

Lessons Learnt for Group Analysis from a Group for Adults with Adult Attention Deficit Hyperactivity Disorder

Susanne Vosmer

The American Society of Clinical Hypnosis; British Psychological Society; American Psychological Society; EMDR Association UK and Ireland; HCPC; and IGA (Institute of Group Analysis, London), United Kingdom

Abstract—Group treatment is beneficial for adult attention deficit hyperactivity disorder (ADHD) and recommended by NICE. The extant literature suggests that short-term cognitive behavioural therapy (CBT) is beneficial for adult ADHD rather than short-term group analytic treatment. Whilst (short-term) CBT and (short-term) specialized psychotherapeutic analysis differ, there are commonalities between these approaches with regard to client selection, preparation with a circumscribed focus, ‘manualised’ treatment groups in the here-and-now, engaging group members and the group, facilitating and maintaining a group structure, pursuing the goal of therapy and paying attention to termination of the group. Hence, I suggest that both approaches can learn from each other. In this article, I shall describe a 12-week structured CBT group for adults with ADHD, which was developed and subsequently evaluated by using qualitative content analysis. I shall then explore what lessons can be learnt from this experience for specialized (applied) group analysis. In so doing, I hope that group analysts will conduct and evaluate groups for this client group on a larger scale, so that the effectiveness of short-term group analytic groups can be established as well as key ingredients for therapeutic change delineated. In this way, group analysis can contribute also to current conceptualization of ADHD and counter stigma attached to this label.

Keywords—Adult Attention Deficit Disorder, ADHD, short-term groups, specialized psychotherapeutic group analysis, CBT.

I. INTRODUCTION

ATENTION Deficit Hyperactivity Disorder (ADHD) is a childhood neurodevelopmental disorder, which frequently persists into adulthood (Philipsen et al., 2007). The world prevalence of ADHD in adults is estimated to be 2.5% or higher (Simon et al, 2009). ADHD is characterised by three core symptoms: inattention, hyperactivity and impulsivity, as well as psychological, occupational, social and/or educational impairments (International Classification of Mental and Behavioural Disorders 10th revision). ADHD symptoms, which are found throughout the normal population, vary in severity and not every person with ADHD has all of the three core symptoms (Barkley, 1998). Symptoms can overlap with Bi-polar and Personality Disorders (e.g. Borderline Personality

Disorder). Co-morbid symptoms associated with ADHD include depression, anxiety, and substance misuse. Thus, misdiagnosis is not uncommon.

Whilst ADHD has commonly been treated with medication only (methylphenidate, atomoxetine or dexamfetamine) (Bramham et al., 2008), medication does not necessarily reduce the functional impairments accompanying ADHD: poor achievement at work, poor organisational skills and relationship difficulties (Knouse et al., 2008). Individuals tend to feel rejected and misunderstood by others. Their self-esteem and self-confidence is often low (Safran, 2006). It is due to these difficulties that people tend to seek treatment.

Individual cognitive behavioural therapy (CBT) has shown promising results in reducing functional impairments (Safran et al., 2005). The National Institute for Health and Clinical Excellence (NICE, 2008) also recommends group interventions, which have proven to be effective (see Hesslinger et al., 2002; Philipsen et al., 2007; Safran et al., 2005a, 2005b; Solanto et al., 2008; Stevenson et al., 2002; Virta et al., 2008). Groups are advantageous because they enable the development of supportive networks whereby skills can be rehearsed without judgement and are also more cost effective than individual treatments (Bramham et al., 2008).

Specialized group psychotherapy (applied group analysis – AGA) has been shown to be effective for various psychological disturbances (e.g. mood, panic, eating disorders) (see Lorentzen, 2006). In group analysis, there is a dearth of papers on working with adults with ADHD. Review of the extant literature only revealed six specifically designed group programmes, based on Cognitive Remediation Therapy (CRT), Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), psychoeducation and/or mindfulness. Groups were conducted in America (Safran et al., 2005; Solanto et al., 2008), Germany (Hesslinger et al., 2002; Philipsen et al., 2007), Finland (Virta et al., 2008) and Australia (Stevenson et al., 2002).

