking, or communicate excitement? Make room for safe stimming in therapy and explore alternatives only when the client wants or needs them.

**Draws from:** Neurodivergent-affirming practice, behavioral functional analysis, somatic regulation, humanistic therapy.

**Clinical note:** Stimming occurs across neurotypes and is particularly discussed within autistic and broader neurodivergent communities. Its presence does not establish ADHD or autism.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 173. Misophonia

**Clinical Antidote:** Treat the response as a real nervous-system event while broadening assessment beyond ADHD.

**Try in session:** Map trigger sounds, context, physiological response, emotion, action urges, anticipatory anxiety, escape options, and recovery. Explore environmental modification, sound management, grounding, communication, and distress-tolerance strategies. Avoid reducing the experience to “being irritated by noises.”

**Draws from:** Behavioral functional assessment, DBT distress tolerance, sensory/environmental modification, somatic regulation.

**Clinical note:** Misophonia is not an ADHD-specific phenomenon.

## 174. Proprioception

**Clinical Antidote:** Bring the body more clearly into space.

**Try in session:** Explore whether pressure, resistance, movement, weighted input, stretching, pushing against a wall, changing seating, or other safe proprioceptive experiences help the client feel more organized or grounded. Notice what happens to attention, regulation, and body awareness.

Where proprioceptive difficulties significantly affect functioning, safety, coordination, or daily activities, consider whether collaboration with an occupational therapist or other appropriate professional would be useful.

**Draws from:** Somatic awareness, sensory-informed practice, environmental adaptation, interdisciplinary collaboration.

# Interoception & Body Awareness

**The Body Has Been Sending Notifications. Delivery Has Been Inconsistent.**

## 175. Interoception

**Clinical Antidote:** Build curiosity about internal signals without turning body awareness into another performance demand.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

**Try in session:** Invite the client to notice one neutral or accessible internal sensation: temperature, pressure, heartbeat, muscle tension, fullness, breath, energy, or movement. Instead of asking, “*What are you feeling?*” try, “*What information, if any, is your body giving you right now?*” Allow “I don’t know” to remain legitimate data.

**Draws from:** Somatic awareness, mindfulness, ACT present-moment awareness, humanistic therapy.

**Clinical note:** Interoception is a broad sensory process and is not specific to ADHD.

## 176. Delayed Body Signals

**Clinical Antidote:** Build external check-ins before the body has to shout.

**Try in session:** Map when the client typically realizes they are hungry, thirsty, exhausted, overstimulated, or physically uncomfortable. If awareness tends to arrive late, create external check-in points before predictable crashes. Ask about needs rather than requiring sensation identification: “*When you stop around noon, what might your body need even if it has not announced it yet?*”

**Draws from:** Behavioral cueing, interoceptive awareness, pacing, environmental scaffolding.

## 177. Hunger Blindness

**Clinical Antidote:** Make nourishment less dependent on noticing hunger at precisely the right moment.

**Try in session:** Explore when eating becomes difficult to remember or initiate and what cues are more reliable than hunger alone. Develop environmental or temporal supports such as visible food, scheduled meal anchors, pairing food with recurring activities, or reducing preparation demands.

**Draws from:** Behavioral cueing, environmental modification, interoceptive support.

**Clinical note:** Persistent appetite changes, restrictive eating, food insecurity, medication effects, gastrointestinal concerns, or eating-disorder symptoms warrant broader assessment rather than being automatically attributed to ADHD.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 178. Thirst Blindness

**Clinical Antidote:** Put hydration where attention already goes.

**Try in session:** Identify when and where the client naturally pauses during the day. Pair hydration with those moments and reduce friction through preferred containers, visible placement, duplicates, temperature preferences, or other personally useful cues.

**Draws from:** Habit pairing, environmental design, interoceptive support.

## 179. Bathroom Cue Delay

**Clinical Antidote:** Respond to early cues before urgency becomes the cue.

**Try in session:** Explore whether the client notices early signals but postpones them during hyperfocus, transitions, work, or social situations, or whether awareness itself arrives late. Develop check-in points around natural transitions rather than relying exclusively on bodily urgency.

