Managing Complex Presentations of ADHD In Adulthood

Craig B.H. Surman, MD

Adult ADHD Research Program
Massachusetts General Hospital
Harvard Medical School

www.drsurman.com
Dr. Surman’s Lifetime Disclosures

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2. "Fast Minds: How to Thrive If You Have ADHD (Or Think You Might)" by Craig Surman, M.D., Tim Bilkey, M.D., with Karen Weintraub.
FAST MINDS

F – Forgetful
A – Achieving below potential
S – Stuck in a rut
T – Time challenged
M – Motivationally challenged
I – Impulsive
N – Novelty seeking
D – Distractible
S – Scattered

Surman, Bilkey & Weintraub, 2013
DSM-5 Inattention Symptoms Include Memory and Organization Deficits

of the following often apply:

• Easily distracted
• Careless mistakes
• Difficulty sustaining attention
• Poor listening
• Leaves tasks unfinished
• Avoids tasks requiring sustained attention
• Loses things
• Forgetful
• Difficulty organizing
DSM-5 Hyperactivity/Impulsivity Traits
Emphasize Internal Drive and Activity

5 of the following often apply:
• Fidgeting
• Inability to stay seated
• Moving excessively (restlessness)
• Difficulty doing quiet activities
• “On the go”
• Talks excessively
• Blurts out answers
• Difficulty awaiting turn
• Interrupting/intruding
## Diagnostic Differences Between DSM-IV and DSM-5 for Adult ADHD

<table>
<thead>
<tr>
<th>Impairments</th>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms that caused impairment were present before age 7 years</td>
<td>&quot;Several inattentive or hyperactive-impulsive symptoms were present prior to age 12&quot;</td>
<td></td>
</tr>
<tr>
<td>Some impairment in at least 2 settings&quot; before age 7</td>
<td>There is no longer the requirement that the symptoms create impairment by age 12</td>
<td></td>
</tr>
<tr>
<td>Clear evidence of clinically significant impairment in social, academic, or occupational functioning</td>
<td>&quot;Several inattentive or hyperactive-impulsive symptoms are present in 2 or more settings.&quot; &quot;Clear evidence that the symptoms interfere with or reduce the quality of social, academic, or occupational functioning.&quot;</td>
<td></td>
</tr>
</tbody>
</table>
Typical Concern in Simple ADHD

“I have trouble getting around to, sticking with and finishing things”
## Clinician Adult ADHD Symptoms and Role Impact Inventory Rating Sheet

<table>
<thead>
<tr>
<th>Inattentive Symptoms</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Age started</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty being accurate with details</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Difficulty sustaining attention</td>
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<tr>
<td>Difficulty listening in conversation</td>
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<td></td>
</tr>
<tr>
<td>Difficulty sticking to and finishing actions</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty organizing</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Putting off tasks requiring mental effort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often losing important items</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forgetfulness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often distracted by things in environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**# of moderate or severe inattentive symptoms:** ____

### Impulsive/Hyperactive Symptoms

| Fidgeting:                             |      |      |          |        |             |
| Restless:                             |      |      |          |        |             |
| Excessively in motion:                |      |      |          |        |             |
| Excessively loud:                     |      |      |          |        |             |
| Excessive internal drive:             |      |      |          |        |             |
| Talking excessively:                  |      |      |          |        |             |
| Speaking at the wrong time in conversation: |      |      |          |        |             |
| Difficulty waiting:                   |      |      |          |        |             |
| Intruding on others:                  |      |      |          |        |             |

**# of moderate or severe impulsive/hyperactive symptoms:** ____

List examples of how Inattentive symptoms impair role functioning:
- for personal daily tasks: __________
- work or school function: ________
- in relationships: ________

List examples of how Impulsive/Hyperactive symptoms impair role functioning:
- for personal daily tasks: __________
- work or school function: ________
- in relationships: ________

Developed by Craig B.H. Surman, MD
Clinical presentation of ADHD changes across development and is related to interplay among environmental demands, external supports available, and typical symptom trajectories.
A. Follow-Forward: Did Those With Childhood ADHD (N=61) Continue to Have Adult ADHD?