Manualised treatment is not uncommon in AGA. Lorentzen (2012) developed a manual for short-term group analytic therapy, which was informed by Kennard et al.’s (1993)

workbook of group analytic interventions. Whilst AGA has not been used for treating adults with ADHD, it has been used in treating specific populations, such as bulimic women, by integrating psycho-educational and cognitive elements into the group analytic approach (see Valbak, 2003).

Hence, cognitive, psycho-educational and mindfulness were combined with a group analytic approach. I suggest that this is possible because of the similarities between these approaches. Both short-term CBT groups and short-term AGA have a preparation phase with a circumscribed focus, 'manualised' treatment groups are run in the here-and-now, therapists engage group members and the group, facilitate and maintain a group structure, pursue the goal of therapy and pay attention to termination of the group.

Furthermore, Foulkes' group-analytic technique, where the group conductor follows a directive and/or interpretative stance during the first stages of the group and in later stages leaves the group to take the place of the therapist through group members' mutual support, is not dissimilar to the therapist's function in CBT groups. In the latter, the therapist uses a directive, present-oriented style and aims to equip clients with 'tools' so that s/he becomes redundant, enabling clients to support each other.

However, in AGA the therapist also enhances the flow of communication within the group boundaries (e.g. facilitating a balance between cohesion and challenge) and attends to events beyond those boundaries, as matter pertaining to the dynamic flow of communication in the 'here and now'. Attending to events of and beyond these boundaries is what Foulkes (1975) called dynamic administration. It is dynamic because the way it is conducted, and the concern and understanding of others that is apparent in that way, provides a good model of relating for other group members.

These principles were integrated into the present group. In this article, I am going to describe the development and evaluation of a manualised group treatment programme for adult ADHD, by integrating psycho-educational, cognitive and group analytic principles. What follows is a discussion about lessons learnt from this experience, in the hope that it will encourage other clinicians to set up and evaluate homogenous groups for adults with ADHD.

II. DESCRIPTION OF CURRENT SHORT-TERM GROUP

A 12-week evening group was set up and evaluated. The content of the groups was devised by drawing on the extant literature, in particular, Hesslinger et al. (2002) and Virta et al. (2008). Twelve weeks were chosen because this duration has shown to be effective. In line with AGA, each session lasted for 90 minutes. Sessions consisted of a structured part, followed by free-floating discussions. The former consisted of psycho-education, mindfulness and CBT techniques (see Appendix A). It was anticipated that group processes would resemble those of other small groups. Group analytic thinking was applied to the structured part of the group, the free-floating

communication, as well as discussions between the group conductors about group processes at the end of groups.

A. Group Members

Ten Caucasian adults, who all had received a diagnosis of ADHD and attended the ADHD research clinic, had been invited to attend the group. Originally, nine (six males, three females) wanted to attend the group. However, three left for personal reasons after the first session (timing of the group was unsuitable) and only six (four males, two females) attended all groups. Members were between 24-49 years of age. Three were in full-time employment, one worked part-time, one was unemployed, and one was a part-time student. Four were prescribed medication for ADHD. The group was jointly run by a male psychiatrist and a female clinical psychologist. Additionally, one psychologist from the research clinic, who knew all members, attended to gain experience of the running of such groups.

B. Method

Group members completed the Weiss Functional Impairment Rating Scale Self-Report (WFIRS-S) prior to the start and at the end of the group, as well as a 4-item feedback questionnaire (see Appendix B). Responses from the WFIRS-S were analysed and the Wilcoxon signed-ranks test in which T1 (prior to treatment) and T2 (end of treatment) were compared, using the Statistical Package for the Social Sciences (SPSS).

Members were encouraged to comment on what they had found helpful and also asked to provide suggestions for improving the programme. Feedback questionnaires were analysed using qualitative content analysis (see Graneheim & Lundman, 2004). After having read all questionnaires once, each question was read across all participants to obtain a sense of the whole. Meaning units were abstracted and coded (e.g. VC1 = verbal communication 1). Codes were compared based on differences and similarities and sorted into sub-categories, categories, sub-themes as well as themes, which constitute the manifest content (see Appendix C).

III. FINDINGS OF GROUP MEMBERS' RESPONSES

Responses on the WFIRS-S rating scale before and after treatment indicate that their tendency to 'rely on others to do things for you' significantly decreased at the end of the programme ($Z = -2.12, p < 0.05$).