**Draws from:** Interoceptive awareness, behavioral cueing, transition planning.

**Clinical note:** New, significant, painful, or persistent changes in elimination patterns should not be presumed to be neurodivergence-related and may warrant medical evaluation.

## 180. Fatigue Lag

**Clinical Antidote:** Learn the client's precursors to exhaustion.

**Try in session:** Instead of asking only what exhaustion feels like, identify what happens thirty minutes, two hours, or a day before the crash. Look for irritability, language difficulty, increased sensory sensitivity, mistakes, restlessness, emotional lability, or unusual effort. Use those signs as earlier opportunities for pacing.

**Draws from:** Somatic tracking, behavioral self-monitoring, pacing.

## 181. Body-Needs Blindness

**Clinical Antidote:** Create a needs inventory when spontaneous body awareness is unreliable.

**Try in session:** Develop a short check-in the client can scan without having to generate the questions themselves: **food, water, bathroom, temperature, movement, medication** if

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

**prescribed, pain, sensory input, rest, and sleep.** Ask which needs tend to disappear from awareness first.

**Draws from:** Interoceptive scaffolding, behavioral cueing, self-monitoring.

## 182. Hyperfocus Body Dropout

**Clinical Antidote:** Let the environment interrupt absorption on the body's behalf.

**Try in session:** Identify what disappears during hyperfocus and build external cues for those needs. Rather than simply setting an alarm labeled “take a break,” attach a concrete action: **stand, drink, eat, bathroom, stretch, check body.** Experiment with cues that are noticeable without being so disruptive that the client immediately disables them.

**Draws from:** Behavioral cueing, interoceptive support, pacing, environmental modification.

# Demands, Autonomy & Access

**“I Want To” and “Now I Have To” Are Apparently Different Neurological Events**

## 183. Demand Avoidance

**Clinical Antidote:** Investigate what the demand changes internally before interpreting avoidance as opposition.

**Try in session:** Take one avoided demand and compare how it feels when it is optional versus required. Explore whether the demand introduces overwhelm, anxiety, uncertainty, anticipated failure, sensory cost, loss of autonomy, executive load, trauma activation, or something else. Let function determine intervention.

**Draws from:** Motivational interviewing, ACT, functional analysis, parts-informed work.

**Clinical note:** Demand avoidance is descriptive language with many possible mechanisms. Do not assume that all demand avoidance reflects PDA or any single diagnosis.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 184. Self-Demand Avoidance

**Clinical Antidote:** Notice when desire becomes coercion the moment the client tells themselves they “have to.”

**Try in session:** Choose something the client genuinely wants to do but repeatedly resists once it becomes an obligation. Listen for the internal language surrounding it. Experiment with replacing command language with choice language: *“I am choosing whether to do this because...”* or *“This matters to me, and I get to decide how I approach it.”* Notice whether access changes.

**Draws from:** ACT values, motivational interviewing, narrative therapy, parts-informed work.

## 185. Demand Accumulation

**Clinical Antidote:** Reduce the number of open demands before treating each one individually.

**Try in session:** Externalize every current demand, including small social obligations and unfinished decisions. Ask which can be delayed, delegated, declined, simplified, or completed quickly. Then reassess the task that originally appeared impossible. Sometimes no individual demand is enormous; the nervous system is simply carrying forty-seven browser tabs labeled “you still need to.”

**Draws from:** Cognitive offloading, behavioral prioritization, ACT, pacing.

## 186. Demand Saturation

**Clinical Antidote:** Stop adding strategies when the system is already full.

**Try in session:** When the client reaches saturation, shift from *“What else can we do?”* to *“What can stop?”* Identify nonessential expectations, decisions, social obligations, sensory demands, and therapeutic homework that can temporarily be reduced.

**Draws from:** DBT distress tolerance, pacing, ACT acceptance, environmental modification.

## 187. Autonomy Friction

**Clinical Antidote:** Restore meaningful choice without pretending responsibilities do not exist.

**Try in session:** Identify where the client experiences a legitimate responsibility as psychologically constricting. Find choices that remain available: when, where, how, in what

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

order, with whom, for how long, or with what support. Preserve the requirement while increasing agency around the route.