B. Follow-Back: Did Those With Adult ADHD (N=31) Have Childhood ADHD?
Understanding Variation in ADHD Impact

Relative deficit in ability to engage proactively leaves people vulnerable to external or internal distractions

“Salient” interesting and consequential things get done

Low-reward, mandatory activities will be done last minute or poorly
### Additional areas of concern impacting attention/cognitive function

<table>
<thead>
<tr>
<th>Differential Disorders</th>
<th>Example of common medical conditions to consider</th>
<th>Points on history/testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory problems</td>
<td>Sleep apnea</td>
<td>Clinical: Snoring, daytime fatigue, hypertension, headaches, polysomnography</td>
</tr>
<tr>
<td>Sleep disorders</td>
<td>Narcolepsy</td>
<td>Excessive daytime sleepiness, cataplexy, hypnagogic hallucination and sleep paralysis</td>
</tr>
<tr>
<td>Sensory deficits</td>
<td>Myopia, hearing impairment</td>
<td>Ophthalmology, audiology</td>
</tr>
<tr>
<td>Hormonal dysregulation</td>
<td>Thyroid</td>
<td>TSH</td>
</tr>
<tr>
<td>Metabolic disorder</td>
<td>Diabetes</td>
<td>Fasting glucose</td>
</tr>
<tr>
<td>Haematological disorder</td>
<td>Anaemia</td>
<td>CBC and differential</td>
</tr>
<tr>
<td>Substance abuse/dependence</td>
<td>Alcohol, cannabis or any illicit drug dependences</td>
<td>CAGE questionnaire (cut down, annoying, guilt, eye opening), urine toxicology</td>
</tr>
<tr>
<td>Neurological disorders</td>
<td>Concussion</td>
<td>History of trauma, headache, confusion, syncope</td>
</tr>
<tr>
<td>Other cognitive disorders</td>
<td>Learning disorder</td>
<td>Psychological testing/cognitive battery</td>
</tr>
<tr>
<td>Psychiatric disorders</td>
<td>Major depression</td>
<td>Depressed mood, anhedonia, worthlessness, suicidal ideation</td>
</tr>
<tr>
<td></td>
<td>Generalized anxiety</td>
<td>Continuous worries with somatic symptoms</td>
</tr>
<tr>
<td></td>
<td>Bipolar Disorder</td>
<td>Grandiosity, psychosis, periodicity</td>
</tr>
</tbody>
</table>
No ADHD without related Impairment

- Evaluate the burden of symptoms
  - Does it show up differently in roles or contexts?
  - Is it an effort to compensate for?
- Consider impairment relative to potential
  - How would individual function if symptoms resolved?
- Is there mismatch with role/environment?
  - Would change in role or environment remedy?
- Is concern exaggerated?
  - “workaholic”, “perfectionistic” or fearful expectations vs. a burden limiting ability to self-actualize/thrive
- Accommodate, don’t enhance
Typical Concern in Comorbid ADHD

“I do not feel or function like I used to”

“My feeling, thinking keeps me from thriving”
Other Mental Health Conditions are Common in Adult ADHD

Structured interview of 124 community ADHD adults

Comorbidity In National Epidemiologic Survey

Any mood disorder 38.3%

- Bipolar Disorder 19.4%
- Major Depression 18.6%
- Dysthymia 12.8%

Any anxiety disorder 47%
Separate Out Challenges By Patterns

“States” vs. “Traits”

- Egs of traits: ADHD, dyslexia, obsessiveness
- Egs of states: depression, hypomania, panic

Patterns of “Pseudo-ADHD”

- ? Impairment due to a state
  eg. depression, sleep impairment?
- ? Environmentally dependent impairment?
  eg. academic setting only; socially only
Differential Diagnosis example: Bipolar Disorder

- **Overlap:**
  
  Core symptoms: distractibility, motor hyperactivity, talkativeness

  Associated traits: irritability, low frustration tolerance

- **Differences (it is a mood disorder!):**
  
  Impairing mood, hypersexuality, impaired judgement, grandiosity

- **Similar rates in child and adult ADHD?**
  
Preoccupied/anxious Mental Style can look like, or be created by, ADHD

• Understand what preoccupies the patient + how often - is it a distraction source?

Key question: What is on your mind when your mind wanders?

• Obsessive/anxious thought may be secondary to ADHD
  - Self-awareness, concern / obsessive behavior may be compensatory – stress helps performance (to a point)
Guide Clients to Manage Primary or Secondary Anxiety:

Key questions:  Are you concerned or stressed for no reason? (eg. generalized anxiety)
Do you experience it physically? (eg. panic)
Do you avoid things? (eg. social, performance anxiety)
Do you relive or recall threats, day or night? (PTSD)

• Anxious ADHD children: lower impulsivity, worse inattention, poorer working memory
Self-Regulation ‘Executive’ Challenges Beyond the Core Symptoms of ADHD:

Control of Engagement across roles and over time

Typical Complaint:

“I don’t do the right things at the right time or keep healthy routines”

(Occurs in other disorders)
ADHD and the Demands of Development

• Early childhood
  – Requires simple responses, demands are limited, environment is structured