Three main themes were identified: social interaction, learning, knowledge, improvement. (An example is given in **TABLE 1**).

All group members rated the group as 'very useful', their tendency to rely on others to do things for them significantly decreased at the end of treatment, and they set up a support group.

IV. DISCUSSION

The current group generated some interesting questions and findings. All group members reported having found the group

‘very useful’, relied significantly less on others to do things for them, and set up a support group at the end of the 12-week group. However, due to methodological and psychotherapeutic weakness in the setting up, running and evaluation of the group

programme, conclusions drawn from these findings are tentative and speculative. I am going to discuss lessons learnt from this experience, in the hope that my reflections will be of benefit to AGA.

TABLE I EXAMPLE OF CONTENT ANALYSIS ON SOCIAL INTERACTION

Theme	Social Interaction	Social Interaction	Social Interaction
Sub-Theme	Verbal Communication	Verbal Communication	Non-verbal Communication
Category	Language	Language	
Sub-Category	Listening	Talking	Relating to others
Meaning Units with Codes	Loved hearing from others (VC1); helpful to hear how it affects people in different ways (VC1); great to hear other people’s experiences (VC1)	Group discussion was good (VC2); I liked that emotional problems were covered (VC3); good to start looking at feelings (VC3); very useful group everybody with ADHD should have the opportunity to talk and do such group (VC4)	Relating (NVC1); relating to others was helpful (NVC1); being aware that I wasn’t alone (NCV1); a general feeling of being understood helped (NCV1); felt a bit intimidated to open up with a big group (NVC1); knowing that help can be found from others when needed (NVC2); opportunity to set up a support group (NVC3); being in the group gave me a focus point (NVC4)

Lessons Learnt

Firstly, in the first session, the therapist’s task is to help the group get started and move it into the direction s/he likes it to go. The therapist listens, models, promotes safety and explores defences and demonstrates group processes at work (Kennard et al., 2000).

Originally, the group consisted of nine members. During the first session, three members announced that they would not be able to attend the whole programme due to change in their circumstances (moving away, taking up employment). This was not only unsettling for group members but also for us, the group facilitators. Managing the boundaries of the group, the interface of the group and the outside world so as to facilitate an experience of safety and protection was crucial to the survival of the group (see Foulkes, 1975). The group needed to be promising something for the future and stay safe otherwise there was no point for the other members to attend.

Working with impulsivity (acting without thinking), one of the hallmarks of ADHD, is particularly challenging in the group setting. Dies (1993) listed impulsive behaviour patterns as one of the exclusion criteria for dynamic group psychotherapy. However, integration of, for example, cognitive, psycho-educational and/or mindfulness techniques, with group analytic principles may be useful for adults with ADHD.

Secondly, following members’ announcement that they could only attend one or two more sessions, there was some discussion about ADHD and how it affected employment. But also regret that they would only meet for a short time.

Drop-out affects group members, the group process and the effectiveness of the group treatment. Whilst members had been given information about the group programme when attending

the research clinic, only one brief assessment had been carried out.

The current experience highlights the importance of selection when setting up a group for adults with ADHD. One of the most important aspects of a successful outcome is selecting the ‘right’ mix of clients for a group, taking into account their presenting problem, personalities and predominant defence styles (Montgomery, 2002). The main focus during assessment had been on presenting problems (ADHD), use of medication, and basic socio-demographic data. Careful client-screening and documentation not only serves to minimise drop-out rate but also prevents their profiles from appearing fragmented and depersonalized, as in the present group.

Furthermore, the therapist may have to pay particular attention as to whether it is realistic for adults with ADHD to commit to regular attendance of all groups because disorganisation and problems with planning are functional impairments commonly found in adult ADHD.

Thirdly, upon reflection, although we discussed group processes after each session, recording the development of the group and group processes could have helped to shed light on whether the positive comments from group members are an expression of idealisation or indicative of real change.

Fourthly, in the current group, three professionals were present, which is unusual. Group analytic groups are normally run by one conductor. What are the implications? Nitsun (1989) compares the role of the conductor in the initial stage of the development of the group to that of the mother nursing the infant in the first few months of life. During this time of development (paranoid-schizoid phase), paranoid anxieties are paramount. It is difficult for the conductor not to be

contaminated by these anxieties. Adults with ADHD often present with heightened anxieties due to their experiences. Thus, the holding function of the conductor becomes particularly important for this client group, both in structured and unstructured groups.

