ADHD Behavioral Strategies, Executive Function Coaching & Lifestyle Management

Comprehensive clinical program for children, adolescents, and adults | Evidence-informed care and implementation framework

Scope: This is a proposed service framework, not a claim that every intervention is currently offered. Treatment must be individualized, developmentally appropriate, and delivered by qualified clinicians or appropriately trained providers. ADHD diagnosis remains a clinical determination based on DSM-5-TR criteria, history, impairment and differential diagnosis.

1. Clinical indications and treatment targets

ADHD presentations: predominantly inattentive (F90.0), predominantly hyperactive/impulsive (F90.1), and combined (F90.2). Behavioral and skills-based interventions address impaired task initiation, planning, working memory compensation, inhibition, organization, time estimation, emotional reactivity, school or work performance, and interpersonal functioning. ADHD often coexists with anxiety, depression, learning disorders, autism, sleep disorders, oppositional symptoms, and substance use; each requires separate assessment and a tailored treatment plan.

Measurement-based goals: define 2-4 observable targets at baseline (e.g., assignments submitted per week, missed appointments, lateness, parent-child conflicts, completion of planned tasks). Reassess symptoms and functioning with age-appropriate tools such as Vanderbilt, ADHD-RS-5, Conners, ASRS, BRIEF-2/BRIEF-A, and Weiss Functional Impairment Rating Scale as appropriate. Rating scales support, but do not replace, clinical evaluation.

2. Evidence-based psychotherapy and behavioral modalities

A. ADHD-focused cognitive behavioral therapy (CBT) - adolescents and adults

Appropriate for: diagnosed ADHD with persistent disorganization, procrastination, distractibility, avoidance, and unhelpful beliefs; also useful alongside medication. **Delivery:** structured weekly sessions, commonly 8-16 or more based on need. Therapist and individual select a real-life problem; map triggers, thoughts, feelings and behavior; build calendar/task systems; break projects into timed steps; practice prioritization, distraction management, and cognitive restructuring. Review homework and barriers each visit. **Goal:** increase task completion and functioning while reducing avoidance and self-defeating beliefs. **Monitor:** completed tasks, punctuality, functional scales, and individualized goal attainment.

B. Behavioral parent training (BPT) - preschool and school-age children

Appropriate for: childhood ADHD, especially ages 4-5 where parent training and classroom behavioral interventions are first-line; also for older children with disruptive behavior. **Delivery:** clinician coaches caregivers to define 1-2 target behaviors, give concise instructions, use predictable routines, immediate labeled praise, token/reward systems, consistent consequences, and planned practice. Review behavior charts and caregiver fidelity weekly or biweekly. Coordinate with school when possible. **Goal:** improve behavior and family functioning and reduce conflict; BPT is not a cure for ADHD. **Monitor:** frequency of target behavior, homework completion, and caregiver-reported stress.

C. Classroom behavioral management and organizational skills training - children and teens

Appropriate for: academic impairment, incomplete assignments, forgotten materials, disorganization, and transitions. **Delivery:** teacher and family establish daily report cards, clear instructions, assignment trackers, folder/backpack systems, check-in/check-out, reinforcement, and scheduled review of missing work. Explicitly teach one organizational skill at a time, practice at school and home, and fade prompts as independence improves. **Goal:** better assignment submission, classroom participation, and self-management. **Monitor:** missing assignments, daily report card metrics, and teacher/parent ratings.

D. DBT-informed skills - emotional dysregulation and impulsive reactions

Appropriate for: ADHD with marked frustration intolerance, impulsive reactions, or interpersonal conflict; especially when co-occurring emotion-regulation difficulties are present. **Delivery:** teach mindfulness of cues, STOP/pause strategies, distress

tolerance, emotion labeling, opposite action where relevant, and interpersonal effectiveness; rehearse in session and assign skills practice. **Goal:** fewer reactive conflicts and improved coping. **Evidence note:** DBT-informed skills are adjunctive and are not a standalone first-line ADHD treatment.

E. Acceptance and commitment therapy (ACT) - adjunct for avoidance and distress

Appropriate for: coexisting anxiety, shame, avoidance, or values-related functional difficulties. **Delivery:** identify values, notice thoughts without automatically following them, use defusion and acceptance exercises, and commit to small measurable actions. **Goal:** greater psychological flexibility and valued action. **Evidence note:** ACT is adjunctive; ADHD-specific evidence is less established than for structured CBT.