**Draws from:** Motivational interviewing, self-determination principles, ACT values, collaborative problem-solving.

## 188. Choice Restoration

**Clinical Antidote:** Give the nervous system evidence that options still exist.

**Try in session:** When the client feels trapped, identify even small authentic choices. Ask, *“What part of this is actually fixed, and what part still belongs to you?”* Avoid offering ten choices to someone already overwhelmed. Two meaningful options may restore more agency than an entire buffet.

**Draws from:** Motivational interviewing, solution-focused therapy, existential therapy, ACT.

## 189. Demand Reframe

**Clinical Antidote:** Change the relationship to the demand without disguising it.

**Try in session:** Take a genuine obligation and experiment with several accurate framings: *“I have to,” “I am choosing to because,” “I don’t want to, and I am willing to because,”* or *“This is required, but I can choose how I meet it.”* Notice which language reduces unnecessary internal struggle without becoming forced positivity.

**Draws from:** ACT acceptance and values, motivational interviewing, existential choice.

# Cognitive Flexibility & Context

## When the Plan Changes and the Brain Files an Objection

## 190. Cognitive Flexibility

**Clinical Antidote:** Practice expanding options rather than demanding instant flexibility.

**Try in session:** Take a low-stakes situation and generate three possible interpretations, approaches, or solutions without requiring the client to prefer them. The exercise is not *“Your way is too rigid.”* It is *“Can we help the brain discover that more than one route exists?”*

**Draws from:** ACT psychological flexibility, DBT dialectics, cognitive flexibility training.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

## 191. Set-Shifting Difficulty

**Clinical Antidote:** Support disengagement before expecting engagement elsewhere.

**Try in session:** Explore what the client needs to leave one cognitive set and enter another. Experiment with closing notes, standing, movement, sensory change, verbal summary, environmental shift, or a brief pause between activities. Treat switching as its own neurological task.

**Draws from:** Executive-function scaffolding, behavioral transition support, mindfulness.

## 192. Context-Switching Cost

**Clinical Antidote:** Reduce unnecessary switching and protect reorientation time when switching is unavoidable.

**Try in session:** Map how often the client changes roles, environments, software, conversations, sensory settings, or cognitive demands across a typical day. Identify switches that can be batched or eliminated and build brief orientation rituals around those that remain.

**Draws from:** Environmental modification, behavioral scheduling, pacing.

## 193. Plan Disruption Lag

**Clinical Antidote:** Allow the nervous system to update before demanding immediate adaptation.

**Try in session:** Reconstruct a recent unexpected change. Identify the original mental model, the moment it became obsolete, and what the client needed before they could engage with the new plan. Develop a disruption script such as: **Pause. Name what changed. Identify what remains true. Find the next known step.**

**Draws from:** DBT mindfulness, ACT acceptance, executive-function scaffolding.

## 194. Cognitive Gear-Stick

**Clinical Antidote:** Use deliberate intermediate gears.

**Try in session:** Identify transitions where the client feels expected to move instantly from fifth gear to reverse. Design an intermediate state: walk around the block, sit quietly for ten minutes, shower, change clothes, listen to one song, or complete a brief closing ritual. The transition activity is not wasted time. It is the gearbox.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Draws from:** Somatic regulation, behavioral transition rituals, mindfulness, pacing.

# Emotional Continuity, Connection & Being Seen

**The Relationship Still Exists Even When the Signal Gets Quiet**

## 195. Emotional Object Permanence

**Clinical Antidote:** Externalize evidence of connection when felt connection becomes difficult to retrieve.

**Try in session:** Ask what happens emotionally when an important person is unavailable, quiet, or physically absent. If the client struggles to access the felt sense of being cared for, create concrete relational anchors: saved messages, photographs, written reminders, meaningful objects, or memories of repair and connection.

**Draws from:** Attachment-informed therapy, relational work, cognitive scaffolding, narrative therapy.

**Clinical note:** “Emotional object permanence” is a community metaphor. It is not the same as developmental object permanence.