Groups tend to perceive the conductor as a powerful figure from whom to expect ‘magical help’ and in that sense the group may look at the therapist as the father or primordial mother’ (Pines, 1984:278). The transference relationship to the conductor is often powerfully charged, involving also gender role expectations. Structured groups are not immune to transference and counter-transference relationships. The presence of another professional in addition to two conductors may have created complicated dynamics. Whilst having both ‘parents’ present (female and male conductor) may dilute transference and counter-transference relationships, enabling the conductors to remain less affected by paranoid anxieties, the presence of a further professional may have hindered this process. Upon reflection, having three professionals in the group is best avoided.

Fifthly, the remaining six members reported having benefited from the group. What are possible reasons? Group members’ primary interest in attending the group programme was to meet other individuals with ADHD in order to feel less isolated. It has been documented in the literature that individuals with ADHD often feel isolated from their peers (Bramham et al., 2008). Attending the current group enabled participants to meet others with similar difficulties. One of the aims of the current programme was to encourage members to set up a support group at the end of the group. Group members indeed informed us after the ending of the group that they had set up a support group. Support groups provide a psycho-social network and provide opportunities for problem-sharing. One aim of support groups is to maintain homeostasis and any change that occurs in gradual and not generally expected. Whilst the regularity and boundaries of such group is as not as stringent or prominently adhered to as in AGA, such groups provide an essential containing function (Montgomery, 2002). Therefore, encouragement to set up support groups for this population after the ending of a group could be explored in APA. Unfortunately, due to lack of time and resources, follow up and gathering information about the support group, its process and continuation was not feasible. All this information is very valuable in order to assess how long the support group lasted and whether any change occurred.

Sixthly, it is generally assumed that teaching client skills and techniques will improve group members’ functioning. In the current group, members reported relying less on others to do things for them. It would be worth assessing as to why this might be the case because group discussions and analyses of feedback forms cast doubt on an explanation that relies on teaching skills. Whilst group members valued being taught strategies for improving their self-esteem their reluctance to complete and practise homework tasks throughout the duration of the group makes this unlikely. Teaching techniques to tackle low self-esteem seems of little therapeutic benefit, when these

techniques are not rehearsed, practised and applied in day-to-day life.

It is a very interesting question as to whether the group process itself is a therapeutic force for change in groups, like the present one, which focuses to a great extent on problem-solving and psycho-education. To shed light on this issue, it would have been beneficial to have gathered detailed information about the group and group processes and analysed this.

Seventhly, over the duration of the group, group members talked about their personal experiences and started to identify with each other. During the free-floating discussions, they talked about their relationship difficulties and their feelings of not being understood by others (e.g. family members, work colleagues, managers, and partners). They also talked about stigma and having been discriminated against by wider society (the large group).

Possibly, in the current group, they felt understood. Examination of the meaning units of the themes ‘social interaction’ and ‘learning’ in this group shows that group members felt connected to each other and the group. Could it be that the formation of affectional bonds have resulted in members becoming more self-efficient or are there are reasons?

The literature reports that CBT technique has been associated with positive therapeutic results. Considering Ahn and Wampold’s (2001) meta-analytic review, which identified factors other than CBT technique that were responsible for positive therapeutic outcome, I would suggest that the therapeutic alliance, which has consistently been identified as the key ingredient to successful therapeutic outcome *across treatment modalities* (see Martin *et al.*, 2000 for meta-analytic review), as well as affectionate bonds, may have contributed to the reported benefits in this group.

It is unclear whether this improvement is due to the development of group processes, the group analytic effect, or due to therapeutic alliance because these aspects were not evaluated. Only basic demographic variables of the group members were selected, resulting in de-personalisation and fragmentation. Clinical and interpersonal details could have been selected to gain a deeper understanding of the processes in order to delineate ingredients for therapeutic change.

Eighthly, often, direct and leading questions were asked. Whilst this may not work for other groups, it felt helpful in this group, and was endorsed by members, who reported that they

“enjoyed the conversation guidance by the professionals”.