• Adulthood
  – Increased need for organization, prioritization, self-structuring and planning
  – Greater consequences from lack of structure in independent life
Executive Function Deficits (broad category of disorganization)

- **Neuropsychologically Defined:**
  - EFD in 31% of ADHD vs. 16% of non-ADHD
  - ADHD+EFD: lower education, occupation, and socioeconomic status than non-ADHD
  - Control+EFD more likely to have repeated a grade

- **Behaviorally defined**
  - eg. BRIEF-A, Barkley scales - more ecological

Biederman et al, Am J Psychiatry 2006
Sleep Dysfunction in 182 Adults with and 182 without ADHD

% reporting “Quite often” or “Often”

*p<0.01; Not accounted for by Axis I comorbidity

Surman et al, 2009
Exacerbation of Comorbidity: Lifetime Bulimia Nervosa in Two Female Cohorts

Surman et al, 2008

82 ADHD, 81 Control
42 ADHD, 110 Control
Deficient Emotional Self Regulation (DESR) Items

1. Quick to get angry or become upset
2. Easily Frustrated
3. Over-react emotionally
4. Easily excited by activities going on around me
5. Lose my temper
6. Argue with others
7. Am touchy or easily annoyed by others
8. Am angry or resentful

DESR in ADHD = > 95th percentile score of controls

Surman et al, American Journal Psychiatry, 2011
Study Subjects with DESR:

> 95\textsuperscript{th} %ile inventory item frequency

(p < 0.001 ADHD vs non-ADHD)

Surman et al, Amer Jour Psych 2011
**Rx effects on DESR Unclear**

**Atomoxetine**

n=529; 170 with WRAADS Emotional Dysregulation (ED)
ED improved to same extent as ADHD
ED predicted CAARS treatment response
(Reimherr et al, 2005)

**OROS-mph, double-blind placebo controlled studies**

1) n=41: 16 ADHD+ED
   25% had 50% lower WRAADS
   18 ADHD+ED+ODD
   50% “
   5 ADHD alone
   49% “
   (Reimherr et al, 2007)

2) n=87: No change in BRIEF-A Emotional subscale for “clinically improved” group (≥ 30% improved, CGI 1/2)
   (Biederman et al, 2007)

**Lisdexamfetamine trial**

- WRAADS + emotion effects not significant
  (Adler et al, 2013)
ADHD Medication Helps
Simple ADHD

“\text quote I have trouble getting around to, sticking with and finishing things”
Therapy, medication, self-help improves other aspects of mental health

“My feeling, thinking keeps me from thriving”
Strategies/Habits

Help Organizational Skill Challenges

“I don’t do the right things at the right time or keep healthy routines”
Pharmacological Treatment for Adult ADHD

Stimulants
- Methylphenidate
- Amphetamine compounds

First Line
Use Long Acting

Active substance use
? Helps anxiety?

ADHD + depression

Sleep disorder fatigue

Pediatric evidence, not studied in adults

*Off-label use.
Ideas to consider

• short term approach for state (eg depression), may be different than longer term approach for trait (eg ADHD, learning disability)

• subthreshold or comorbid presentations require more assessment – over time or by a team

• accommodate challenges tracking symptoms and keeping treatment goals in mind– discuss and add structure to the treatment plan
Ideas for Collaborative Optimization of ADHD Pharmacotherapy

• Consider discussing the extent to which individuals like them have been systematically studied
  – little research over age 55
  – little research on comorbidity
  – ADHD traits are primary outcome measure in studies – is that their primary concern?

• Many patients follow how they feel – rather than function: Discussing and tracking target ADHD symptoms may help

• Need for medication may change over time - particularly with maturation, change in priorities, or amount of accommodation
Useful Things to Know in optimizing Stimulant Treatments

• Side effects differ between agents & release patterns
  – ? Peak or valleys may create side effects

• Adult methylphenidate studies separated from placebo when dosing allowed > 1 mg/kg/day
  – Many patients benefit from higher than FDA limit dosing but little safety guidance

• Methylphenidate approx. 50% potency of amphetamine

• Taking breaks to overcome “tolerance” more appropriate than dose escalation
Some Signs ADHD Medication Is Not Appropriate or Optimized:

• Side effect burden
  – Sympathomimetic effects eg:
    >several point change in HR or BP
  – Physical discomfort
  – Sleep impairment (onset, lighter sleep)
  – Mood or personality change
    (moody, “irritable”, withdrawn, cognitive problems)