F. Family therapy, psychoeducation, and motivational interviewing

Appropriate for: family conflict, adolescent autonomy, treatment ambivalence, or adherence difficulties. **Delivery:** teach ADHD neurodevelopmental concepts, map family interaction patterns, practice collaborative problem-solving and communication, negotiate realistic responsibilities, and use motivational interviewing to explore ambivalence. **Goal:** better treatment engagement, consistent supports, and reduced blame. Treat family therapy as supportive care rather than a substitute for core ADHD treatment.

3. Executive-function coaching: practical step-by-step workflow

Role: coaching is a practical skills and accountability service, not diagnostic testing or a substitute for psychotherapy/medication. Clearly distinguish licensed clinical care from nonclinical coaching.

• **1. Functional assessment:** identify concrete breakdowns (late bills, missed deadlines, lost items, homework, chores); establish baseline frequencies.

• **2. Select one priority:** choose a specific measurable target (e.g., submit 90% of assignments by deadline for 4 weeks).

• **3. Externalize working memory:** one calendar, one task-capture inbox, reminders, visual checklists, and fixed locations for essentials.

• **4. Break down and time-box:** turn projects into next physical actions; use 10-25-minute work blocks and planned breaks; adjust to age.

• **5. Create initiation cues:** if-then plans, environmental prompts, body doubling, and a consistent first-step ritual.

• **6. Reduce friction:** remove phone notifications, use website blockers when appropriate, stage supplies, and arrange a low-distraction workspace.

• **7. Weekly review:** inspect what was completed, troubleshoot failed systems without blame, and modify one variable at a time.

• **8. Generalize and fade support:** practice at home, school, and work; gradually transfer reminders and tracking to the individual.

Coaching goals: improved self-efficacy, task initiation, time management, sustained routines, and reliable follow-through. **Outcome measures:** missed deadlines, punctuality, completed tasks, and individualized quality-of-life ratings. Evidence for coaching is less robust than for behavioral parent training and ADHD-focused CBT; avoid promising specific outcomes.

4. Lifestyle and environmental interventions

Sleep and circadian regularity

Screen for delayed sleep phase, insomnia, sleep apnea, restless legs, insufficient sleep, and stimulant timing effects. Establish consistent wake times, age-appropriate sleep duration, a wind-down routine, reduced evening caffeine and screens, and morning light exposure. Consider sleep-medicine referral for suspected sleep disorders. **Goal:** improve alertness, irritability, and daytime function; sleep hygiene alone does not treat core ADHD in all individuals.

Physical activity and movement

Encourage developmentally appropriate regular aerobic activity and resistance or play-based movement, using enjoyable and sustainable choices. Add short movement breaks during long tasks. **Goal:** support mood, sleep, physical health, and attention regulation. Exercise is adjunctive, not a replacement for indicated medication or behavioral treatment.

Nutrition, hydration, and caffeine

Encourage regular meals, adequate protein and balanced nutrition, hydration, and planned snacks when appetite is reduced by stimulants. Review caffeine and energy drink intake because they may worsen insomnia, palpitations, and anxiety, especially with stimulants. Avoid unsupported elimination diets or supplements as routine ADHD treatment; investigate specific deficiencies or food reactions only when clinically indicated.

Digital hygiene, routines, and environmental design

Use designated work zones, phone boundaries, calendar alarms, visual schedules, task lists, and predictable transitions. For children, build simple morning and bedtime routines and reinforce independently completed steps. For teens, co-design systems to preserve autonomy. For adults, use work batching, written meeting summaries, automated bill payment, and realistic buffer time.

Mindfulness and stress management

Brief guided mindfulness, grounding, breathing, and self-compassion practices may support distress management and attentional awareness. Use as adjuncts with realistic expectations; evidence is heterogeneous and these are not substitutes for first-line ADHD treatment.