Observing emphatic and sympathetic social interaction is a form of ‘emotional, experiential learning’ (the formation on affectional bonds, feeling understood). It may be particularly beneficial for adults with ADHD because it does not require intermediate cognitive mediation, which makes demand on cognitive domains. Attention difficulties, a core symptom of ADHD, may interfere with cognitive mediation and the development of affectional bonds may be as important as skills-based group programmes.

However, in order to disentangle what specific therapeutic factors resulted in reported improvement, it would have been useful to assess the therapeutic alliance since it has been identified as core ingredient of change across treatment modalities (see Martin *et al.*, 2000 for meta-analytic review).

Finally, with regard to the research design, questionnaires with semi-structured and structured questions could have been constructed (e.g. by drawing on the pertinent literature; piloting them; assessing inter-rater reliability) to increase trustworthiness of findings. Moreover, the current sample drawn from one group with six members is too small. Running more groups and using a pool of data would enable meaningful analyses.

V. CONCLUSION

Foulkes (1948) postulated that group analysis can be used for all kind of 'disturbances'. I am hoping that this article contributes to considering such ventures and the running of groups in AGA because people, irrespective of their diagnoses, have a desire for communication and to communicate (see Foulkes, 1964). The group members described the devastating effect continuous rejection had on their selves. It resulted in feelings of alienation and loneliness. Perhaps unsurprisingly, their primary interest in attending the group was to feel less isolated and meet others with ADHD, because their experiences led them to believe that only people with ADHD could understand them. Setting up a support group seems a natural conclusion then. However, whilst leaderless groups can be effective, therapist led group allows also for personality structuring because experiential learning also occurs in groups partially through identifying with the leader as an idealised object. I hope that the current ADHD group and lessons learnt from designing, running and evaluating it, will contribute to the dearth of papers on adult ADHD in AGA, and encourage other group psychotherapists to set up groups for adults with ADHD.

ACKNOWLEDGEMENT

I would like to thank A. Rossini for her data entry and U. Mueller for interesting discussions and help in running the group.