## 196. Connection Cue Dependence

**Clinical Antidote:** Understand which signals make connection perceptible.

**Try in session:** Explore how the client knows someone cares. Is connection easiest to feel through words, physical presence, shared activity, responsiveness, touch where appropriate, humor, predictability, or explicit reassurance? Then explore whether important relationships are communicating care in ways the client can actually detect.

**Draws from:** Attachment/relational therapy, interpersonal work, humanistic inquiry.

## 197. Reassurance Half-Life

**Clinical Antidote:** Explore why reassurance fades rather than endlessly increasing the dose.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Try in session:** After reassurance is received, track what happens as its emotional impact diminishes. Does ambiguity return? Does the client lose access to the felt memory? Does an internal critic invalidate it? Does a new cue reactivate threat? Work with the mechanism that erodes reassurance rather than simply providing more reassurance.

**Draws from:** Attachment therapy, ACT defusion, parts-informed work, metacognitive awareness.

## 198. Being-Seen Activation

**Clinical Antidote:** Treat visibility as a nervous-system event, not automatically as vanity or avoidance.

**Try in session:** Explore what happens when the client is watched, praised, evaluated, noticed, or asked about something meaningful. Track body activation and associated meanings: exposure, expectation, intimacy, judgment, pressure, pride, vulnerability, or fear of future disappointment. Ask, *“What becomes dangerous or important about being visible?”*

**Draws from:** Relational therapy, somatic tracking, attachment work, Jungian/depth exploration.

**Clinical note:** “Being-seen activation” is descriptive language rather than a formal clinical construct.

## 199. Recognition Responsive Euphoria / RRE

**Clinical Antidote:** Explore the relational meaning of recognition without pathologizing pleasure in being understood.

**Try in session:** Ask what happens when the client feels accurately seen, appreciated, included, or recognized. Explore whether the intensity reflects joy, relief, belonging, validation after chronic misunderstanding, attachment needs, or something else. Then examine how the client can cultivate relationships and environments where recognition is available without becoming wholly dependent on external approval.

**Draws from:** Humanistic therapy, attachment/relational therapy, ACT values, narrative identity work.

**Clinical note:** RRE is community and social-media language, not an established diagnostic or research construct.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

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# Stress Load, Burnout & Recovery

**The Nervous System Has Been Keeping Receipts**

## 200. Allostatic Load

**Clinical Antidote:** Treat cumulative stress as cumulative.

**Try in session:** Map stress across domains rather than focusing only on the presenting crisis: work, relationships, finances, caregiving, discrimination, sensory load, health, executive demands, masking, uncertainty, and insufficient recovery. Ask which burdens are modifiable and where recovery can realistically be increased.

**Draws from:** Stress physiology, behavioral health, pacing, systems-informed formulation.

**Clinical note:** Allostatic load is an established stress-physiology concept and is not specific to neurodivergence.

## 201. Cumulative Stress Load

**Clinical Antidote:** Count the pebbles, not only the boulder.

**Try in session:** Build a recent stress timeline including small repeated demands that would normally be dismissed individually. Explore how accumulation changes the client's threshold for emotion, sensory input, executive demands, and relationships. Identify which recurring stressors can be reduced rather than asking the client to become endlessly more resilient.

**Draws from:** Stress formulation, narrative mapping, behavioral problem-solving, pacing.

## 202. Masking Load

**Clinical Antidote:** Include self-monitoring in the energy budget.

**Try in session:** Ask what the client actively manages in social or professional settings: facial expression, tone, movement, eye contact, tangents, sensory reactions, emotional expression, processing time, organization, or conversational timing. Explore where masking is necessary for safety or chosen goals and where it might be reduced.

**Draws from:** Neurodivergent-affirming practice, ACT authenticity, humanistic therapy, relational work.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 203. Recovery Debt

**Clinical Antidote:** Stop treating postponed recovery as cancelled recovery.

**Try in session:** Identify what restorative needs have repeatedly been deferred. Ask what the client's system seems to be collecting payment on now: sleep, solitude, sensory reduction, movement, play, connection, unstructured time, or cognitive quiet. Build repayment gradually rather than prescribing a single weekend of heroic self-care.