• Tolerance to effect
• Physiologic Dependence
  – Physically intolerant of cessation: eg. strong fatigue, mood effect
• Psychological Dependence
  – Irrational fear about lack of medication
  – “Can’t be myself” without medication
Clinical Presentations ADHD Rx May Exacerbate:

– Extreme states (psychosis, bipolar)
  • Stimulants, atomoxetine, ?others

– Seizure risk (eg. Bulimia Nervosa, Binge drinking)
  • bupropion

– Birth Control • Modafinil reduces levels

– Orthostatic vulnerability • Guanfacine, clonidine

– Tics or Tourette syndrome • Stimulants exacerbate

Cortese et al, J Child Psychol Psychiatry. 2013
Sympathetic Exacerbation by Atomoxetine, Stimulants

- Hypertension, Arrhythmia
  Small HR, BP effect typical, monitor for outliers, regularly.
- Urologic / sexual function
- Narrow Angle Glaucoma
- Poor Peripheral Circulation (eg. Reynaud's)
- MAOI-related hypertensive crisis
- Stress, vigilance (PTSD, anxiety)

Patient should consult treat on how to monitor for and minimize possible exacerbation

Limiting sympathomimetic burden (eg. caffeine, pseudoephedrine) may help
Other Specific ADHD Rx Concerns:

Atomoxetine:
- Black Box: Suicidal Thought/Action in Children + Teenagers
  • estimated 4/1000 from 2200 clinical cases
- Several reports severe liver injury – onset within 3-12 weeks

Stimulants, Atomoxetine:
- Reports of pediatric priapism (recent mph alert by FDA)

Modafanil
- life-threatening rash rate > background

FDA Medication Guide
livertox.nlm.nih.gov
FDA 2007
Change Prescription If:

• Has side effects on Rx or as wears off
• Is “not myself” in mood or personality
• Has dependence
  – (strong fatigue, personality change)
• Partial coverage

Good to know that:

• Side effects differ between agents & release patterns
• Nonstimulants can take several weeks to work
• Methylphenidate approx. 50% potency of amphetamine
• “Tolerance” is reported - may resolve with breaks from medicine
Common Elements of Behavioral Therapy for ADHD

– Target disorganization related to ADHD
  • Time + method of planning
  • Prioritization / Time management practice
  • Problem-solving practice (pro-con lists, generating alternatives)
  • Breaking task into steps

– Skills to reduce distractibility
  • “Out of sight out of mind”
  • Write down “popcorn” thoughts; In planner or ONE list
  • Right environment - eg. card table for effortful work

– Alter distracting automatic thoughts
  • Blame ADHD, not you; Rational vs. emotional thought patterns
  • Mantras: “Not getting started? First step is too big”

TAKES ACCOUNTABILITY AND REVIEW TO PRACTICE AND MAINTAIN HABITS

Eg. Safren et al, 2010; Group - Solanto et al, 2010Surman, Bilkey & Weintraub: FASTMINDS
### Critical Moment Planner

<table>
<thead>
<tr>
<th>Need to Address</th>
<th>Action to take</th>
<th>What days should you act?</th>
<th>6 a.m.</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>Noon</th>
<th>1 p.m.</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep</td>
<td>Start getting ready for bed</td>
<td>Every day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*</td>
<td></td>
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</tr>
<tr>
<td>Healthy Eating</td>
<td>4 small meals</td>
<td>Every day</td>
<td></td>
<td></td>
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<td>*</td>
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</tr>
<tr>
<td>Exercise</td>
<td>Prepare Gym Bag</td>
<td>Tuesday, Thursday, Saturday</td>
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</tbody>
</table>

Surman, Bilkey & Weintraub: FASTMINDS, 2013
Accommodations

Standard School Accommodations
- Copy of class notes, extra time and quiet for tests

Create structure:
- use natural accountability (group work; mentoring; reward schedules)
- stimulation (adapt work to interests)
- reminder systems (calendars with alarms)

Match optimal work style and pattern
- sedentary vs. on the road, breaks, variety of projects

Outsource to “peripheral brains” - devices + people
- planning, prioritization, decisions
- schedule management
- capturing information (eg. recording pens; alarms to head for class)
Assessment & Treatment Priorities

Alcohol and substance abuse
Mood disorders
Bipolar and MDD
Anxiety disorders
Obsessive-compulsive disorder, generalized anxiety disorder, panic
ADHD

Order of treatment also considers the severity of the concurrent disorders.