REFERENCES

- [1] Ahn, H. and Wampold, B. (2001) 'Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy', *Journal of Counseling Psychology*, 48: 251-7. [CrossRef](#)
- [2] Barkley, R. (1998) *Attention Deficit Hyperactivity Disorder. A handbook for diagnosis and treatment*. New York: Guilford Press.
- [3] Behr, H. (1993). The Group Therapist as Dynamic Administrator. In E. Schneider (1996) *Holding and Caring: A Borderline Patient in A New Psychotherapy Group*, p. 128.
- [4] Behr, H. (2008) 'Education about Group Analysis is as Important as Research: Response to 'From Freud to Foulkes to the Future: The Development of Group Analysis and its Continual Evolution' by Az Hakeem', *Group Analysis*, 41: 53-9. [CrossRef](#)
- [5] Bramham, J., Young, S., Bickerdike, A., Spain, D., McCartan, D. and Xenitidis, K. (2008) 'Evaluation of group cognitive behavioural therapy for adults with ADHD', *Journal of Attention Disorders*: 1-8.
- [6] Brown, D. (1979) '27th November, 1978 – Developing Concepts in Group Analysis', *Group Analysis*, 12: 69-72. [CrossRef](#)
- [7] Dies, R. (1993) Research on group psychotherapy: overview and clinical application. In (A. Allonso & H. Swiller, eds.) *Group Therapy in Clinical Practice*. Washington, DC: American Psychiatric Press.
- [8] Foulkes, S. (1948) *Introduction to Group Analytic Psychotherapy*. London: Karnac, 1983.
- [9] Foulkes, S. (1964) *Therapeutic Group Analysis*. London: Maresfield.
- [10] Foulkes, S. (1975) *Group Analytic Psychotherapy: Method and Principles*. London: Maresfield.
- [11] Glenn, I. (1987) 'Attachment Theory and Group Analysis: The Group Matrix as a Secure Base', *Group Analysis*, 20: 109-17. [CrossRef](#)
- [12] Graneheim, U. And Lundman, B. (2004). 'Qualitative content analysis in nursing research: concepts, procedures and measure to achieve trustworthiness. *Nurse Education Today*, 24: 105-12. [CrossRef](#)
- [13] Hesslinger, B., Van Elst, T., Nyberg, E., Dykierek, P., Richter, H., Berner, M., and Ebert, D. (2002) 'Psychotherapy of attention deficit hyperactivity disorder in adults. A pilot study using a structured skills training program', *European Archives of Psychiatry and Clinical Neuroscience*, 252: 177-184. [CrossRef](#)
- [14] Johansson, L. and Werbart, R. (2009) 'Patients' Views of Therapeutic Action in Group Psychoanalytic Psychotherapy', *Group Analysis*, 42: 120-42. [CrossRef](#)
- [15] Kennard, D., Roberts, J. and Winter, D. (1993) *A Work Book of Group-Analytic Interventions*. London: Routledge.
- [16] Knouse, L., Cooper-Vince, C., Sprich, S., and Safren, S. (2008) 'Recent developments in the psychosocial treatment of adult ADHD', *Expert Review of Neurotherapeutics*, 8: 1-12. [CrossRef](#)
- [17] Lorentzen, S. (2006) 'Special Section: Contemporary Research Challenges for Group Analysis', *Group Analysis*, 39: 321-40. [CrossRef](#)
- [18] Lorentzen, S. (2012) 'Writing Manuals for Psychodynamic Group Treatments', *Group Analysis*, 45: 28-45. [CrossRef](#)
- [19] Martin, D., Garske, J. and Davis, K. (2000) 'Relation of the Therapeutic Alliance with Outcome and Other Variable: A Meta-Analytic Review', *Journal of Consulting and Clinical Psychology*, 68(3): 438-50. [CrossRef](#)
- [20] Montgomery, C. (2002) 'Role of dynamic group therapy in psychiatry. *Advances in Psychiatric Treatment*', 8: 34-41. [CrossRef](#)
- [21] National Institute of Health and Clinical Excellence (2008) 'Attention Deficit Hyperactivity Disorder: diagnosis and management of ADHD in children, young people and adults. [VIEW](#).
- [22] Nitsun, M. (1989) 'Early development linking the individual and the group', *Group Analysis*, 22(3): 49-60. [CrossRef](#)
- [23] Pines (ed.) (1984) 'The contribution of S. H. Foulkes to group therapy' in M. Pines (ed.) *The evolution of group analysis*. London: Routledge Kegan and Paul.
- [24] Philipsen, A., Richter, H., Peters, J., Alm, B., Sobanski, E., Colla, M., Münzebrock, M., Scheel, C., Jacob, C., Perlov, E., Van Elst, T. and Hesslinger, B. (2007) 'Structured group psychotherapy in adults with attention deficit hyperactivity disorder. Results of an open multicentre study', *The Journal of Nervous and Mental Disease*, 195: 1013-1019. [CrossRef](#)
- [25] Ramsay, J. and Rostain, A. (2008) *Cognitive-Behavioral Therapy for Adult ADHD. An Integrative Psychosocial and Medical Approach*. Oxon: Routledge.
- [26] Rizzolatti, J., Fabbri-Destro, M. and Cattaneo, L. (2009) 'Mirror neurons and their clinical Relevance', *Nature Clinical Practice Neurology*, 5: 24-34. [CrossRef](#)
- [27] Safran, S. (2006) 'Cognitive-behavioral approaches to ADHD treatment in adulthood. *Journal of Clinical Psychiatry*', 67: 46-50.
- [28] Safran, S., Otto, M., Sprich, S., Winett, C.L., Wilens, T. and Biederman, J. (2005a) 'Cognitive-behavioural therapy for ADHD in medication-treated adults with continued symptoms. *Behaviour Research and Therapy*', 43: 831-842. [CrossRef](#)
- [29] Safran, S., Perlman, C., Sprich, S. and Otto, M. (2005b) *Mastering your adult ADHD: a cognitive behavioural treatment program. Therapist Guide*. New York, NY: Oxford University Press. [CrossRef](#)
- [30] Schermer, V. (2010) 'Reflections on 'Reflections on Mirroring'', *Group Analysis*, 43(3): 214-27. [CrossRef](#)
- [31] Simon, V., Czobor, P., Balint, S., et al. (2009) 'Prevalence and correlates of adult attention-deficit hyperactivity disorder: meta-analysis', *British Journal of Psychiatry*, 194: 204-211. [CrossRef](#)
- [32] Solanto, M., Marks, D., Mitchell, K., Wasserstein, J. and Kofman, M. (2008) 'Development of a new psychosocial treatment for adult ADHD', *Journal of Attention Disorders*: 1-9.