**Draws from:** Pacing, behavioral scheduling, ACT values, somatic regulation.

**Clinical note:** "Recovery debt" is metaphorical language, not a formal clinical construct.

## 204. Capacity Crash

**Clinical Antidote:** Reduce expectations before rebuilding output.

**Try in session:** When capacity abruptly falls, assess what preceded the crash and what functions are currently least accessible. Help the client identify a **minimum viable day** containing essential care and responsibilities while temporarily reducing optional demands. Investigate the crash after stabilization rather than demanding explanation from a depleted system.

**Draws from:** Pacing, behavioral triage, DBT distress tolerance, somatic awareness.

## 205. Neurodivergent Burnout

**Clinical Antidote:** Reduce chronic mismatch rather than making recovery another performance project.

**Try in session:** Map the months preceding burnout, including masking, sensory demands, executive load, transitions, social performance, inadequate accommodations, chronic stress, and insufficient recovery. Identify what cannot simply resume unchanged if the client begins feeling better.

**Draws from:** Neurodivergent-affirming practice, pacing, ACT values, environmental modification, disability-affirming care.

**Clinical note:** Neurodivergent burnout is not a DSM diagnosis. Autistic burnout has a growing research literature, while broader uses of "neurodivergent burnout" remain more variable.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 206. Shutdown

**Clinical Antidote:** Reduce demand and support safety before requiring communication or action.

**Try in session:** Collaboratively identify the client's early shutdown signs and what helps once speech, decision-making, movement, or social engagement becomes less accessible. Develop low-language options such as written communication, yes/no choices, sensory reduction, quiet, predictable presence, or delayed processing.

**Draws from:** Somatic/nervous-system-informed work, sensory accommodation, relational safety, DBT distress tolerance.

**Clinical note:** "Shutdown" is descriptive language used across several communities and clinical contexts. Clarify what it means for the individual client.

## 207. Restraint Collapse

**Clinical Antidote:** Understand collapse as information about what was required to hold everything together beforehand.

**Try in session:** Map what the client was suppressing, tolerating, monitoring, performing, postponing, or overriding before the collapse. Explore sensory load, being perceived, accumulated demands, hunger, fatigue, decision-making, and relational expectations. Develop a predictable landing ritual that reduces demands, provides appropriate sensory support, and restores choice before requiring conversation or connection.

**Draws from:** Nervous-system-informed work, relational therapy, sensory regulation, pacing, parts-informed work.

**Clinical note:** "Restraint collapse" is descriptive/community language rather than a formal ADHD diagnosis or established clinical construct.

# Emotion Identification & Processing

**Sometimes the Body Knows Before Language Gets the Memo**

## 208. Alexithymia

**Clinical Antidote:** Stop making immediate emotion naming the admission price for emotional work.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Try in session:** Begin with what is accessible: body sensation, image, impulse, temperature, color, metaphor, situation, behavior, or *“pleasant, unpleasant, or neutral.”* Allow emotional language to emerge later if it does. Ask, *“If you did not have to name the emotion yet, what do you notice?”*

**Draws from:** Humanistic therapy, somatic work, ACT present-moment awareness, expressive/depth-oriented approaches.

**Clinical note:** Alexithymia is not unique to ADHD and occurs across neurodevelopmental and mental-health contexts.

## 209. Emotional Granularity

**Clinical Antidote:** Expand emotional vocabulary through differentiation rather than correction.

**Try in session:** Start with a broad emotional category and gently compare nearby experiences. Is “angry” closer to irritated, betrayed, trapped, overstimulated, resentful, frightened, or powerless? Use words, images, body cues, or emotion cards according to the client’s preferred processing style.

**Draws from:** Affective science, DBT emotion regulation, humanistic inquiry, somatic awareness.

## 210. Delayed Emotional Processing

**Clinical Antidote:** Give emotion permission to arrive on its own timeline.

**Try in session:** When a client understands an event intellectually but says they “felt nothing” until hours or days later, map the sequence without assuming avoidance. Build intentional processing windows after demanding experiences and normalize returning to events once emotional information becomes available.