Evaluate Opportunity Cost of Rx vs. no Rx

Unclear Diagnosis
Hx of agitation
Hx of sub use disorder
Sympathetic vulnerability
Subpopulation specific risk
Misuse/ diversion
Lack of outcome measure

Clear Diagnosis
No comorbid history
Typical effects
Medically healthy agenda
Clear adaptive improvement
Clear outcome measure
Do No Harm: ADHD & SUD

- Prioritize SUD over ADHD – 12 step programs; CBT; motivational interviewing
- SUD helps people not tell the truth to themselves, let alone you - third party reports and team treatment may identify unhealthy relationships with substances
- Consider if risk of treating outweighs predictable benefit
- Tapering off medicine once or twice a year intermittently is a good way to re-evaluate ongoing need
- Taking 1-2 day breaks on weekends is preferable to me to increasing dose to chase reduced effect
- Ideal SUD patient for ADHD mgmt:
  - robust narrative of ADHD impairment
  - solidly in early recovery; no past misuse of stimulants
  - seeking treatment for healthy reasons
Misuse & Abuse of Stimulants

• Can’t predict who will misuse stimulants, or develop addiction – other than prior substance use disorder

• Nonprescribed use: much more common than it used to be – normative or warning sign for bad Rx outcome?

• Treating children with ADHD may reduce or leave unchanged the risk of SUD in adolescence – risk may resurge by adulthood

• Little ADHD symptom reduction with prescriptions during treatment in presence of SUD Motivational interviewing and CBT for SUD may have higher utility than ADHD txt. See Zulauf et al et al. Curr Psych Reports, 2014
Consider Tolerance and Dependence

• Tolerance and dependence occur on stimulants

• Signs of possible tolerance or dependence:
  – Dose escalation over time
  – Taking breaks to keep effect

• Signs of dependence
  – Fatigue, personality change, other impairment on stopping medication
  – “I am not myself when I am off the medication”

• Patients can end up “trapped” by dependence or addiction on stimulants that are not helping them
Clinical Presentation, Diagnosis and Treatment of Attention-Deficit Hyperactivity Disorder (ADHD) in Older Adults: A Review of the Evidence and its Implications for Clinical Care

David W. Goodman\textsuperscript{1,2,3} · Sara Mitchell\textsuperscript{4} · Lauren Rhodewalt\textsuperscript{5} · Craig B. H. Surman\textsuperscript{5,6}

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**Abstract** Although previously considered a disorder of childhood, studies in the last decade have demonstrated that attention-deficit hyperactivity disorder (ADHD) continues to impair function into adulthood and responds to pharmacotherapy. Due to age-specific changes in roles and challenges, it is possible that presentation and response to intervention may differ between older and younger adults. A literature search for papers that identified older adults with ADHD, including papers describing its epidemiology, manifestation, and treatment, was the basis for this paper. There is a paucity of data on ADHD in older adults; however, small observational studies have characterized the presence, impact, and treatment of ADHD in adults over the age of 50 years, and larger epidemiologic studies have demonstrated that ADHD symptoms exist in older adulthood. Optimal criteria for diagnosis of ADHD and methods of treating ADHD in older individuals have not been systematically explored. In light of the limited data, this review discusses considerations for differential diagnosis and safe pharmacotherapy of ADHD in older adults.

**Key Points**

- Attention-deficit hyperactivity disorder (ADHD) is a chronic neuropsychiatric disorder that may impact 3% of older adults.

- While diagnostic assessment of adult ADHD has been recently refined, the symptom definitions may need to be modified for use in older adults.

- Diagnosis in older adults requires identification of past and current symptoms, and differential diagnosis should include other neuropsychiatric conditions.
Healthy Management

Systematically diagnose
Systematically evaluate risk / benefit of txt
Establish a mutual health-oriented agenda
  your office can sustain
Guide clients to personalized pathways compensate for ADHD:
  • Low-risk medical management
  • Adaptive compensatory skill development
  • Accommodating, nurturing environments
Some Resources

For consumers:

CADDAC.ca

CHADD.org and National Resource Center

ADD.org

For professionals:

APSARD.com

CADDRA.ca
Treatment Planning

For Core ADHD Symptoms: list medication options that could improve core ADHD symptoms (new agent, dose change, cover longer duration)

For Improved Organization: List critical situations where better habits (decisions or actions) can be practiced (e.g., taking time to prioritize/plan; more reliance on others or electronic devices; using reminders; isolating from lower priority distractions).

For Adherence: List what will ensure practice of the treatment plan. Consider factors in past success (e.g., deadlines, reminders, tracking, involving others, other accountability).

For Environmental Accommodation: List accommodations, e.g.: for weaknesses (e.g., extra time to check work, recording meetings/class); to make tasks more engageable (e.g., clearer steps/goals, better match to interests); for accountability (e.g., involving others, deadlines); for work space (lower distraction).
Thank you!

www.DrSurman.com

csurman@partners.org