[33] Stevenson, C., Stevenson, R., and Whitmont, S. (2003) ‘A self-directed psychosocial intervention with minimal therapist contact for adults with attention deficit hyperactivity disorder’, *Clinical Psychology and Psychotherapy*, 10: 93-101. [CrossRef](#)

[34] Stevenson, C., Whitmont, S., Bornholt, L., Livesey, D. and Stevenson, R. (2002) ‘A cognitive remediation programme for adults with Attention Deficit Hyperactivity Disorder’, *Australian and New Zealand Journal of Psychiatry*, 36: 610-616. [CrossRef](#)

[35] Valbak, K. (2003) ‘Specialized Psychotherapeutic Group Analysis: How do we make group analysis suitable for ‘non-suitable’ patients?’’, *Group Analysis*, 36: 73-86. [CrossRef](#)

[36] Virta, M., Vedenpää, A., Grönroos, N., Chydenius, E., et al. (2008) ‘Adults With ADHD Benefit From Cognitive—Behaviorally Oriented Group Rehabilitation: A Study of 29 Participants’, *Journal of Attention Disorders*, 12: 218-226. [CrossRef](#)

[37] Vlastelica, M., Pavlovic, S. Urlic, I. (2003) ‘Patients’ ranking in therapeutic factors in group analysis’, *Collegicum Antropologicum*, 27: 779-88.

[38] Young, S. and Toone, B. (2000) ‘Attention deficit hyperactivity disorder in adults: clinical issues. A report from the first NHS clinic in the UK’, *Counselling Psychology Quarterly*, 13: 313-319. [CrossRef](#)

[39] Young, S. and Bramham, J. (2005) *ADHD in Adults. A Psychological Guide to Practice*. Chichester: John Wiley & Sons Ltd.

APPENDIX A

The following components were used: Psychoeducation is important as it enables individuals to understand the cores symptoms and associated functional impairment of ADHD and their presentation. It also helps to appreciate the neurodevelopmental basis of ADHD and its effect on behaviour, thus, repairing self-esteem (Bramham et al., 2008). Both psychoeducation and ‘mindfulness’ exercises were rated by participants in Germany as the “most helpful” components of the programme (Philipson, Richter, Peters, Alm, Sobanski, Colla, Münzebrock, Scheel, Jacob, Perlov, Tebartze van Elst and Hesslinger, 2007). Hence, mindfulness exercises as described by Babat-Zinn (2004) were included in the current programme. Since adults with ADHD also need concrete skills and strategies for coping with associated functional impairment and CBT has proven effective (see Safren, Perlman, Sprich & Otto, 2005b; Ramsay & Rostain, 2008; Young & Bramham, 2007), CBT strategies were integrated to modify maladaptive thoughts that interfered with the treatment programme (acquisition of new skills). The content of the current programme is summarised below:

Session Number	Content
1	Welcome Getting to know each other Completion of questionnaires Introduction to group programme (handout)
2	Agreement on rules for Group Psychoeducation on ADHD (handout) Homework task: re-read/reflect on information at home Feedback from Participations/Group Discussion
3	Discussion of homework task Psychoeducation on medication and neurobiological aspects of ADHD Attention/memory Homework task: re-read/reflect on information at home Feedback from Participations/Group Discussion
4	Discussion of homework task Psychoeducation on Planning and Organisation/Stress Management (handout) Techniques for improving organisation/Stress