**Draws from:** Humanistic therapy, mindfulness, narrative processing, somatic awareness.

## 211. Emotional Buffering

**Clinical Antidote:** Become curious about what the buffer makes possible.

**Try in session:** Explore periods when emotion seems temporarily distant. Ask what the client needed to do during that time and whether emotional distance helped them function, remain safe, or manage overload. Rather than immediately dismantling the buffer, explore whether and when the client wants greater access to what is behind it.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerditherapist.com](http://www.thenerditherapist.com)

**Draws from:** Parts-informed therapy, ACT acceptance, humanistic therapy, trauma-informed stabilization.

## 212. Body-First Emotion

**Clinical Antidote:** Follow sensation toward meaning rather than demanding meaning first.

**Try in session:** Begin with the physical experience: tight chest, hot face, restless legs, heavy stomach, buzzing hands, collapsed posture, pressure behind the eyes. Ask what the body seems inclined to do and what was happening when the sensation appeared. Let emotional understanding emerge through tracking rather than interrogation.

For clients drawn to imagery, this can also become depth work: *“If that sensation had an image, shape, creature, landscape, or voice, what appears?”* The symbol can provide a bridge between bodily experience and psychological meaning without requiring premature intellectual explanation.

**Draws from:** Somatic tracking, Jungian/depth work, experiential therapy, ACT mindfulness, humanistic inquiry.

# Overlapping Neurodivergent Experiences

**When ADHD May Be Part of the Story, but Not Necessarily the Whole Story**

## 213. Monotropism

**Clinical Antidote:** Work with the architecture of attention rather than continually demanding wider distribution of it.

**Try in session:** Explore how the client experiences attention when deeply engaged. What happens when multiple demands compete for the same attentional resources? What is the cost of interruption? What supports transition into and out of an attentional tunnel? Consider whether therapy itself would benefit from fewer simultaneous questions, clearer agendas, additional processing time, or permission to remain with one subject longer.

Rather than asking only, *“How do we make your attention more flexible?”* also ask, *“What becomes possible when your attention is allowed to go deeply where it naturally wants to go?”*

**Draws from:** Neurodivergent-affirming practice, ACT psychological flexibility, environmental accommodation, strengths-based and humanistic therapy.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Widen the lens:** Monotropism has particular roots in autistic scholarship and theory. It should not be presented as an ADHD-specific construct. If the framework resonates strongly, remain curious about the client's broader neurodevelopmental profile.

## 214. Double Empathy Problem

**Clinical Antidote:** Locate misunderstanding between nervous systems rather than automatically inside the neurodivergent person.

**Try in session:** Take a recent interpersonal rupture and map both perspectives without assuming one communication style is the normative reference point. Ask: *"What did you mean? What did they appear to understand? What might they have meant? What did you understand?"* Look for mismatches in directness, implied meaning, emotional signaling, pacing, context, expectations, and communication conventions.

This can be especially important in therapy itself. If therapist and client repeatedly misunderstand one another, do not assume the client has a social-skills deficit. The misunderstanding is occurring **between two people**, and both nervous systems are in the room.

**Draws from:** Relational therapy, Rogerian empathy, mentalization, narrative therapy, cultural humility.

**Widen the lens:** The Double Empathy Problem was developed by Damian Milton in relation to autistic and non-autistic communication. It is not an ADHD construct, although its relational implications can be useful more broadly.

## 215. Hypervigilance

**Clinical Antidote:** Treat vigilance as a protective strategy before asking the protector to stand down.

**Try in session:** Ask what the client's attention is continuously scanning for: criticism, conflict, rejection, danger, changes in tone, mistakes, sensory threat, disappointment, or loss of control. Explore when the scanning began to make sense and what it has successfully protected against. Then work toward increasing discrimination between **possible danger, remembered danger, ambiguous cues, and present safety** rather than simply teaching relaxation.

Parts-oriented language may be particularly useful: *"What does the part of you that keeps watch believe would happen if it stopped?"*

**Draws from:** Trauma-informed therapy, parts-informed work, somatic tracking, attachment therapy, ACT, DBT.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

**Widen the lens:** Hypervigilance is more strongly associated with trauma, anxiety, chronic stress, and threat-related processes than ADHD itself. Do not collapse persistent threat monitoring into ordinary ADHD distractibility.