5. Matching modalities to presentation and coexisting diagnosis

Clinical pattern	Preferred / appropriate interventions
Preschool ADHD (4-5)	Behavioral parent training and classroom behavior interventions first; medication only when guideline criteria are met.
School-age ADHD (6-12)	FDA-approved medication when indicated plus BPT and classroom interventions; organizational skills training and school supports.
Adolescent ADHD (13-17)	Medication when appropriate with assent, organizational skills training, CBT-informed skills, family collaboration, school supports.
Adult ADHD	Medication when appropriate; ADHD-focused CBT, practical executive-function systems; coaching as adjunct.
ADHD + anxiety	ADHD treatment plus CBT for anxiety, graded exposure for specific anxiety disorders; monitor stimulant tolerability.
ADHD + depression	Assess suicidality and severity; evidence-based depression therapy (CBT/IPT) and ADHD-specific treatment, sequenced by clinical need.
ADHD + bipolar disorder	Stabilize active mood disorder first; cautiously reassess ADHD treatment after mood stability.
ADHD + PTSD	Trauma-focused psychotherapy for PTSD when indicated; ADHD supports tailored to concentration and arousal.
ADHD + ODD/disruptive behavior	Behavioral parent training, consistent reinforcement, coordinated school behavior plan.
ADHD + learning disorder	Psychoeducational assessment, targeted educational interventions, and accommodations.

6. School and workplace accommodations

School: assess eligibility for Section 504 or IDEA/IEP supports; recommend appropriate classroom accommodations such as written instructions, structured assignment systems, organizational check-ins, and reduced-distraction testing when justified. Schools determine eligibility. **Workplace:** discuss written priorities, predictable check-ins, noise reduction, scheduling supports, and task-management tools; employers determine reasonable accommodations under applicable law. Document the functional limitation and requested support rather than guaranteeing approval.

7. Integrating behavioral treatment with medication

Behavioral care may begin before, alongside, or after medication depending on age, severity, preferences, and access. At each follow-up, distinguish medication effects from skills acquisition: medication may improve capacity to focus and inhibit impulses, while CBT and coaching teach durable strategies for planning and task completion. Monitor blood pressure, pulse, weight/appetite, sleep, adverse effects, symptom scores, and functional outcomes as appropriate to the prescribed medication. Do not stop or adjust medication without a prescriber-guided plan.

8. Proposed implementation at 24-7 Shalom Psychiatry

• **Intake:** confirm DSM-5-TR diagnosis, impairment, developmental history, comorbidities, risk and treatment preferences.

• **Baseline:** select age-appropriate symptom/functional measures and 2-4 observable goals.

• **Care plan:** identify primary evidence-based modality, medication plan if indicated, family/school/work collaboration and referrals.

• **Session documentation:** record the intervention actually performed, homework assigned, participation, response, measurable change and next steps.

• **Review:** evaluate progress after approximately 4-8 sessions or sooner if needed; revise approach or refer for specialized care when targets are not improving.

• **Safety:** assess suicidality, substance use, severe mood symptoms, and safeguarding concerns when indicated; refer urgently for acute risk.

9. Clinical references

American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.; DSM-5-TR). https://doi.org/10.1176/appi.books.9780890425787

Wolraich, M. L., et al. (2019). Clinical practice guideline for the diagnosis, evaluation, and treatment of ADHD in children and adolescents. Pediatrics, 144(4), e20192528. https://doi.org/10.1542/peds.2019-2528

National Institute for Health and Care Excellence. (2018, updated). Attention deficit hyperactivity disorder: Diagnosis and management (NG87). https://www.nice.org.uk/guidance/ng87

Centers for Disease Control and Prevention. (n.d.). Treatment of ADHD. https://www.cdc.gov/adhd/treatment/index.html

Safren, S. A., et al. (2005). Behavioral treatment for adults with ADHD. Behavior Research and Therapy, 43(7), 831-842. https://doi.org/10.1016/j.brat.2004.07.001

Solanto, M. V., et al. (2010). Efficacy of meta-cognitive therapy for adult ADHD. American Journal of Psychiatry, 167(8), 958-968. https://doi.org/10.1176/appi.ajp.2009.09081123

Evans, S. W., Owens, J. S., & Bunford, N. (2014). Evidence-based psychosocial treatments for children and adolescents with ADHD. Journal of Clinical Child & Adolescent Psychology, 43(4), 527-551. https://doi.org/10.1080/15374416.2013.850700

Pfiffner, L. J., et al. (2007). A randomized controlled trial of integrated home-school behavioral treatment for ADHD, predominantly inattentive type. Journal of the American Academy of Child & Adolescent Psychiatry, 46(8), 1041-1050.

Clinical disclaimer: This program is educational and should be adapted to clinician scope, current guidelines, patient-specific assessment, local regulations, and actual services available. Modalities listed as adjunctive should not be represented as equally established first-line treatments.