	Management Feedback from Participations/Concluding Group Discussion
5	Discussion of homework task Psychoeducation on memory functioning and link with ADHD (handout) Techniques to improve memory functioning Homework task: practise daily at home Feedback from Participations/Concluding Group Discussion
6	Discussion of homework task Techniques for improving attention: Mindfulness Psychoeducation on mindfulness – basic skills (handout) Group Exercise to practise mindfulness Homework task: practice mindfulness daily at home Feedback from Participations/Concluding Group Discussion
7	Discussion of homework task Introduction of Mindfulness – advanced skills (handouts) Psychoeducation on initiation and motivation Techniques to improve initiation and motivation (handouts) Homework task: practise daily mindfulness advanced skills at home Feedback from Participations/Concluding Group Discussion
8	Discussion of homework task Psychoeducation on self-esteem and link between ADHD and low self-esteem (handout) Techniques for improving self-esteem Homework task: practise techniques daily at home Feedback from Participations/Concluding Group Discussion
9	Discussion of homework task Psychoeducation on behaviour (handout) Behaviour Analysis – basic skills group practice Homework task: practise own behaviour analysis daily at home Feedback from Participations/Concluding Group Discussion
10	Discussion of homework task Psychoeducation on Impulsiveness (handout) Behaviour Analysis of Impulsiveness Techniques for improving impulsivity Homework task: practise techniques daily at home Feedback from Participations/Concluding Group Discussion
11	Discussion of homework task Relapse Prevention – Setting up Self-Help Group Group discussion of how to set up a self-help group Feedback from Participations/Concluding Group Discussion
12	Discussion of homework task Recap of Programme Completion of questionnaires/feedback Goodbye

APPENDIX B: FEEDBACK FORM

	Not at all	Just a little	Pretty much	Very much
Knowledge – the programme helped me gain a better understanding of ADHD				
Relevance – the topics taught were relevant				
Skills – the programme has equipped me with new skills				
Usefulness – overall the group programme was useful				

APPENDIX C: CONTENT ANALYSIS OF FEEDBACK

Category	Knowledge	
Meaning Units	<p>Already read up a lot about it; information on neurobiology, CBT model was very interesting, some of the ‘facts’ about ADHD were interesting; good to get a basic understanding of the biology behind ADHD; understanding of ADHD much better; made me aware of issues previously had no knowledge of; Liked the fact that practical issues were covered; some large topics could only be touched upon; found self-esteem, anxiety, memory, mindfulness, improving attention, and impulsiveness particularly useful; learned tips on getting a regular sleep pattern; learning about the strategies that exist for dealing with the various aspects of ADHD; Some more on practical ADHD solutions to time management e.g. how to use an organiser/online calendar; more on how to cope with various comorbidities;</p>	<p>some ADHD facts seemed as though they were a product of a very small demographic; might be better to send information ahead of the session then it can be done and discussed within the session;</p>

Category	Content of Psychoeducation
Meaning Units	<p>Keep neurobiology but perhaps simplify information; essentially a lay audience and therefore even mention of synapses may be new to some; lots of complicated talking for doctors at start, bit confusing; would have liked more on the neurobiological side; more on medicines (x2); would like to discuss coping strategies; Would like handouts/diagrams etc to be very bright, clear and concise; diagrams and stuff a bit complicated; diagram on board was good; powerpoint printouts (on neurobiology) don’t lend themselves to an easy and simple interpretation</p>

Category	Skills	
Meaning Units	<p>Learned a few techniques for maintaining attention; helpful stuff; first time had come across the mindfulness meditation in reference to ADHD</p>	<p>Rediscovered existing skills, rather than equipped with new skills; already practising many of the techniques offered; might be an idea (should you get the funding) to provide people with an ADHD diary book where words, thoughts etc. can be gathered</p>

Category	Communication
Meaning Units	<p>Loved hearing from others with ADHD; enjoyed the conversation guidance by the professionals; Group discussion was good; felt a little intimidated to open up with a big group; helpful to meet others with ADHD; good to start looking at feelings, thoughts</p>

Category	Feeling Connected
Meaning Units	<p>Being aware that I wasn’t alone; a general feeling of being understood helped ; great to hear other people’s experiences; relating; I like the fact that emotional problems were covered; helpful to hear how it affects people in different ways; had the opportunity to set up a support group; knowing that help can be found from others if needed;</p>

Category	Learning From Each Other
Meaning Units	<p>Learnt a lot from others in the group, like what we have in common (strengths and weaknesses); the most valuable lessons I feel I have learned from other members of the group (i.e. coping mechanisms); enjoyed going through techniques with other ADDers looking at how they’ve worked; being in group gave me a focus point; stimulated me into being proactive; given a lot of inspiration for more things I can do (starting a group); really useful group; every person with ADHD should have the opportunity to do a group like this;</p>