## 216. Derealization

**Clinical Antidote:** Restore orientation and safety before pursuing interpretation.

**Try in session:** If the client describes the environment as unreal, dreamlike, distant, foggy, artificial, or somehow “not quite there,” slow the work down. Invite gentle orientation to concrete aspects of the present environment without insisting the sensation disappear: where they are, what day it is, what they can see, hear, or physically contact, and what helps them feel more anchored.

After stabilization, explore context: stress, panic, trauma reminders, exhaustion, sensory overload, sleep disruption, substances or medications, and other contributing factors. If experiences are recurrent, intense, impairing, new, or clinically concerning, assess further rather than simply placing them under the ADHD umbrella.

**Draws from:** Grounding and orientation, trauma-informed stabilization, somatic work, mindfulness.

**Widen the lens:** Derealization is a dissociative experience, not an ADHD symptom.

## 217. Depersonalization

**Clinical Antidote:** Support reconnection with embodied selfhood without forcing immediacy.

**Try in session:** When the client describes feeling detached from themselves, outside their body, robotic, unreal, or as though they are observing themselves from elsewhere, orient gently toward present experience. Ask what increases versus decreases the sense of distance. Concrete sensory contact, movement, familiar objects, environmental orientation, or relational presence may help.

Avoid demanding intense inward focus if that increases disconnection. For some clients, orienting **outward** to a safe environment is more regulating than attempting to dive further into internal sensation.

**Draws from:** Trauma-informed stabilization, somatic therapy, grounding, relational safety.

**Widen the lens:** Depersonalization is a dissociative phenomenon rather than an ADHD symptom. Recurrent or significant experiences warrant appropriate assessment and differential consideration.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

[www.stormhavenwellness.com](http://www.stormhavenwellness.com) | [www.thenerdietherapist.com](http://www.thenerdietherapist.com)

## 218. Anhedonia

**Clinical Antidote:** Do not mistake diminished pleasure for ordinary ADHD boredom or low stimulation.

**Try in session:** Ask what has changed. Are previously enjoyable activities still interesting once begun? Does the client want pleasure but cannot access it? Is motivation absent, pleasure absent, or both? Explore duration, mood, sleep, appetite, energy, hopelessness, medication or substance changes, stress, burnout, and overall functioning.

Behavioral activation may still be useful, but the formulation matters. A client saying, *“Nothing feels good anymore,”* deserves a different clinical response from a client saying, *“This spreadsheet contains absolutely no neurological seasoning.”*

**Draws from:** Behavioral activation, depression assessment, ACT values, humanistic inquiry.

**Widen the lens:** Anhedonia is associated particularly with depressive disorders and other clinical conditions. It should not be casually explained as ADHD understimulation. Assess depression and safety when clinically indicated.

## 219. Functional Freeze

**Clinical Antidote:** Determine whether immobility reflects executive inaccessibility, overwhelm, threat, depletion, dissociation, or several processes at once.

**Try in session:** Slow down one freeze episode and map what happened immediately beforehand. Ask about body state, thoughts, sensory load, emotion, demands, perceived consequences, fatigue, shame, fear, and available choices. Instead of asking *“Why didn’t you just do something?”* ask, *“What became inaccessible in that moment?”*

Intervention follows function. Executive overload may need externalization and task reduction. Threat activation may need safety and regulation. Dissociation may require orientation. Burnout may require demand reduction. Shame may need relational repair. Sometimes the client needs several of these simultaneously because nervous systems have never shown much respect for tidy treatment manuals.

**Draws from:** Functional analysis, somatic/nervous-system-informed therapy, DBT, ACT, parts-informed work, executive-function scaffolding.

**Widen the lens:** “Functional freeze” is descriptive language rather than a discrete ADHD diagnosis. Avoid assuming all inability to act represents the same mechanism.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

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## 220. Neurodivergent Restraint

**Clinical Antidote:** Explore what the client is continuously holding back, holding together, or overriding.

**Try in session:** Ask what the client consciously or automatically restrains in different environments, such as movement, emotion, sensory responses, communication style, processing time, needs, or the urge to leave. Explore what the restraint protects them from, what it costs, and where greater choice, accommodation, expression, or recovery might be possible. Avoid making unmasking the automatic goal.

**Draws from:** Neurodivergent-affirming practice, humanistic therapy, ACT, parts-informed work, somatic tracking, relational therapy.

**Clinical note:** “Neurodivergent restraint” is descriptive language rather than an established clinical construct and may overlap with masking, suppression, compensation, inhibition, and restraint collapse.

## Closing the Field Guide

### The Antidote Is Not Normalization

The goal of this guide is not to memorize 220 interventions or to develop a perfectly indexed therapeutic response for every term a client might bring into the room. Neurodivergent language will continue to evolve. Communities will create new metaphors, researchers will refine old constructs, clinicians will borrow language from one another, and the internet will occasionally name an experience so perfectly that we will all be mildly irritated nobody thought of it sooner.

The more useful clinical skill is knowing what to do when a client says, “**There. That’s the thing.**”

Begin with their language. Ask what the term captures. Describe what actually happens. Locate where access changes. Explore the conditions surrounding it. Consider what function the experience, adaptation, or behavior may be serving. Widen the formulation when the experience points beyond ADHD. Then choose support collaboratively.

Sometimes the clinical antidote will be an ACT intervention. Sometimes it will be DBT, behavioral scaffolding, narrative reauthoring, relational repair, parts work, sensory regulation, existential exploration, or a depth-oriented conversation about the meaning underneath the pattern. Sometimes it will be a whiteboard, a visual timer, a basket placed somewhere that would make an organizational expert twitch, or permission to wear headphones.

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

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And sometimes the therapeutic intervention will be recognizing that **nothing about the behavior actually needs to be fixed.**

The question is not simply:

**How do we make this stop?**

It is:

**What is happening here? What does it mean for this person? What is it doing for them? What is it costing them? What support is missing? And what, if anything, would they like to be different?**

That is the difference between using neurodivergent language as another collection of symptoms and using it as a doorway into formulation.

## A Final Clinical Compass

Across all 220 terms, return to four principles:

**Access, Not Ability.** Difficulty accessing a skill consistently does not necessarily mean the skill is absent.

**Curiosity Before Correction.** Understand what a behavior, response, adaptation, or experience is doing before trying to change it.

**The Term Is the Beginning of Formulation.** Recognition can be enormously validating, but the label does not tell us everything we need to know about function, context, differential diagnosis, or intervention.

**Explanation Is Not Exoneration.** Understanding why something happens does not erase its impact. Neurodivergent-affirming therapy can hold intention, impact, accountability, accommodation, repair, and compassion in the same room.

When a client finally says, **“There. That’s the thing,”** we do not necessarily need to already know the answer.

We need to know how to help them investigate the thing.

## Scope & Educational Use

This guide is intended as a clinical educational resource and companion to *The ADHD Field Guide: Terms for the Things You Thought Were “Just You.”* It is not a treatment protocol, diagnostic instrument, or substitute for individualized assessment, clinical judgment,

Jen Hyatt, LMFT

Licensed Marriage and Family Therapist #99355

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professional competence, supervision, consultation, or applicable legal and ethical requirements.

Some terms in the Field Guide reflect established psychological or neuropsychological constructs. Others come from clinicians, educators, neurodivergent communities, popular psychology, or metaphorical language that captures a lived experience particularly well. A client recognizing themselves in a term does not establish a diagnosis, and not every experience described here is unique to ADHD.

Clinical formulation should remain attentive to co-occurring and alternative explanations, including autism, anxiety, trauma, depression, OCD, dissociation, sleep difficulties, medication effects, medical factors, chronic stress, attachment and relational experiences, disability, culture, environmental mismatch, and other relevant influences.

Use these antidotes as **possibilities to explore collaboratively rather than prescriptions to impose**. An intervention that does not help is information about the formulation, not evidence that the client failed the intervention.